North Carolina Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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

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.

CPT codes, descriptors, and other data only are copyright 2005

American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Table of Contents

Introduction Provider Enrollment	
Eligible Recipients	4
EPSDT Special Provision: Exceptions to Limitations in Policy for Recipients Under 21 Years of Age	4
Service Definitions	5
Community Supports – Adult (Individual and Group). Community Support Treatment Team (Adult) (CST). Assertive Community Treatment Team (ACTT). Child and Adolescent Day Treatment (MH/SA). Diagnostic Assessment. Intensive In-Home Services. Mobile Crisis Management. Multisystemic Therapy (MST). Partial Hospitalization. Professional Treatment Services in a Facility-Based Crisis Programs. Psychosocial Rehabilitation. Substance Abuse Comprehensive Outpatient Treatment. Substance Abuse Intensive Outpatient Program. Substance Abuse Medically Monitored Residential Treatment. Substance Abuse Non-Medical Community Residential Treatment. Ambulatory Detoxification.	78913141617181921222525
Medically Supervised Detoxification/Crisis Stabilization	28
Billing Summary	
Instructions for Completing a Claim	
Claim Form Examples	34

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

С	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
0	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.
- 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 psychoeducational 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 yendor.

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 yendor.

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 yendor.

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	Service
	Character	
H0036 HB	В	Community Supports Services – Adult
H0036 HA	В	Community Support Services – Child
H0036 HQ	В	Community Support Services – Group – Adult or Child
H2015 HT	В	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	Н	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	О	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		
	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	Place an X in the appropriate block for each question.		
condition?			
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	Enter the ICD-9-CM codes to describe the primary diagnosis		
Illness	related to the service. You may also enter related secondary		
	diagnoses. Entering written descriptions is optional.		
22. Medicaid Resubmission	Leave blank.		
Code			
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			
22 Name and Address (64)	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	Community Su	port Services - Adu	ılt		
N THIS AREA					
TIPICA	HEALT	INSURANCE CL	AIM FOR	NF	PICA
I. MEDICARE MEDICAID CHAMPUS CHA	MPVA GROUP FECA	THER 18. INSURED'S LD NUM	MBER	(FOR P	ROGRAM IN ITEM 1)
(Medicare #) X (Medicaid #) (Sponsor's SSN) (V)	File #) HEALTH PLAN BLK LUNG (SSN or ID) (SSN)	(D) 999999999T			
: PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (L	ast Name, First	Name, Middie	Intiali
Recipient, Jane D.	07 13 1978 M	X			
i. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURE	7. INSURED'S ADDRES	S (No., Streat)		
123 Any Street	Self Spouse Child Ot		rinner, marraggia ay makejur	renewater was a second	~~~
	TATE IN PATIENT STATUS	CITY			STATE
TP CODE TELEPHONE (Include Area Code	Single Married Clin			enacemphinal experience of these	
12345 (919) 123-4567	Employed Full-Time Pan-Ti	ZIP CODE	TELE	EPHONE (INC)	LUDE AREA CODE)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Student Studen 10. IS PATIENT'S CONDITION RELATED		1 000000	to a boune	
OTHER MAUNED STRAME (Less nums, First Haire, House Haile)	10. IS PAIRE TO CONDITION RELATED	7. INSURED S POLICY	GROUP ON F	ECA NUMBER	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREV	(S) a. INSURED'S DATE OF		M ("")	SEX F [7]
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLAC	State) b. EMPLOYER'S NAME	UB SURVIVE P	ISME	
MM DO YY	YES NO		The same of the same of		
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN N	AME OR PROS	SPAM NAME	and the house of the contract
	YES NO				
INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d IS THERE ANOTHER	HEALTH BENE	EFIT PLAN?	
	Avelonment	Yes Ti	NO If yes,	return to and c	complete item 9 a-d.
READ BACK OF FORM BEFORE COMPL 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 author		13. INSURED'S OR AUT			
 PATIENTS OF AUTHORIZED PERSONS STEART OFET LAbord to process this claim, Lateo request payment of government benefic below. 			benetits to the a elow.	indersigned ph	ysician or supplier for
SIGNED	DATE	SIGNED	P. A. A. A. F. A. B. A	N. B. C. B. M. L. C. Sanghar and A. San	
4. DATE OF CURRENT: (ILINESS (First symptom) OR MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR GIVE FIRST DATE MM DD YY	VESS 16. DATES PATENT UN FROM DO	NABLE TO WOR	RK IN CURRE MM TO	NT OCCUPATION 00 YY
7, NAME OF REPERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAL	18. HOSPITALIZATION	DATES RELAT	ED TO CURRI	ENT SERVICES
and the second second		FROM		70	, bb , yy
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?	,	SCHARGES	1
		VES H			
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE !	EMS 1,2.3 OR 4 TO (TEM 24E BY LINE)	22, MEDICAID RESUBM	RISSION ORIG	INALIAEF, NO	
290	To Emanason s now	23. PRIOR AUTHORIZA	TION NUMBER		an (h Mili Halah san (dharan an Aireanna an
2 1	4. L				
	DEDURES, SERVICES, OR SUPPLIES NAME	SiS F	DAYS EPSDT		RESERVED FOR
	(Explain Unusual Circumstances) CC	\$ CHARGES	OR Family UNITS Plan	EMG COS:	. LOCAL USE
03 20 06 03 20 06 12 H	036 НВ	60 96	4		TO THE PERSON OF
and the same of th				(To a Stratification of the strategic o	
				Ì	
				_	
			1 1 1	9	
				<u> </u>	
				ĺ	
5. FEDERAL TAX LO. NUMBER SSN EIN 26. PATIE	VT'S ACCOUNT NO. 27, ACCEPT ASSIGNATION (For gov), claims, se		29. AMOU	MT PAID	30. BALANCE DUE
	YES N	\$ 60 96			\$ 60 96
	AND ADDRESS OF PACILITY WHERE SERVICES FRED (If other than home or office)	ERE 33. PHYSICIAN'S, SUPP 8 PHONE #	TEAS BELIAT	S NAME, ADDI	RESS, ZIP CODE
(f carrify that the statements on the reverse apply to this bill and are made a part thereof.)		-	rovider		
which is a sure and an enter an extension of \$455.5 First Arts ?		12 An	y Street		
. Provider 03/20/06		1	own, NC		
IGNED DATE		PRIN 8300000B	l a	RP# 83000	00

