North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

Please visit our website at www.dhhs.state.nc.us/dma.

May **2006**

Attention:

All Providers of Enhanced Benefit Mental Health/Substance Abuse Services

Note: Outpatient, inpatient, PRTF and residential services for children are not addressed in this document in detail.

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

Please refer to the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/MentalHealthlink.htm for the complete definition of each service including all of the specific requirements, limitations, and provider qualifications. The September 2005 and January 2006 Enhanced Benefit Mental Health Bulletin Phase I and Phase II is replaced with the May 2006 Special bulletin.

Provider Enrollment

Providers must be endorsed by the local management entity (LME) for each service before enrolling as a Medicaid provider. Information about the endorsement process can be found in Communication Bulletin #44 on the Division of Mental Health, Developmental Disability, and Substance Abuse Services (DMH/DD/SAS) website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.

After endorsement, providers must complete and sign a Medicaid provider enrollment application and agreement. The application and instructions are available on DMA's website at http://www.dhhs.state.nc.us/dma/MentalHealthlink.htm. The completed application and all attachments (including your endorsement letter) must be mailed to:

DMA Provider Services
Attn: Mental Health Enrollment Specialist
2501 Mail Service Center
Raleigh, NC 27699-2501

Please remember to complete and attach postage to the application acknowledgement card if you wish to be notified that DMA has received your application.

Once the application is approved, the provider will be issued a core Medicaid provider number to use as the billing provider number. As the provider enrolls for each service they wish to provide, they will be issued an additional service specific attending provider number, which is the core number with an alpha suffix.

Note: For each service providers wish to provide, they must be endorsed and enrolled to receive reimbursement. Each of the 22 enhanced mental health/substance abuse services require a separate endorsement and alpha suffix to be added to the core billing provider number.

The following table outlines each service and the alpha suffix that will be assigned as providers are endorsed and enrolled for a particular service.

Alpha Character	Service
B	Community Supports – Adults (Individual and Group)
B	Community Supports – Child (Individual and Group)
B	Community Support Treatment Team (CST)
A	Assertive Community Treatment Team (ACTT)
R	Child and Adolescent Day Treatment
G	Diagnostic Assessment
H	Intensive In-Home Services
F	Mobile Crisis Management
I	Multisystemic Therapy (MST)
D	Partial Hospitalization

C	Professional Treatment Services in Facility-Based Crisis Programs
S	Psychosocial Rehabilitation
Alpha Character	**Service**
P	Substance Abuse Comprehensive Outpatient Treatment
Q	Substance Abuse Intensive Outpatient Program
O	Substance Abuse Medically Monitored Residential Treatment
N	Substance Abuse Non-Medical Community Residential Treatment
L	Ambulatory Detoxification
U	Medically Supervised or ADATC Detoxification/Crisis Stabilization
M	Non-Hospital Medical Detoxification
T	Outpatient Opioid Treatment

Eligible Recipients

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for the enhanced mental health/substance abuse services.

EPSDT Special Provision: Exceptions to Limitations in Policy for Recipients Under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under 21 years of age with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. While there is no requirement that the service, product, or procedure be included in the State Medicaid Plan, the service, product, or procedure must be listed in the Social Security Act (the Act) at 1905(a). It should be noted that the Act does not require a state Medicaid agency to provide any service, product, or procedure that it determines to be unsafe, ineffective, or experimental.

Service limitations on scope, amount, duration, and/or frequency described in clinical coverage policies may be exceeded provided documentation supports it is medically necessary to exceed policy limitations in order to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. In accordance with EPSDT requirements, health care services shall be provided in a frequency and amount to reasonably achieve their purpose and shall be consistent with the recipient's medical needs.

When providing services to a recipient under 21 years of age, it is important to consider the following:

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

2. Requests to exceed established limitations in clinical coverage policies must be submitted to the appropriate fiscal agent along with documentation that supports it is medically necessary to exceed policy limitations in order to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening.

3. If the recipient needs a service not covered by the North Carolina State Medicaid Plan, the physician or other licensed clinician must submit a request for the non-covered state Medicaid Plan service on behalf of the recipient to:

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

919.715.7679 FAX

4. The federal listing of Medicaid covered services may be found in the Social Security Act at 1905(a). Additionally, this listing is appended to the DMA EPSDT Policy Instructions.

For additional information about EPSDT, please review the resources identified below.

- DMA EPSDT Policy Instructions published January 28, 2005
  http://www.dhhs.state.nc.us/dma/epsdt_policy.pdf

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

Service Definitions

1. Community Supports – Adult – H0036 HB (Individual) H0036 HQ (Group)

This service is available to adults and is the clinical home for the adult. The interventions include preventive and therapeutic activities that assist with skill building, development of a person centered plan (PCP), relational skills, symptom monitoring, therapeutic mentoring, and case management functions of arranging, linking, referral to services, and monitoring of the provision of the services. The providers of this service also serve as a first responder in a crisis situation.

The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner prior to or on the day that the services are to be provided. The Community Support provider organization will be allowed an initial 30 days in which the Diagnostic Assessment and PCP will be completed. Subsequent authorizations will be required by the statewide vendor. The Community Support provider organization will be identified in the PCP.

Provider and Staffing Requirements

The service is provided as an agency based service with qualified professionals, paraprofessionals, and associate professionals who must have 20 hours of training within the first 90 days of employment specific to the requirements of the service definition. The provider qualifications for the associate professional, paraprofessional, and qualified professional are listed in 10A NCAC 27G.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive Community Support services from only one Community Support provider organization at a time. Community Support Services (individual and/or group) can only be billed 32 units per date of service.

Community Support services can only be billed a maximum of eight units per calendar month for individuals receiving any of the following services in the same calendar month:

H0035 - Partial Hospitalization
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)
H0012 HB - Substance Abuse Non-Medical Community Residential Treatment
H0040 - Assertive Community Treatment Team
H0013 - Substance Abuse Medically-Monitored Community Residential Treatment
H0010 - Non-Hospital Medical Detoxification

This service will be billed in 15 minute increments.

This service will not be subject to Third Party Commercial Insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character B appended to the service specific attending number.

Community Support Group services cannot be billed for individuals receiving any of the following services on the same date of service:
H0040 – Assertive Community Treatment Team
H2012 HA – Child and Adolescent Day Treatment
H2022 – Intensive In-Home
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically-Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/ Crisis Stabilization
H0035 – Partial Hospitalization
H2017 – Psychosocial Rehabilitation (This refers to H0036 HQ only.)
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem

This service will be billed in 15 minute increments.