PLEASE DO NOT STAPLE IN THIS	Community Support	Services - Child			
AREA					
PICA	HEALTH INS	SURANCE CLAIM	FORM	Płoa	
1. MEDICARE MEDICAID GHAMPUS CHAMPVI	GROUF FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMSER	(FOR PI	ROGRAM (NITEM!)	
(Medicare #) X (Medicaid #) (Sponsor's SSN) (VA File	#) (\$SN or (D) (\$SN) (1D)	999999999T			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Nan	na, First Name, Middle	(retinal)	
Recipient, Jane D.	07 13 2001 M F X				
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No.,	Street)		
123 Any Street	Self Spouse Child Other				
Any Town NC	B. PATIENT STATUS	CITY		STATE	
	Single Married Other			essenticion lutinos de sentiralization de sentirali	
ZIP CODE TELEPHONE (Include Area Code)	Employed Fut-Time Part-Time	ZIF CODE	TELEPHONE INCL	UDE AREA CODE)	
12345 (919) 123-4567	Skident Student		1 ()		
OTHER INSUREO'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROU	IP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH	4	SEX	
	YES NO		M	FO	
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SC	HOOL NAME		
M F	YES NO			***************************************	
C. EMPLOYER'S NAME OR SCHOOL NAME	c, OTHER ACCIDENT?	o, INSURANCE PLAN NAME O	P PROGRAM NAME		
	LIYES LINO				
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEAL!			
DESCRIPTION OF PART DEPARTMENT OF THE PARTY	C a continue to the	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 SIGNIATURE I surherize the reliage of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself of to the party who accepts assignment below.		 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of modical banefits to the undorsigned physician or supplier for services described below. 			
SIGNED	DATE	SIGNED			
	IF PATIENT HAS HAD SAME OR SIMB AR BUNESS.	16. DATES PATIENT UNABLE	TO WORK IN CURRE	IT OCCUPATION	
MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	GIVE FIRST DATE MA DD YY	FROM DD YY	TO MM	00 YY	
La companya de la companya del companya de la companya del companya de la companya del la companya de la compan	a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM , DD , YY MM , DD , YY			
		FROM	: 70	. 00 . 11	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?	8 CHARGES	Administrative and control of the second con	
		YES NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS	1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION	ORIGINAL REF. NO		
290	3. L				
5 - Summarian annotation V restaure	Co. Sanadanon I, rem	23. PRIOR AUTHORIZATION N	LIMBER		
2 1	4.				
24. A 8 C	RES. SERVICES, OR SUPPLIES CHARGE	F G DAYS	H I J	K	
From d of (Exp	lain Unusual Circumstances)	S CHARGES OR UNITS	Plemity caro one	RESERVED FOR LOCAL USE	
		8	7 4001		
03 20 06 03 20 06 12 H0036	5 HA	60 96 4			
			100		
				######################################	
25 FEDERALTAX ID NUMBER SSN EN 26 PATIENTS	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 2	9. AMOUNT PAID	30. BALANCE DUE	
(For govt, claims, see back)		s 60 96 s		S 60 96	
25 DEMATTING AS DISCOURSE ON CUING ISS 124 HAVE AND	YES NO	33. PHYSICIAN'S, SUPPLIER'S			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE INCLUDING DEGREES OR CREDENTIALS 33. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE INCLUDING DEGREES OR CREDENTIALS 34. SIGNATURE OF PHYSICIAN OR SUPPLIER 35. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE		33. PHYSICIAN'S, SUPPLIERS & PHONE #	DILLING NAME, ADDI	seas air coot	
() cardly that the statements on the reverse apoly to his bit and are made a part thereof)		Any Provider			
		12 Any Street			
A. Provider 03/20/06		Any town,	ī		
SIGNED DATE		Pais 8300000B	GRP# 83000	OO	

DO NOT STAPLE		Commu	nity Support	Services - Gr	coup				
THIS REA		Child	ren and Adul	ts					
PICA	***************************************	H	EALTH INS	SURANCE CL	AIM	FORM		PiC	А —
MEDICARE MEDICARD CHAMPI	JS CHAMPY		CA OTHER	1a. NSURED'S LD. N	UMBER	No o Minkello endo in	FOR PE	ROGRAM IN	(TEM 1)
(Madicars #) X (Madicaid #) (Sportsor	8 SSN) (VA File	(SSN or ID)	SSN) (ID)	999999999T					
PATIENT'S NAME (Last Name, First Name, Micc.	Se initial)	3. PATIENT'S BIRTH DATE	SEX	4. (NSURED'S NAME	Last Name	, First Name,	Middle	initial)	
Recipient, Jane D.		07 13 2001 ™	e X		THE PARTY OF THE P				
PATIENT'S ADDRESS (No.: Street)		6 PATIENT RELATIONSHIP TO	O INSURED	7. INSURED'S ADDRE	SS (No., S	treet)			
123 Any Street		Self Spouse Child	Other [
MA	STATE	8. PATIENT STATUS		CITY	(periodi idi ini) gʻindggala) y			STA	TE
Any Town	NC	Single Married	Other						
IP CODE. TELEPHONE (In	nclude Area Code)			Z:P GCOE		TELEPHON	Œ (INGL	UDE AREA	(3000)
12345 (919) 1	23-4567	Employed Fus-Time Student	Part-Time			()		
OTHER INSURED'S NAME (Last Name, First Na	me, Middle Inidal)	16. IS PATIENT'S CONDITION	RELATED TO:	11. INSURED'S POLIC	CY GROUP	OR FECA N	UMBER		***************************************
. OTHER INSURED'S POLICY OR GROUP NUME	en e	a. EMPLOYMENT7 (CURRENT YES	OR PREVIOUS)	a, INSURED'S DATE O	DF BIRTH		4 (T).	SEX F	
MM DD YY	SEX F (^^)	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAM	E OR SCH	OOL NAME	tenna -		and a
EMPLOYER'S NAME OR SCHOOL NAME		VES (JNO	c. INSURANCE PLAN	MANEAR	DECODER	STALES		
ENTLUTER O RAME ON SUPLAN BRANC		C. STREE AUGIDENTY	"INO	U STOUMANUE FLAN	neres um	- musinam	Thursday.		
I INSURANCE PLAN NAME OR PROGRAM NAM		10d. RESERVED FOR LOCAL		d IS THERE ANOTHE	O WEAT	DENECT "	1.5829		
EINSUMANCE POAN NAME ON PROGRAM NUM	c	TOU NEBERVES FOR LOOPE	USE.	frank (rank)					
DEAD BACK OF FORM	BEEDBE COMMISTE	NG & SIGNING THIS FORM.		13. INSURED'S OR AL	~~~~~~	if yes, return			
 PATIENT'S OR AUTHORIZED PERSON'S SIG to process this claim. I also request payment of g below. 	MATURE I authorize the	he release of any medical or other in	formation necessary opts assignment	psyment of medical services described	d benefits t				
SIGNED		DATE		SIGNED					
4. DATE OF CURRENT: A RENESS (First symp	ptom) OR 16	5. IF PATIENT HAS HAD SAME OF	SIMILAR ILLNESS.	16. DATES PATIENT I	UNABLE T	O WORK IN	CURREN	et occupat	TION
MM DD YY INJURY (Accident)	OR	GIVE FIRST DATE MM DI) W	FROM DO	YY :	70	5,63,6	DD Y	Y
17, NAME OF REFERRING PHYSICIAN OR OTHE	R SOURCE 1	7s. I.D. NUMBER OF REFERRING	PHYSICIAN	18. HOSPITALIZATIO		ELATED TO			
	R SOURCE 1	7s. i.D. NUMBER OF REFERRING	PHYSICIAN				MM	. DD ; Y	
grander of the state of the sta	R SOURCE 1	7a. LD, NUMBER OF REFERRING	PHYSICIAN	18. HOSPITALIZATION		77	MM		
grander of the state of the sta	R SOURCE 1	7s. i.D. NUMBER OF REFERRING	PHYSICIAN	18. HOSPITALIZATION MM DO FROM 20. OUTSIDE LAR?		77	MM.	. DD ; Y	
19. RESERVED FOR LOGAL USE				18. HOSPITALIZATION MAA OO FROM 26. OUTSIDE LAR?	NO	\$ CHJ	ARGES	. 00 Y	
9. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OF IN.				18. HOSPITALIZATION MM DO FROM 20. OUTSIDE LAR?	NO YY	77	ARGES	. 00 Y	
8. RESERVED FOR LOGAL USE				18. HOSPITALIZATION MAY OD FROM 26. OUTSIDE LAB? [] YES [] 22. MEDICAID RESULE	NO MISSION	\$ CHJ ORIGINAL F	ARGES	. 00 Y	
19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 3. 1 290	JURY (RELATE ITEM	\$ 1,2,3 OR 4 TO ITEM 24E BY LIN 3	E)	18 HOSPITALIZATION MM DO FROM 20. OUTSIDE LAB?	NO MISSION NE	TO SICHU ORIGINAL F MBER	ARGES	. 50 Y	
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 2 10 4 A 6	DURY (RELATE ITEM	\$ 1,2,3 OR 4 TO FEM 24E BY LIN 3	E)	18 HOSPITALIZATION FROM 20 OUTSIDE LAR? YES 22 MEDICAID RESUR	NO BMISSION NE	TO SCHU ORIGINAL F MBER	ARGES	. DD Y	
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OF IN. 11. L 290 22. L E DATE(S) OF SERVICE. PI	JURY (RELATE ITEM	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3	E)	18 HOSPITALIZATION MM DO FROM 20. OUTSIDE LAB?	NO MISSION NE	ORIGINAL F	ARGES .	. 50 Y	Y
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 2. L 4. A B FROM FROM FROM FROM FROM FROM FROM FRO	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 URBES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? YES 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F	NO SMISSION NO DAYS E CA IS	ORIGINAL F	ARGES .	N RESERVE	Y
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1290 2 L 14. A E 15. DATE(S) OF SERVICE 16. FROM 17. DATE(S) OF SERVICE 18. AMM DD YY MM DD YY Ser	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 URBES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYS E OR FUNITS	ORIGINAL F	ARGES .	N RESERVE	Y
21. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 290 2 L DATE(S) OF SERVICE FROM OD YY MM DD YY Ser	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 URBES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYS E OR FUNITS	ORIGINAL F	ARGES .	N RESERVE	Y
21. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 2. 290 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 2. 1 3.	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 URBES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYS E OR FUNITS	ORIGINAL F	ARGES .	N RESERVE	Y
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1290 2 L 14. A E 15. DATE(S) OF SERVICE 16. FROM 17. DATE(S) OF SERVICE 18. AMM DD YY MM DD YY Ser	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 UIRES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYS E OR FUNITS	ORIGINAL F	ARGES .	N RESERVE	Y
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1290 2 L 14. A E 15. DATE(S) OF SERVICE 16. FROM 17. DATE(S) OF SERVICE 18. AMM DD YY MM DD YY Ser	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 UIRES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYS E OR FUNITS	ORIGINAL F	ARGES .	N RESERVE	Y
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1290 2 L 14. A E 15. DAYE(S) OF SERVICE 16. FROM 17. DAYE(S) OF SERVICE 18. ADD YY MM DO YY ISSE	C C PROCED TYPE PROCED OF STATE OF STAT	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3. 4. 1 UIRES, SERVICES, OR SUPPLIES plain Unuqual Circumstances; PCS MODIFIER	E DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYS E OR FUNITS	ORIGINAL F	ARGES .	N RESERVE	Y
9. RESERVED FOR LOCAL USE 1. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 2. L 4. A	JURY (RELATE ITEM TOP PROCED of of Exp vice Service CPT/HC 2 H003	S 1,2,3 OR 4 TO L'EM 24E BY LIN 3. 4. L D URBS, SERVICES, OR SUPPLIES plain (Prupasia Circumstances) 6 HQ S ACCOUNT NO. 27 ACCE	E DIAGNOSIS CODE	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES	NO DAYSE TO ATTOM NO.	ORIGINAL F	MA ARRES COB	N RESERVE	Y DFOR USE
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1. 290 2. L 14. A	JURY (RELATE ITEM TOP PROCED of of Exp vice Service CPT/HC 2 H003	S 1,2,3 OR 4 TO L'EM 24E BY LIN 3. 4. L D URBS, SERVICES, OR SUPPLIES plain (Prupasia Circumstances) 6 HQ S ACCOUNT NO. 27 ACCE	E DIAGNOSIS CODE T ASSIGNMENT? T Oalms, see backg	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S CHARGES 19 60	NO NO DAYS EATTON NO. OF THE UNITS!	ORIGINAL F	MA ARRES COB	K RESERVE LOCAL	Y DEPORT
S. RESERVED FOR LOCAL USE II. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 290 2 L M. A BOATE(S) OF SERVICE TO YY MM DO YY Sor 03 20 06 03 20 06 1. S. SIGNATURE OF PHYSICIAN OR SUPPLER	CORV. (RELATE ITEM B C C CORV. (RELATE ITEM B C C CORV. (RELATE ITEM B C C CR. (RELATE ITEM B C CR.	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3	E DIAGNOSIS CODE PT ASSIGNMENT? R Gelms, see backg	18. HOSPITALIZATION FROM 1 OC FROM 20. OUTSIDE LAB? 22. MEDICAID RESUB 23. PRIOR AUTHORIZ F S CHARGES 19 60 28. TOTAL CHARGE S 19 6 33. PHYSICIAN'S, SUB	NO STATION NO. CONTROL OF THE CONTRO	ORIGINAL F ORIGINAL F MMSER H I PSOTI PROPRIEME AMOUNT PA	MAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	R RESERVE LOCAL	Y ED FOR USE
S. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1290 2. L. A. B.	CORV. (RELATE ITEM B C C CORV. (RELATE ITEM B C C CORV. (RELATE ITEM B C C CR. (RELATE ITEM B C CR.	S 1,2,3 OR 4 TO FEM 24E BY LIN 3.	E DIAGNOSIS CODE PT ASSIGNMENT? R Gelms, see backg	18. HOSPITALIZATION FROM 1 OC FROM 20. OUTSIDE LAB? 22. MEDICAID RESUE 23. PRIOR AUTHORIZ F S CHARGES 19 60 26. TOTAL CHARGE 5 19 6 37. PHYSICIANS, SUR 8 PHONE #	NO DAMISSION IN CATION IN CAT	ORIGINAL F ORIGINAL F MBEH H I I PSOT amby Pain EMG AMGUNT PA	MAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	R RESERVE LOCAL	Y SE DUE 19 60
9. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF REINESS OR IN. 1. 290 2. L 14. A BATE(S) OF SERVICE_TO PROTECTION OF SUPPLIER 15. SEDERAL TAX I.O. NUMBER SSN EN 15. SIGNATURE OF PHYSICIAN OR SUPPLIER 16. SIGNATURE OF SUPPLIER 16. S	CORV. (RELATE ITEM B C C CORV. (RELATE ITEM B C C CORV. (RELATE ITEM B C C CR. (RELATE ITEM B C CR.	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3	E DIAGNOSIS CODE PT ASSIGNMENT? R Gelms, see backg	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? 22. MEDICAID RESULE CODE 23. PRIOR AUTHORIZ F S CHARGES 19 60 28. TOTAL CHARGE S 19: 6 30. PHYSICIANS, SUR 3 PHONE #	NO DAYS E	OPIGINAL F	MAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	R RESERVE LOCAL	Y SE DUE 19 60
S. RESERVED FOR LOCAL USE 11. DIAGNOSIS OR NATURE OF ILLNESS OR IN. 1290 2. L. A. B.	200 PATIENT'S 200 PATIENT'S 200 PATIENT'S 200 PATIENT'S 200 PATIENT'S	S 1,2,3 OR 4 TO ITEM 24E BY LIN 3	E DIAGNOSIS CODE PT ASSIGNMENT? R Gelms, see backg	18. HOSPITALIZATION FROM 1 00 FROM 20. OUTSIDE LAB? 22. MEDICAID RESUR 23. PRIOR AUTHORIZ F S-CHARGES 19 60 26. TOTAL CHARGE S 19 6 33. PHYSICIANS, SUR 3 PHONE # Any 12 A	NO PARTIES OF THE PROVIDENCE O	OPIGINAL F	MARGES COB	R RESERVE LOCAL	Y SE DUE 19 60