This service will not be subject to Third Party Commercial Insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character B appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

2. Community Supports – Child –H0036 HA (Individual) H0036 HQ (Group)

This service is available to children ages three through 20 and is the clinical home for the child. The interventions include training of the caregiver, preventative and therapeutic activities that will assist with skill building, development of a PCP, relational skills, symptom monitoring, therapeutic mentoring, and case management functions of arranging, linking, referring to services, and monitoring of the provision of services.

The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner. The providers of this service also serve as a first responder in a crisis situation. The Community Support provider organization will be allowed an initial 30 days in which the Diagnostic Assessment and PCP will be completed. Subsequent authorizations will be required by the statewide vendor. The Community Support provider will be identified in the PCP.

Provider and Staffing Requirements

This service is also provided as an agency based service with qualified professionals, paraprofessionals, and associate professionals who must have 20 hours of training within the first 90 days of employment specific to the requirements of the service definition. The provider qualifications for the associate professional, paraprofessional, and qualified professional are listed in 10A NCAC 27G.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive Community Support services from only one Community Support provider organization at a time. Community Support Services (individual and/or group) can only be billed 32 units per date of service.

Community Support services can only be billed a maximum of 8 units per month for individuals receiving any of the following services:
H2022 – Intensive In-Home
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2012 HA – Child and Adolescent Day Treatment
H0035 – Partial Hospital
H2020 – Therapeutic Behavioral Services – per diem
H0019 – Behavioral Health – Long Term Residential

This service will be billed in 15 minute increments.

This service will not be subject to Third Party Commercial Insurance or Medicare.

This service will not be subject to a copayment.

This service is billed with the alpha character B appended to the service specific attending number.
Community Support Group services cannot be billed for individuals receiving any of the following services:
H2022 – Intensive In-Home
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically-Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/ Crisis Stabilization
H0035 – Partial Hospitalization
H2017 – Psychosocial Rehabilitation
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem

This service will be billed in 15 minute increments.

This service will not be subject to Third Party Commercial Insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character B appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

3. Community Support Teams (CST) – Adult – H2015 HT

Services provided by this team consist of mental health and substance abuse services and supports necessary to assist adults (**18 and older**) in achieving rehabilitation and recovery goals. It assists individuals to gain access to necessary services; reduce psychiatric and addiction symptoms; and develop optimal community living skills. The services include assistance and support to individuals in a crisis situation; service coordination; psycho-education and support for individuals and their families; independent living skills; development of symptom monitoring and management skills; monitoring medications and self-medication. The CST provider assumes the role of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient. A service order for CST must be completed by physician, licensed psychologist, physician's assistant or nurse practitioner. Prior approval will be required by the statewide vendor.

Provider and Staffing Requirements

A CST team is comprised of three staff persons, one of whom is the team leader and must be a qualified professional. The other two may be a qualified professional, an associate professional or a paraprofessional (according to the requirements listed in 10A NCAC 27G), or a certified peer

specialist. The team maintains a consumer to practitioner ratio of no more than fifteen consumers per staff person. All staff providing this service must have a minimum of one year documented experience with the adult population and completion of a minimum of 20 hours of crisis management and community support team service within the first 90 days of hire.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive Community Support services from only one Community Support services provider organization at a time.

Community Support Team services can only be billed a maximum of 8 units per month for individuals receiving any of the following services:
H0036 HA – Community Support Services – Child
H0036 HB – Community Support Services – Adult
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H0012 HB - Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification
H0035 – Partial Hospital

Community Support Team services cannot be billed for individuals receiving any of the following services:
H0040 – Assertive Community Treatment Team
H2017 – Psychosocial Rehabilitation

This service will be billed in 15 minute increments. This service cannot be billed more than 32 units per date of service, unless billed with one of the above services.

This service will not be subject to Third Party Commercial Insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character B appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

4. Assertive Community Treatment Team (ACTT) – H0040

This existing service is provided by a multidisciplinary team to recipients ages 21 years and older when it has been determined that the needs are so pervasive and/or unpredictable that they cannot

be met by a combination of other services. The team provides evaluation (an assessment to determine the extent of the problems), outpatient treatment, case management, and community based services (described below) for individuals with mental illness. Priority is given to adults with schizophrenia, other psychotic disorders, and bipolar disorder. Individuals with a primary diagnosis of substance abuse disorder or mental retardation are not the intended recipient group. These are all bundled into therapeutic interventions and include crisis response as the first responder. It is available 24/7/365, in any location (except jails, detention centers, clinic settings, and hospital inpatient settings) and the recipient to staff ratio is 10 to 1. The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the statewide vendor.

Provider and Staffing Requirements

Minimum staff per team to meet the 10 to 1 staff to consumer ratio includes a team leader who must be a master's level qualified professional, a registered nurse, two additional clinical staff, and a paraprofessional staff or a certified peer specialist, for teams that serve approximately 100 individuals(not counting physician time). This is consistent with staffing requirements specified in the service staff composition in the service definition. For smaller teams serving no more than 50 individuals, minimum staff to meet a minimum of 6-8 FTE multidisciplinary clinical staff including one team leader, one registered nurse and one FTE peer specialist. There must be a minimum of 16 hours per week of physician time for every 50 clients in both scenarios. The team is employed by an agency that has contracted with the LME to provide this service.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive ACTT services from only one ACTT provider organization at a time. The must be a minimum of four face-to-face contacts per month by any member of the team (this is billed per diem but the system is set so it will not reimburse for more than four in one month). The service is intended to provide support and guidance in all areas of functional domains to enhance the recipient's ability to remain in the community.

ACTT services cannot be billed for individuals receiving any of the following services on the same date of service:
H0036 HQ – Community Support Services - Group
H0001 – Alcohol and/or Drug Assessment
H0004 – Behavioral Health Counseling and Therapy, per 15 minutes
H0015 – Substance Abuse Intensive Outpatient Program
H0031 – Mental Health Assessment, by non-physician
T1017 HI – Targeted Case Management
H2015 HT – Community Support Teams (CST)
H2011 – Mobile Crisis
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0014 – Ambulatory Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H0035 – Partial Hospital

S9484 – Professional Treatment Services in Facility-Based Crisis Programs
H2017 – Psychosocial Rehabilitation
H0036 HQ – Community Support Services - Group

This service is billed on per event with a maximum of four events per month.