PLEASE DO NOT STAPLE IN THIS AREA	Community Suppor Adults	t Team
PICA	HEALTH IN	SURANCE CLAIM FORM PICA
	APVA GROUP FECA OTHE HEALTH PLAN BEKILUNG	R 1a. INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) X (Medicaid #) (Sponsors SSN) (Vi	File #1 (SSN of ID) (SSN) (ID)	99999999T
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle India)
Recipient, Jane D.	07 13 1978 M F X	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Street	Self Spouse Child Other	
	ATE 8. PATIENT STATUS	CITY STATE
	Single Married Other	
SP CODE TELEPHONE (Include Area Code)	Employed Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
12345 (919) 123-4567	Student Student	
, OTHER INSURED'S NAME (Las) Name, First Name, Middle Initial)	18. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	A. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY M F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	B. EMPLOYER'S NAME OR SCHOOL NAME
MM 55 TT	YES NO	
EMPLOYER'S NAME OR SCHOOL NAME	c, OTHER ACCIDENT?"	L INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
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.c.
READ SACK OF FORM BEFORE COMP- 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author to process this claim. I also request payment of government banefit below.	te the release of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S SKONATURE I surhorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT: LLNESS (First symptom) OR MM DD YY NAJHY (Accident) OR	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE PIRST DATE MM DD YY	MAR DO YY MM DO YY
PREGNANCY(LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a LD, NUMBER OF REFERRING PHYSICIAN	FROM TO URRENT SERVICES 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
7, NEME OF REFERENCE PRINCIPLE OF OTHER SOURCE	174, 16, 160 may 5 may sympa i fil galany	FROM TO YY MM DO YY
B. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
grand and a second seco		TYES TWO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT	EMS 1.2.3 OR 4 TO ITEM 24E BY LINE)	22 MEDICAID RESUBMISSION
290	3	ORISINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER
2 L	4. L.	E B H
	EDURES, SERVICES, OR SUPPLIES DIAGNOSIS	DAYS EPSOT DESCRIPTION OF THE
	(Explain Unosual Circumstances) CODE HCPCS (MODIFIER CODE	S CHARGES OH PRINTS Plan EMG COS LOCALUSE
03 20 06 03 20 06 12 H2	015 HT	66 08 4
1 10 10 10 10 10 10 10 10 10 10 10 10 10		
		The state of the s
5 PEDERAL TAX LD NUMBER SSN EIN 26 PATIE	IT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 28 AMOUNT PAID 30 BALANCE DUE
D. FEDERAL INA LES NUMBER 30% ESP (25, PASE)	(For govt claims, see back)	
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME	ND ADDRESS OF FACILITY WHERE SERVICES WERE	\$ 66 08 \$ 8 66 08 23. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
RICLUDING DEGREES OR CREDENTIALS RENDE	RED (If other than home or office)	8 PHONE #
(I certify that the statements on the reverse apply to this bill and are made a part thereot.)		Any Provider
		12 Any Street
		Any town, NC 12345
. Provider 03/20/06		