This service is not subject to Third Party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character A appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

5. Child and Adolescent Day Treatment – H2012 HA

This service is available for children ages 3 through age 20 and includes therapeutic or rehabilitation goals of the consumer in a structured setting. This is an existing service that has been modified to increase provider qualifications, require additional training for providers, and to require prior authorization. The interventions are outlined in the child/adolescent PCP and include behavioral interventions, social and other skill development, enhancement of communication, problem-solving skills, anger management, monitoring of psychiatric symptoms, and psycho-educational activities. These interventions are designed to support symptom stability, to increase the recipient's ability to cope and relate to others, and to enhance the highest level of functioning possible. The service also contains a case management component with assessment, monitoring, linking to services, and coordination of care. This service must be available in a licensed program at least three hours a day at a minimum of two days a week. An order by a physician, PHD, nurse practitioner or physician's assistant for the service is required and prior authorization is required by the statewide vendor.

Provider and Staffing Requirements

All services in the milieu are provided by a team that whose members must meet the qualified professional, associate professionals, and paraprofessionals requirements (according to 10A NCAC 27G). Programs serving children with substance abuse disorders must have a certified clinical supervisor, licensed clinical addiction specialist, or certified substance abuse counselor providing services.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service can only be provided by one day treatment provider at a time and cannot be billed in the same day as any inpatient, residential or any other intensive service.

The following services cannot be billed on the same day as Child and Adolescent Day Treatment:
H0036 HQ – Community Support Services - Group
H2022 – Intensive In-Home
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H0035 – Partial Hospital
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic behavioral Services, per diem
RC911 – Behavioral Health Treatment Services – Rehabilitation
Any inpatient hospital claim

This service will be billed in one hour increments and cannot be billed more than six hours per date of service.

This service will not be subject to Third Party commercial insurance or Medicare.

This service will not be subject to a copayment.

This service is billed with the alpha character R appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

6. Diagnostic Assessment – T1023

This is an intensive clinical face-to-face evaluation of a recipient's mental health/developmental disability/substance abuse condition that will act as a determining factor for the enhanced benefit package of services. This diagnostic/assessment report includes an order for the Enhanced Benefit services that provides the basis for the development of the PCP.

Provider and Staffing Requirements

The assessment must be signed and dated by the physician, a doctor of osteopathy, physician's assistant, nurse practitioner or licensed psychologist and will serve as the initial order for the services included in the PCP.

The diagnostic assessment team must include at least two qualified professionals (according to the requirement listed in 10A NCAC 27G), both of whom are licensed or certified clinicians. For substance abuse-focused diagnostic/assessment, the team must include a certified clinical supervisor or licensed clinical addition specialist. For developmental disabilities, the team must include a master's level professional with at least two years experience with developmental disabilities. One of the team members must be a qualified practitioner whose professional licensure

authorizes the practitioner to diagnose mental illnesses and/or addictive disorders. One of the team members must be a physician, a doctor of osteopathy, physician's assistant, nurse practitioner or licensed psychologist.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

A recipient may receive one diagnostic assessment per year. Order requirements for additional services added after the development of the initial PCP are specific to the service that is being added. Refer to DMA's website http://www.dhhs.state.nc.us/dma/mentalhealthlink.htm for a copy of the service definitions. If psychological testing or specialized assessments are indicated, they are to be billed separately using CPT codes 96100, 96110, 96111, 96115, or 96117.

This service is billed per event, which is defined as a complete assessment from two different disciplines as defined above.

This service is provided to recipients ages three and older.

This service can be billed by only one Diagnostic Assessment team at one time.

This service is subject to both Third Party commercial insurance and Medicare.

This service is subject to a $3.00 copayment.

This service is billed with the alpha character G appended to the service specific attending number.

7. Intensive In-Home Services – H2022

This is a time-limited service that can be provided to recipients ages 3 through 20 to diffuse current crisis, intervene to reduce the likelihood of re-occurrence, ensure linkage to community services and resources, monitor and manage presenting psychiatric and/or addictions symptoms, and provide skills trainings and other rehabilitative supports to prevent out of home placement for the child.

The service requires a minimum of 12 face to face contacts the first month with the contact being defined as all visits within a 24 hour period. A minimum of two hours of service must be provided before the service is billable.

The number of visits per month for the second and third month of the service will be titrated with the expectation of six visits per month. There are limitations on the provisions of other services to prevent duplication of service. This service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner prior to or on the day that the services are to be provided. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

This is a team service provided by qualified professionals, associate professionals, and paraprofessionals according to the requirements listed in 10A NCAC 27 G. There is a team to

family ratio to keep caseload manageable. Staff must have a minimum of one year documented experience with this population and must complete the intensive in-home training with in the first 90 days of employment.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive intensive in-home services from only one intensive in-home provider organization at a time. Services are provided in the home or community and are not billable for children in detention or inpatient settings. This service is not delivered in a group setting.

The following services cannot be billed on the same date of service as Intensive In-Home:
H0036 HQ – Community Support Services - Group
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program
H2012 HA – Child and Adolescent Day Treatment
H0035 – Partial Hospital
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Health Services – per diem
RC911 – Behavioral Health Treatment Services - Rehabilitation

This service is billed on a per diem basis.

This service is not subject to Third party commercial insurance or Medicare.

This service will not be subject to a copayment.

This service is billed with the alpha character H appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

8. Mobile Crisis Management – H2011

This involves all supports, services, and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. It is available 27/7/365 and provides immediate evaluation, triage, and access to acute mental health, developmental disability, and substance abuse services, treatment, and supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for stabilization. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

It is provided by a team that includes qualified professionals according to the requirements listed in 10 A NCAC 27G and who must be either a nurse, a clinical social worker or psychologist as defined by this administrative code. Teams include substance abuse professionals, developmental disabilities professionals, and a board-certified or eligible psychiatrist must be available for face-to-face or phone consultation to crisis staff.

Paraprofessionals with crisis management experience may also be included on the team but must work under the supervision of a professional. Experience with the population is required and 20 hours of crisis intervention training within the first 90 days of employment is necessary.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service has a limitation; however, the nature of the service requires stabilization or movement into an environment that can stabilize so it is not a termination of service. The maximum length of the service is 24 hours per episode and prior authorization is required after the first two hours for the remaining 22 hours. Mobile Crisis Management should be used to divert individuals from inpatient psychiatric and detoxification services. These services cannot be used as "step down" services from inpatient hospitalization.

This service will be billed in 15 minute increments. A maximum of 96 units may be billed within any two consecutive days.

The following services cannot be billed on the date of service as Mobile Crisis:
H0040 – Assertive Community Treatment Team (ACTT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification
H0035 – Partial Hospital
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem
RC911 – Behavioral Health Treatment Services - Rehabilitation

This service is subject to Third party commercial insurance and Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character F appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

9. Multi-systemic Therapy (MST) – H2033

This program is designed for youth between the ages of **seven and 17** who have antisocial, aggressive/violent behaviors and are at risk for out-of-home placement due to delinquency; adjudicated youth returning from out-of-home placement and/or chronic or violent juvenile offenders; and youths with serious emotional disturbances or abusing substances. This is a team services that has the ability to provide service 24/7/365. The services include assessment, individual therapeutic interventions with the youth and family, case management, crisis stabilization, and respite. Specialized therapeutic interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner prior to or on the day that the services are to be provided. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

The provider qualifications are, at a minimum, a master's level qualified professional team supervisor and three qualified professional staff (according to the requirements listed in 10A NCAC 27G). Staff is required to participate in Multi-systemic Therapy introductory training and quarterly training on topics related to the needs of Multi-systemic Therapy youth and their family on an ongoing basis. All Multi-systemic Therapy staff shall receive a minimum of one hour of group supervision and duplication of services. Multi-systemic Therapy team member to family ratio shall not exceed one to five for each member.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive Multi-systemic Therapy services from only one Multi-systemic Therapy provider organization at a time. A minimum of 12 contacts are required within the first month of the service and for the next two months an average of six contacts per month must occur. It is the expectation that service frequency will be titrated over the last two months.

This service will be billed in 15 minute increments. Providers may bill a maximum of 32 units per day but should not exceed 480 units in a three month period.

The following services should not be billed on the same date of service as Multi-systemic Therapy:
H0036 HQ – Community Support Services - Group
H2022 – Intensive In-Home
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification
H0035 – Partial Hospital
H2012 HA – Child and Adolescent Day Treatment

H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem
RC911 – Behavioral Health Treatment Services - Rehabilitation

This service is not subject to Third party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character I appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

10. Partial Hospitalization – H0035

This is a service for children and adults (ages three and older) that is used as an interim treatment for the prevention of an acute hospitalization or as a step down from an acute hospitalization. Therapeutic approaches may include: individual/group therapies that increase the individual's ability to relate to others, community living skills/training, coping skills, and medical services. The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner prior to or on the day that the services are provided. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

All services in the partial hospitalization are provided by a team, which may have a the following configuration: social workers, psychologists, therapists, case managers, or other mental health/substance abuse paraprofessional staff. A physician must participate in diagnosis, treatment, planning, and admission/discharge decisions.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service is also used for special treatment programs (i.e., eating disorders program). The current program for children and adolescents is located in a hospital setting and staffed according to JCAHO requirements.

This service will be billed on a per diem basis.

The following services should not be billed on the same date of service as Partial Hospital:
H0040 – Assertive Community Treatment Team (ACTT)
H0036 HA – Community Support Services - Child

H0036 HB – Community Support Services - Adult
H0036 HQ – Community Support Services - Group
H2011 – Mobile Crisis
H2022 – Intensive In-Home
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H2012 HA – Child and Adolescent Day Treatment
S9484 – Professional Treatment Services in Facility-Based Crisis Programs
H2017 – Psychosocial Rehabilitation
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem
Any inpatient hospital setting

This service is subject Third Party commercial insurance and Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character D appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

11. Professional Treatment Services in Facility-Based Crisis Programs – Adults – S9484

This existing service serves as an alternative to hospitalization for adults (age 21 and older) who have mental illness/developmental disability/substance abuse disorder. It is a 24 hour residential facility that provides support and crisis services in a community setting. The services are provided under the supervision of a physician with interventions implemented under the physician direction. The purpose is to implement intensive treatment, behavioral management, interventions or detoxification protocols to stabilize the immediate problems and to ensure the safety of the individual. It is offered seven days/week and must be provided in a licensed facility. Medicaid does not reimburse for room and board. Prior approval is required by the statewide vendor at the end of eight hours if additional hours are needed.

Provider and Staffing Requirements

At no time will the staff to recipient ratio be less than one to six for adult mental health recipients and one to nine for substance abuse recipients.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This is a short-term service that does not exceed 15 days. This service cannot be billed for more than a total of 30 days in a 12 month period.

This service is billed on an hourly basis and cannot exceed 16 units each day.

The following services cannot be billed on the same date of service as Professional Treatment Services in Facility-Based Crisis Programs:
H0040 – Assertive Community Treatment Team
H0035 – Partial Hospital
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H2012 HA – Child and Adolescent Day Treatment
H2017 – Psychosocial Rehabilitation
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem
H0046 – Mental Health Services (not otherwise specified)
S5145 – Foster Care Therapeutic – Child – per diem
RC911 – Behavioral Health Treatment Services - Rehabilitation

This service is subject to Third Party commercial insurance and Medicare.

This is service is not subject to a copayment.

This service is billed with the alpha character C appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

12. Psychosocial Rehabilitation – H2017

This service provides skill development activities, life skills development to support educational progress, and pre-vocational training to adults (ages 21 and older) who have serious mental illness or severe and persistent mental illness. It is available for a period of five or more hours per day at least five days per week and it may be provided on weekends or in the evening. The interventions must be included in the PCP and may be any of the following: behavioral interventions/management, social and other sill development, adaptive skill training, enhancement of communication and problem solving skills, anger management, family support, medication

monitoring, monitoring of changes in psychiatric symptoms or functioning, and positive reinforcement. It is provided in a licensed facility with staff to recipient ratio of one to eight. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the statewide vendor.

Provider and Staffing Requirements

Psychosocial rehabilitation services must be delivered by a mental health provider organization that meets the provider qualifications established by DMH/DD/SAS and the requirements listed in 10A NCAC 27G.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

An individual can receive psychosocial rehabilitation services from only one psychosocial rehabilitation provider organization at a time. Psychosocial rehabilitation is a service that shall be available 5 hours per day minimally and the setting shall meet the licensure requirements of 10A NCAC 27G.1200. The amount, duration, and frequency of services must be included in the individual PCP and authorized on or before the day services are to be provided.

Initial authorization for services must not exceed a six month period.

This service will be billed in 15 minute increments. Providers may bill a maximum of 32 units per day.