PLEASE									
IO NOT TAPLE V THIS REA	Asser	tive Communi	ty Treatment T	eam (A	CTT)				
TTPICA		JEAI TU ING	SURANCE CL	AILS	copis				
A CONTRACTOR AND LICENSE AND ADDRESS OF THE CONTRACTOR AND ADDRESS	elion pipe parente compensor i parinte la Romana e regione e esta comp		Is INSURED'S LD. NU	nicolateri entre e	(() (119)	/EOIR R	ROGRAM	PICA	mine ()
(Medicare #) (X) (Medicard #) (Sponsor's SSN)	HEALTH PLAN BL	K LUNG SSN) //DI	999999999T	MULT.		(10111	110011200	THE PERSON	
PATIENT'S NAME (Last Name, First Name, Middle initial)	3 PATIENT'S BIRTH DATE		4. INSURED'S NAME (per Name	: Sivet Marrie	: Miroda	inalsh		No. of Post
Recipient, Jane D.	MM , DD , YY	SEX F X	e, indoned a rouse (.0051 +9.251105	r, r i se restre	z, woons	HINGS O		
A three dressed as A company of the control of the	07 13 1978 M		The second second	minutetakan term		wheeverve	Museum property and	N. W. C. St. St. St. St. Co. Co. St. St. St. St. St. St. St. St. St. St	pa, ace
PATHENT'S ADDRESS (No., Street) 123 Any Street	com com	personal personal	7. INSURED'S ADDRES	35 (49., S	nreetj				
	Self Spouse Chil	d Other				et nervetet over over over			
illy	STATE B. PATIENT STATUS	arrang promote	CITY					STATE	
iny Town	Single Murried	Olher	} } }	and the second of the second	·	namentur a transport		ulatin kalikunti dan kerajai	garjanta Garjanta
P CODE TELEPHONE (Include Area C	Employed Fut-Time -	Part-Time	ZIP CODE		TELEPHO	NE (INC)	LUDE ARE	(A CODE)	į
2345 (919) 123-4567	Student [Student	9 9 8		()			
OTHER INSURED'S NAME (Last Name, First Name, Middle In	(a) 10. IS PATIENT'S CONDITION	N RELATED TO:	11 INSURED'S POLIC	Y GROUP	OR FECA	NUMBER	1	*************	
			9						
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT7 (CURREN	TOR PREVIOUS)	e. INSURED'S DATE O	FBRITH		and an infrastructure of such and	SEX	and the second second second	medica
	YES	NO	MM ; DD	. AA	1	u 🗀		F	
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME	OR SCH	OOL NAME			- Investment	heri
MM DO YY	TYES	NO .	majarjerije						
EMPLOYER'S NAME OF SCHOOL NAME	c. OTHER ACCIDENT?	and immediate	c. INSURANCE PLAN N	IAME OR	PROGRAM	NAME			
	Tyes	T NO		,		7.00			
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL		d. IS THERE ANOTHER	HEALTE	GENEET	Pi ZNO			ren
INDUPARCE FLAN RAME OR FROM HAME	TOU PLOGETY LO FON LOOPL	. GOL.	promp promp						
READ BACK OF FORM BEFORE CO	UPLETALC & CICARRO TURC ESCAL		Land and the second		if yes, return		-	relative are as as	
 PATIENT'S OR AUTNORIZED PERSON'S SIGNATURE 1 as to process this claim, I also request payment of government be below. 	thorize the release of any medical or other in	dormation necessary opts assignment	13. INSURED'S OR AU payment of medical services described to	benefits to					05
ALAST MA	DATE		a a a a a a a a a a a a a a a a a a a						
SIGNED_	DATE		SIGNEO		nierosistelėmami	neinterenten.	ROSE MATERIAL PROPERTY AND ADDRESS OF THE PARTY AND ADDRESS OF THE PART	WITHOUT THE T	in
4. DATE OF CURRENT: ILLNESS (First symptom) OR MAI DD YY INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME O GIVE FIRST DATE MM : D	RISIMBLAR BLINESS. D. : YY	16 DATES PATIENT U	MABLE TO		5,63,6	NT OCCU	PATION	
		1	FROM		-	0			_
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING	FPHYSICIAN	18. HOSPITALIZATION	DATES		5/65/6	ENT SERV	YY	
		-	FROM			0	<u> </u>		nga Lu
9. RESERVED FOR LOCAL USE			20. OUTSIDE LAB?	60	- \$7CH	ARGES	ľ		
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELAT	E ITEMS 1,2,3 OR 4 TO ITEM 24E BY LIN	E)	22 MEDICAID RESUBI	MISSION		055 46			
1. 290	3. Lagrana	*	23. PRIOR AUTHORIZI		ORIGINAL MBER	HEM. NO	2,	egenneget til til stansvente	lana
2.1	4 - 1		and the same of th						
4 A B C I	D D	5	F	G	H. [: 1	TJ	1	K	
DATE(S) OF SERVICE. Place Type F	ROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstanous)	DIMORPOSIO	}	DAYS E	amilto.	L		VED FOR	A
	(EXPLAIN CHOSCAL CITCUMSTANCES) CPT/HCPCS MODIFIER	CODE	5 CHARGES	UNITS	Plan EMG	COB	1.00	AL USE	
03 20 06 03 20 06 12	H0040		323 98	1					
		ļ				-	ļ	*********	
The state of the s									
		Į				-	ļ		,,,,,,
	t :		District Control of the Control of t			1	1		
		3				ļ	ļ		igen.
					į.	1	1		
		I		1				0.088414	, in
	4								
					-				
			1	-					
		Į i	N. Control of the Con	4	í				
FEDERAL TAX : D. NUMBER SSN 6IN 26. PA	TIENT'S ACCOUNT NO. 27. ACCE	PT ASSIGNMENT? vi. claims, see back)	28. YOTAL CHARGE	29.	AMOUNT P	AIO	SC. BALA	INCE OUR	Ē
mm	YES		s 323 9	8 \$	100	00	ŝ	223. 9	9
	ME AND ADDRESS OF FACILITY WHERE	harrier and the second	33 PHYSICIAN'S, SUPI	LIER'S B	and the second s	ria a commen			
INCLUDING DEGREES OR CREDENTIALS RE	NDERED (If other than home or office)		3 PHONE #	_					
(I certify that the statements on the reverse apply to this bill and are made a part thereof)				rovid					
			12 Ar	y Str	eet				
. Provider 03/20/06					NC 123	45 83000			