The following services cannot be billed on the same date of service as Psychosocial Rehabilitation:
H0040 – Assertive Community Treatment Team
H0036 HQ – Community Support Services - Group
H2015 HT – Community Support Services - Team
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H0035 – Partial Hospital
S9484 – Professional Treatment Services in Facility-Based Crisis Programs

This service is not subject to Third Party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character S appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

13. Substance Abuse Comprehensive Outpatient Treatment (SACOT) – H2035

This is a periodic service that is a time-limited, multifaceted service approach for adults (ages 21 and older) who require structure and support to achieve and sustain recovery. It emphasizes reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse and development of support network necessary to support necessary life style changes, and the continued commitment to recovery. The individual components of the services include individual and group counseling, family counseling and support, biochemical assays to identify drug use, strategies for relapse prevention, life skills, crisis contingency planning, disease management, and treatment support for recipients with physical disabilities or co-occurring disorders. Recipients must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring disorder. Prior approval is required by the statewide vendor and medical necessity is imbedded in the definition.

The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. It must operate at least 20 hours per week and offer a minimum of four hours of scheduled services per day with availability of at least five days per week with no more than a two-day lapse between the services. Recipient must be in attendance for a minimum of four hours per day in order to bill for the service.

Provider and Staffing Requirements

Staff must meet the requirements for certified clinical supervisor, licensed clinical addiction specialist and certified substance abuse counselor or a qualified professional or associate professional (according to the requirements listed in 10A NCAC 27G). Paraprofessionals can provide services if under the supervision of the certified clinical supervisor or, licensed clinical addiction specialist but not in lieu of a qualified professional position.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service will be billed on a per hour basis. Service must be billed 4 units per day.

The following services cannot be billed on the same date of service as Substance Abuse Comprehensive Outpatient Treatment:
H0040 – Assertive Community Treatment Team
H0036 HQ – Community Support Services - Group
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification

H0035 – Partial Hospital

This service is subject to Third Party commercial insurance and Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character P appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

14. Substance Abuse Intensive Outpatient Program (SAIOP) – H0015

This service provides motivational enhancement and engagement strategies, random alcohol/drug testing, and strategies for relapse prevention to include community and/or other strategies for relapse preventions. Therapies include individual, group and family counseling and support, crisis contingency planning, and disease management.

The service must be available for a minimum of three hours per day, operated out of a licensed substance abuse facility, and can be provided in a variety of settings. Service must be available a minimum of three days per week for a maximum of 19 hours per week with no more than a two-day lapse between services. The maximum face-to-face ratio is an average of not more than 12 recipients to one direct service staff based on average daily attendance. The recipient must in attendance for a minimum of three hours per day in order to bill for the service. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

This service can only be provided by qualified substance abuse professional staff with the following licenses or certifications: Licensed psychological associates (LPA), licensed professional counselors (LPC), licensed clinical social workers (LCSW), certified substance abuse counselors (CSAC), licensed clinical addiction specialists (LCAS), and certified clinical supervisor (CCS). Qualified professional (QP), associate professional (AP), or a paraprofessional with substance abuse (SA) experience may also provide services if they are under the supervision of certified clinical supervisor or licensed clinical addiction specialists. The program must be under the clinical supervision of a certified clinical supervisor or licensed clinical addiction specialist who is onsite a minimum of 50 percent of the hours of operation.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

The amount, duration, and frequency of services must be included in the individual PCP and authorized on or before the day services are to be provided. The initial authorization for services must not exceed 12 weeks. Under exceptional circumstances, one additional reauthorization for up to 2 weeks can be approved.

This service will be billed on a per diem basis.

The following services cannot be billed on the same date of service as Substance Abuse Intensive Outpatient Program:
H0040 – Assertive Community Treatment Team
H0036 HQ – Community Support Services - Group
H2022 – Intensive In-Home
H2033 – Multi-systemic Therapy
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H2012 HA – Child and Adolescent Day Treatment
H0035 – Partial Hospital
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem
RC911 – Behavioral Health Treatment Services - Rehabilitation

This service is not subject to Third Party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character Q appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

15. Substance Abuse Medically Monitored Residential Treatment – H0013

This is a non-hospital medically monitored facility with fewer than 16 beds that provides 24-hour medical/nursing monitoring. It also includes a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for adults with alcohol and other drug problems/addictions. Medicaid does not pay room and board. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

Staff requirements are certified clinical supervisor, licensed clinical addiction specialist, certified substance abuse counselor, qualified professional, associate professional, and paraprofessional (according to the requirements listed in 10A NCAC 27G) with training

and expertise with this population. The program is under the supervision of a certified clinical supervisor or a licensed clinical addiction specialist who is onsite a minimum of eight hours per day and available 24 hours per day by phone. A registered nurse must be available to conduct nursing assessments upon admission and oversee monitoring of progress and medication administration on an hourly basis. A physician must be available 24 hours per day by telephone and must conduct assessments within 24 hours of admission.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service is billed on a per diem basis.

This service cannot be billed for more than 30 days in a 12 month period.

This service is provided to recipients ages 21 and older.

The following services cannot be billed on the same date of service as Substance Abuse Medically Monitored Residential Treatment:
H0036 HQ – Community Support Services - Group
H2011 – Mobile Crisis
H2033 – Multi-systemic Therapy
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H0035 – Partial Hospital
S9484 – Professional Treatment Services in Facility-Based Crisis Programs
H2017 – Psychosocial Rehabilitation

This service is not subject to Third Party commercial insurance or Medicare.

This code is not subject to a copayment.

This service is billed with the alpha character O appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

16. Substance Abuse Non-Medical Community Residential Treatment - H0012 HB

This service is not available in any facility that has more than 16 beds. It is a 24-hour professionally supervised residential recovery program that works intensively with substance abuse disorders of adults who provide or have the potential to be the primary caregiver for their minor children. It is a rehabilitation facility without medical nursing/monitoring where a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for individuals with as addictions disorder. Programs include assessment/referral, individual and group therapy, family recovery, recovery skills training, case management, disease management, symptoms monitoring, medication monitoring, and self management of symptoms. Education services will be arranged although they are not reimbursed as part of this service. For programs serving individuals with their children, the PCP will include services such as training in therapeutic parenting skills, basic independent living skills, and child supervision. In addition, their children shall receive services in accordance with 10A NCAC 27G.4100. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

Staff requirements are a certified clinical supervisor, licensed clinical addiction specialist and a certified substance abuse counselor (according to the requirements listed in 10A NCAC 27G). The program is supervised by a certified clinical supervisor or licensed clinical addiction specialist who is onsite a minimum of eight hours per day and available by phone 24 hours per day. A qualified professional, associate professional, and paraprofessionals can provide services under the supervision of a certified clinical supervisor or a licensed clinical addiction specialist.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service is billed on a per diem basis. It cannot be billed more than 30 days in a 12 month period.