PLEASE DO NOT STAPLE N THIS AREA	Child and Adoleso	cent Day Treatment	
TTPICA	HEALTH IN	SURANCE CLAIM FORM	PICA TT
1. MEDICARE MEDICAID CHAMPUS CHA	MPVA GROUP FECA OTHER	Ta. INSURED'S LD. NUMBER (FOR PROGRAM)	N (TEM 1)
(Medicare #) X (Medicaid #) (Sponsor's SSN) (WA	File #7 SSN er (D) (SSN) ((D)	99999999T	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4, INSURED'S NAME (Last Name, First Name, Widdle Initial)	
Recipient, Jane D.	07 13 2001 M F X		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
123 Any Street	Self Spause Child Other		
	TATE B. PATIENT STATUS	CITY	TATE
	NC Single Married Other		
P CODE TELEPHONE (Include Area Code)	Employed Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA	A CODE)
12345 (919) 123-4567	Student Student	()	
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	
. OTHER INSURED'S POLICY OR GROUP NUMBER	A. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF SIRTH SEX	
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENY? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	- String
MM DO YY	YES NO		
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
	TYES NO		
INSURANCE PLAN NAME OF PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	Marie Contract of the Contract
		YES NO # yws, return to and complete its	m 9 a-d.
READ BACK OF FORM BEFORE COMPL 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorities to process this claim. I also request payment of government benefits below.	as the release of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I au payment of medical benefits to the undersigned physician or si services described below. 	
avalute.	0.000		
SIGNED	DATE 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	SIGNED	delenant/opension
4. DATE OF CURRENT: ALLNESS (First symptom) OR MM DD YY	GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP	ATION
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVI	ree
FORTILE OF THE BUSINESS FOR STOREST OF THE CONTROL		FROM DD YY MM DD	YY
D. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES	
s. restricts to reconstruct		Tyes Two	
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, IRELATE IT	EMS 1.2.3 OR 4 TO ITEM 24E BY LINE)	22. MEDICA:D RESUBMISSION	
	5. hammun ann	CODE OFIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER.	, eminosani navorano con
		43. PRIOR ACTOURISEFUCK NUMBER.	
2: <u>}</u>	4. L	F G H I I I	
DATE(S) OF SERVICE Place Type PROX	EDURES, SERVICES, OR SUPPLIES DIAGNOSIS	DAYS EPSOT DECEMBER	VED FOR
1 50 1 01-1	(Explain Unusual Circumstances) CODE		L USE
03 20 06 03 20 06 11 H2	012 HA	62 50 2	
			induka ana ana ana ana
1 1 1000			
			anandoros describentes anales e
			Observation of a linear series was subs
S FEDERAL TAX LO. NUMBER SSN EIN 26 PATIEN	IT'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALAN	CE DUF
ПП	(For govt. claims, see back) YES NO	s 62 50 s s	62 50
1: SIGNATURE OF PHYSICIAN OR SUPPLIER 32: NAME (AND ADDRESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP O	
	RED (If other than home or office)	8 PHONE #	
apply to this bill and are made a part thereof.		Any Provider	
		12 Any Street	
. Provider 03/20/06		Any town, NC 12345	
GNED DATE			

PLEASE DO NOT STAPLE N THIS AREA	Diagnostic Assess \$3.00 Copay deduc	ment ted for this service	
PICA	HEALTH IN	SURANCE CLAIM FORM	PICA TTT
I. MEDICARE MEDICAID GHAMPUS CHAM		R 1a. INSURED'S LD. NUMBER (FOR PROGR	AM IN ITEM 1)
(Medicare #; X (Medicaid #) (Sponsor's SSN) /VA	Fig. #) HEALTH PLAN BLK LUNG (ID) (SSN) (ID)	99999999T	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	energia de marco de la companio della companio dell
Recipient, Jane D.	07 13 2001 M SEX		
5. PATIENT'S ADDRESS (No. Street)	S. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADORESS (No., Street)	
123 Any Street	Self Spouse Child Other		
CRY ST	TE 6. PATIENT STATUS	CITY	TSTATE
Any Town			
ZIP CODE TELEPHONE (Include Area Code)	THE STREET WASHINGTON CONTROLLED	ZIP COOR TELEPHONE (INCLUDE A	REA CODE:
12345 (919) 123-4567	Employed Full-Time Part-Time-	1 1	men works
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	TIGUS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER	
CHARLE MAGGINES O COMME (Code Manuel Linds Learner Mindrick Linital)	io. Services occurrences records	13. MOORED S POSICY ORDOP OR PECA NORSER	
LOTHER INSURED'S POLICY OR GROUP NUMBER	« EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a insured's date of Birth SEX	F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
MM OD YY	YES NO		
EMPLOYERS NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	THE RESERVE OF THE PERSON NAMED IN COLUMN
	MYES MYC		
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH SENERIT PLAN?	
		YES NO If yes, recurs to and complete	a ithrin S. n. el
READ BACK OF FORM BEFORE COMPLETE. PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE 1 (authorized person's SIGNATURE 1)	the release of any repdice or other information recessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE payment of reedical benefits to the Undersigned physician	i authorize
to process this claim, I also request payment of gavernment benefits below.	Hither to myself or to the party who accepts assignment	services described below.	
SIGNED	DATE	SIGNED	
4. DATE OF CURRENT: (LLNESS (First symptom) OR MM DD YY NAULRY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMPLAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPANT OD YY MM DD	DUPATION
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.O. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SE	RVICES
		FROM	1.
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES	7.4.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITE	MS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION	
1. 290	3. 1	CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
2 [West of the second seco	
2 B C	D E	FIGHTIJI	K
From To of of	DURES, SERVICES, OR SUPPLIES DIAGNOSIS Explain Unusual Circumstances CODE CODE		ERVED FOR DOAL USE
03 20 06 03 20 06 11 T10	23	169 06 1	
		To the second se	
		<u> </u>	
		* AA 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
		THE STATE OF THE S	
5. FEDERAL TAX LD. NUMBER SSN EIN 26. PATIEN	'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT)	DO TOTAL CHARGE TOO ALIENDED	1 64/00/ 10/10/
to resident the to register 50% em 20, PAREN	[For govt daims, see back]		LANCE DUE
	YES NO	\$ 169.06 s 50.00 s	119.06
	ND ADDRESS OF FACILITY WHERE SERVICES WERE (ED. (If other than home or office)	SS. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS. I & PHONE #	RP CODE
(I certify that the statements on the reverte		Any Provider	
		Any Provider 12 Any Street	
(I certify that the statements on the reverte			

LEASE										
O NOT TAPLE V THIS	Intens	sive In-Home	Services							
REA		** A 1 TL J 5510	ni im a sin	r 01	A 13.6	FOI	mss			
FICA		EALTH IN		MARKATAN AND AND AND AND AND AND AND AND AND A	NAME OF THE PERSONNELS OF THE	rV:				PICA
MEDICARE MEDICAID CHAMPUS CHAMPUS [Medicare #] [] [Medicaid #] [] (Sponsor's SSN) [] (VA File.		IA OTHER (LUNG ISM) [77 (10)	1a. INSURED		MBCH			FURF	HOGHAR	IN ITEM ()
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File PATIENT'S NAME (Last Name, First Name, Middle Intial)		**************************************	99999999 4. NSURED'S		necessarias	umanananan Mark	re-en-en-en-en-en-en-en-en-en-en-en-en-en	E. E. el. de .	rate de management	with the second
ecipient, Jane D.	3. PATIENT'S BIRTH DATE MM DO YY	SEX	4. INSURED	S PARSONE CO	Latest system	ne, rasi	17480770.	MIGBIE	