This service is available for recipients ages 21 and older.

The following services cannot be billed on the same date of service as Substance Abuse Non-Medical Community Residential Treatment:
H0040 – Assertive Community Treatment Team
H0036 HQ – Community Support Services - Group
H2015 HT – Community Support Services - Team
H2011 – Mobile Crisis
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H0035 – Partial Hospital
S9484 – Professional Treatment Services in Facility-Based Crisis Programs

H2017 – Psychosocial Rehabilitation

This service is not subject to Third Party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character N appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

17. Ambulatory Detoxification – H0014

Ambulatory detox is an organized service delivered by trained practitioners who provide medically supervised evaluations, detoxification, and referral services according to a predetermined schedule. A physician is available 24/7 by phone and to conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and to oversee the monitoring of the patient's progress and medications. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

These services are provided in regularly scheduled sessions by a certified clinical supervisor, licensed clinical addiction specialist, qualified professional or associate professional (according to the requirements listed in 10A NCAC 27G).

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service cannot be billed prior to dates of service June 1, 2006.

This service is billed in 15 minute increments. Providers may bill a maximum of 8 units per day.

The following services cannot be billed on the same date of service as Ambulatory Detoxification:
H0040 – Assertive Community Treatment Team
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0010 – Non-Hospital Medical Detoxification
H2036 – Medically Supervised Detoxification/Crisis Stabilization

H0035 – Partial Hospital
S9484 – Professional Treatment Services in Facility-Based Crisis Programs
H2017 – Psychosocial Rehabilitation
H0020 – Opioid Treatment
H0019 – Behavioral Health – Long Term Residential
H2020 – Therapeutic Behavioral Services – per diem
RC911 – Behavioral Health Treatment Services – Rehabilitation

This service is not subject to a Third Party commercial insurance or Medicare.

This service is billed with the alpha character L appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

18. Medically Supervised Detoxification/Crisis Stabilization – H2036

This is an organized service delivered by medical and nursing personnel that provides 24-hour medically supervised evaluation and withdrawal management to adults in a permanent facility with 16 or fewer beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Recipients are often in crisis due to co-occurring severe substance-related mental disorders and are in need of short-term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation. Recipients are carefully evaluated to ensure they obtain the appropriate level of care. Medicaid does not reimburse for room and board. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

The program is staffed by physicians and psychiatrists who are available 24 hours per day by phone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medications on an hourly basis. Appropriately licensed and credentialed staff is available to administer medications in accordance with the physician's orders.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service cannot be billed prior to dates of service June 1, 2006.

This service is billed on a per diem basis. It cannot be billed for more than 30 days in a 12 month period.

This service is available for recipients ages 21 and older.

The following services cannot be billed on the same date of service as Medically Supervised Detoxification/Crisis Stabilization:
H0040 – Assertive Community Treatment Team
H0036 HA – Community Support Services - Child
H0036 HQ – Community Support Services - Group
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H0014 – Ambulatory Detoxification
H0010 – Non-Hospital Medical Detoxification
H0035 – Partial Hospital
S9484 – Professional Treatment Services in Facility-Based Crisis Programs
H2017 – Psychosocial Rehabilitation

This service is subject to Third Party commercial insurance and Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character U appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

19. Non-Hospital Medical Detoxification – H0010

Medically monitored detoxification is an organized service by medical and nursing professionals that provides for 24 hour medically supervised evaluations and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. The specifics of admission criteria are included in the definition; the service is provided to adults. Medicaid does not reimburse for room and board. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

It is staffed by a certified clinical supervisor, a licensed clinical addiction specialist, a certified substance abuse counselor, a qualified professional, an associate professional, and paraprofessionals (according to the requirements of 10A NCAC 27G). A physician is available 24 hours a day by phone and conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of the patient's progress and medications.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service cannot be billed prior to dates of service June 1, 2006.

This service is available for recipients ages 21 and older.

This service is billed on a per diem basis. It cannot be billed for more than 30 days in a 12 month period.

The following services cannot be billed on the same date of service as Non-Hospital Medical Detoxification:
H0036 HA – Community Support Services - Child
H0036 HQ – Community Support Services - Group
H2011 – Mobile Crisis
H0015 – Substance Abuse Intensive Outpatient Program (SAIOP)
H2035 – Substance Abuse Comprehensive Outpatient Treatment (SACOT)
H0012 HB – Substance Abuse Non-Medical Community Residential Treatment
H0014 – Ambulatory Detoxification
H0013 – Substance Abuse Medically Monitored Community Residential Treatment
H2036 – Medically Supervised Detoxification/Crisis Stabilization
H0035 – Partial Hospital
S9484 – Professional Treatment Services in Facility-Based Crisis Programs
H2017 – Psychosocial Rehabilitation

This service is not subject to Third Party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character M appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

20. Outpatient Opioid Treatment – H0020

The program must be licensed and must meet the state and federal guidelines for this program before beginning the endorsement process. This medical service is for the treatment of opioid addiction. The service must be provided in conjunction with rehabilitation and medical services. It is provided for detoxification, treatment, and maintenance. Prior approval is required by the statewide vendor.

Provider and Staffing Requirements

The program is provided by a registered nurse, licensed practical nurse, pharmacist, or physician.

Service Limitations

EPSDT allows a recipient under 21 years of age to receive services in excess of the limitations in this section when such services are medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a screening. For additional information about **EPSDT**, see special provision, page 4.

This service is billed on a per diem basis.

This service is available for recipients ages 21 and older.

The following services cannot be billed on the same date of service as Opioid Treatment:
H0014 - Ambulatory Detoxification

This service is not subject to Third Party commercial insurance or Medicare.

This service is not subject to a copayment.

This service is billed with the alpha character T appended to the service specific attending number.

Documentation Requirements

The minimum documentation standard is a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, and describes the provider's interventions, including time spent performing the interventions and the effectiveness of the intervention and the signature and credentials of the staff providing the service.

21. Evaluation/Assessment/Individual Outpatient Psychotherapy/ Outpatient Family Therapy/Group Therapy

The January 2005 and May 2005 Medicaid Special Bulletins contains information about these services, the provider types, and billing information. These bulletins are available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm. Service requirements and limitations as well as billing information are also available in Clinical Coverage Policy #8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers,* on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mp.index.htm.

22. Psychiatric inpatient hospital, Level I through IV Residential Treatment Services and Psychiatric Residential Facility Treatment Services

For information regarding inpatient services, residential services Levels I-IV, and psychiatric residential treatment facilities, refer to the individual clinical coverage policies for behavioral health services on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mp.index.htm.

Billing Summary

HCPCS Code	Alpha Character	Service
H0036 HB	B	Community Supports Services – Adult
H0036 HA	B	Community Support Services – Child
H0036 HQ	B	Community Support Services – Group – Adult or Child
H2015 HT	B	Community Support Treatment Team (CST)
H0040	A	Assertive Community Treatment Team (ACTT)
H2012 HA	R	Child and Adolescent Day Treatment
T1023	G	Diagnostic Assessment
H2022	H	Intensive In-Home Services
H2011	F	Mobile Crisis
H2033	I	Multi-systemic Therapy (MST)
H0035	D	Partial Hospital
S9484	C	Professional Treatment Services in Facility-Based Crisis Programs
H2017	S	Psychosocial Rehabilitation
H2035	P	Substance Abuse Comprehensive Outpatient Treatment
H0015	Q	Substance Abuse Intensive Outpatient Program
H0013	O	Substance Abuse Medically Monitored Residential Treatment
H0012 HB	N	Substance Abuse Non-Medical Community Residential Treatment
H0014	L	Ambulatory Detoxification
H2036	U	Medically Supervised Detoxification/Crisis Stabilization
H0010	M	Non-Hospital Medical Detoxification
H0020	T	Outpatient Opioid Treatment

DMA will begin to phase out the Area Mental Health provider specialty effective with specific dates of service in order to encourage endorsement and provider enrollment. The four windows under which this provider specialty will no longer be able to bill for Enhanced Mental Health/Substance Abuse Services are as follows:

Window	Last date of service for Billing	Service that will be phased out for AMH providers
1	March 19, 2006	H0036, H0036 HI, H0036 HM, H0036 TL, H0036 U1, T1017 HE, H0035 HA, H0035 HB, H2012 HB, S9485, S9485 HA
2	May 31, 2006	H0040, H0036 HA, H0036 HB, H0036 HQ, H2015 HT, H2011, H2022, H2033, T1023, H2035, H0035, H2017
3	June 30, 2006	H0012 HB, H0013, H2012 HA, S9484, H0020, H0015
4	September 30, 2006	H0014, H0010, H2036

Instructions for Completing a Claim for Enhanced Mental Health/Substance Abuse Services

Refer to the following information for completing a CMS-1500 claim form for the above services.

Block #/Description	Instruction
1.	Place an X in the MEDICAID block.
1. a. Insured's ID Number	Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) exactly as it is shown on the recipient's Medicaid ID card.
2. Recipient's Name	Enter the recipient's last name, first name and middle initial exactly as it is shown on the Medicaid ID card.
3. Recipient's Birth Date/Sex	Enter eight numbers to show the recipient's date of birth – MMDDYYYY. The birth date is on the Medicaid ID card. Example: July 13, 1978 is 07131978 Place an X in the appropriate block to show the recipient's sex.
4. Insured's Name	Leave blank.
5. Recipient's Address	Enter the recipient's address, including the city, state, and zip code. The information is on the Medicaid ID card. Entering the phone number is optional.
6. – 8.	Leave blank.
9. Other insurer's name	Enter applicable private insurer's name.
9. a. – 9. d.	Enter applicable insurance information.
10. Is recipient's condition…?	Place an X in the appropriate block for each question.
11. – 14.	Optional.
15. – 16.	Leave blank.
17., 17. a., and 18.	Optional.
19. Reserved for Local Use	Leave blank.
20. Outside Lab	Leave blank.
21. Diagnosis or Nature of Illness	Enter the ICD-9-CM codes to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. Medicaid Resubmission Code	Leave blank.
23. Prior Authorization #	Leave blank.

Note: Blocks 24A through 24 K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a detail. When completing these blocks:

- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same service on one day, include all the units of the service on the same line.
- Include only dates of service for which the recipient is eligible for Medicaid.

Block #/Description	Instructions
24.a. Date(s) of Service, From/To	Enter the date of service in the "From" date field and then the same date in the "To" date field.
24. b. Place of service	Enter the appropriate place of service code.
24. c. Type of service	Leave blank.
24. d. HCPCS code	Enter the appropriate HCPC code and modifier (if applicable) for the service being provided.
24. e. Diagnosis Code	Leave blank.
24. f. Charges	Enter the total charge for the service on the line.
24. g. Days or Units	Enter the number of units. (i.e. 1 unit = 15 minutes or 1 unit = 1 day)
24. h. – 24. i.	Leave blank.
24. j. – 24. k.	Optional.
25. Federal Tax ID number	Optional.
26. Recipient's account #	Optional. If you enter a number, it will appear on your RA.
27. Accept assignment	Leave blank.
28. Total Charge	Enter the sum of the charges listed in item 24 F.
29. Amount Paid	Enter the total amount received from the Third Party commercial insurance if the service is subject to Third Party commercial insurance.
30. Balance Due	Subtract the amount in Block 29 from Block 28 and enter the result.
31. Signature of Agency	Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.
32. Name and Address of the facility	Optional.
33. Billing Name and Address	Enter your agency's name, address, including zip code, and phone number. The name and address must be EXACTLY as shown on your Medicaid participation agreement.
PIN#	Enter you seven-digit Medicaid attending provider number with the appropriate alpha character which defines the service being provided.
GRP#	Enter your seven digit Medicaid billing provider number.

PLEASE DO NOT STAPLE IN THIS AREA

Community Support Services - Adult

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 290
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
03 20 06	03 20 06	12		H0036	HB		60 96	4				

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 $ 60 96

29. AMOUNT PAID $

30. BALANCE DUE $ 60 96

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000B GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Community Support Services - Child

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 2001 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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 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. 290
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	20	06	03	20	06	12		H0036	HA		60 96	4				

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 $ 60 96

29. AMOUNT PAID $

30. BALANCE DUE $ 60 96

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000B GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Community Support Services - Group
Children and Adults

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): 999999999T

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

3. PATIENT'S BIRTH DATE (MM DD YY): 07 13 2001 — SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town — STATE: NC

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

CITY — STATE

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (919) 123-4567

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

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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) (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. 290
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	20	06	03	20	06	12		H0036	HQ		19 60	4				

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: $ 19 60

29. AMOUNT PAID: $

30. BALANCE DUE: $ 19 60

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.)

A. Provider — 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000B — GRP# 8300000

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Community Support Team
Adults

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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: 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. 290
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 20 06	03 20 06	12		H2015	HT		66 08	4				

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 $ 66 08

29. AMOUNT PAID $

30. BALANCE DUE $ 66 08

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000B GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Assertive Community Treatment Team (ACTT)

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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 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	20	06	03	20	06	12		H0040			323 98	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 $ 323 98

29. AMOUNT PAID $ 100 00

30. BALANCE DUE $ 223 98

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.)

A. Provider SIGNED 03/20/06 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000A GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Child and Adolescent Day Treatment

HEALTH INSURANCE CLAIM FORM

1. MEDICARE / MEDICAID [X] / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.
3. PATIENT'S BIRTH DATE: 07 13 2001 SEX: F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street
6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)

CITY: Any Town STATE: NC
8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student
ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME

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. 290
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	Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
03	20	06	03	20	06	11		H2012	HA		62 50	2				

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 50
29. AMOUNT PAID $
30. BALANCE DUE $ 62 50

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.)
A. Provider 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 #
Any Provider
12 Any Street
Any town, NC 12345
PIN# 8300000R GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Diagnostic Assessment
$3.00 Copay deducted for this service

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 2001 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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 20 06	03 20 06	11		T1023		169 06	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 $ 169 06

29. AMOUNT PAID $ 50 00

30. BALANCE DUE $ 119 06

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000G GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Intensive In-Home Services

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 2001 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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: 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. 290
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 20 06	03 20 06	11		H2022			190 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 $ 190 00

29. AMOUNT PAID $

30. BALANCE DUE $ 190 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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000H GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Mobile Crisis

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): 999999999T

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

3. PATIENT'S BIRTH DATE (MM DD YY): 07 13 1978 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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: 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. 290
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	20	06	03	20	06	12		H2011			127 16	4				

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 $ 127 16

29. AMOUNT PAID $ 25 00

30. BALANCE DUE $ 102 16

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.)

A. Provider 03/20/06
SIGNED DATE

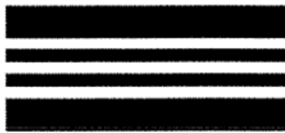
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000F GRP# 8300000

PLEASE
DO NOT
STAPLE
IN THIS
AREA



Multi-systemic Therapy (MST)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [X] 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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1999 SEX M F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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 20 06	03 20 06	12		H2033			94 16	4				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 94 16

29. AMOUNT PAID: $

30. BALANCE DUE: $ 94 16

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000I GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Partial Hospital

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1999 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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: 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. 290
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 20 06	03 20 06	21		H0035		121 69	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 $ 121 69

29. AMOUNT PAID $ 50 00

30. BALANCE DUE $ 71 69

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000D GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Professional Treatment Services in Facility-Based Crisis Programs

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): 999999999T

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

3. PATIENT'S BIRTH DATE (MM DD YY): 07 13 1978 — SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town — STATE: NC

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

CITY / STATE:

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (919) 123-4567

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 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. 290
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	20	06	03	20	06	21		S9484			300 48	16				

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: $ 300 48

29. AMOUNT PAID: $ 50 00

30. BALANCE DUE: $ 250 48

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.)

A. Provider — 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000C — GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Psychosocial Rehabilitation

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ____ DATE ____

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

SIGNED ____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. 290
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 20 06	03 20 06	11		H2017		9 36	4				

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 $ 9 36

29. AMOUNT PAID $

30. BALANCE DUE $ 9 36

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000S GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Substance Abuse Comprehensive Outpatient Treatment (SACOT)

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 290
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 20 06	03 20 06	11		H2035		45 76	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 $ 45 76

29. AMOUNT PAID $ 20 00

30. BALANCE DUE $ 25 76

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000P GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Substance Abuse Intensive Outpatient Program (SAIOP)

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): 999999999T

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

3. PATIENT'S BIRTH DATE (MM DD YY): 07 13 1978 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY / STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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 20 06	03 20 06	11		H0015		131 93	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: $ 131 93

29. AMOUNT PAID: $

30. BALANCE DUE: $ 131 93

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000Q GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Substance Abuse Medically Monitored Residential Treatment

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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: 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. 290
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 20 06	03 20 06	21		H0013		265 25	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 $ 265 25

29. AMOUNT PAID $

30. BALANCE DUE $ 265 25

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 83000000 GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Substance Abuse Non-Medical Community Residential Treatment

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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 20 06	03 20 06	21		H0012 HB		145 50	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: $ 145 50

29. AMOUNT PAID: $

30. BALANCE DUE: $ 145 50

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000N GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Ambulatory Detoxification

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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 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. 290
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
06 01 06	06 01 06	11		H0014		81 72	4				

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 $ 81 72

29. AMOUNT PAID $

30. BALANCE DUE $ 81 72

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.)

A. Provider 06/01/06

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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000L GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Medically Supervised Detoxification/Crisis Stabilization

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER — (Medicaid #) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

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

3. PATIENT'S BIRTH DATE: 07 13 1978 SEX: F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Any Town STATE: NC

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

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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
06	01	06	06	01	06	21		H2036			100 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: $ 100 00

29. AMOUNT PAID: $ 20 00

30. BALANCE DUE: $ 80 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.)

A. Provider 06/01/06

SIGNED DATE

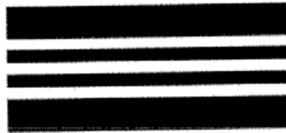
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000U GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA



Non-Hospital Medical Detoxification

HEALTH INSURANCE CLAIM FORM

1. MEDICARE / MEDICAID [X] / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER

1a. INSURED'S I.D. NUMBER: 999999999T

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

3. PATIENT'S BIRTH DATE: 07 13 1978 SEX: F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A 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
06	01	06	06	01	06	21		H0010			325 88	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 $ 325 88

29. AMOUNT PAID $

30. BALANCE DUE $ 325 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.)

A. Provider 06/01/06
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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000M GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA

Outpatient Opioid Treatment

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): 999999999T

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

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

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

CITY: Any Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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. 290
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 20 06	03 20 06	11		H0020		19 17	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 $ 19 17

29. AMOUNT PAID $

30. BALANCE DUE $ 19 17

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.)

A. Provider 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 #

Any Provider
12 Any Street
Any town, NC 12345

PIN# 8300000T GRP# 8300000

Mark T. Benton, Sr
Senior Deputy Director and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS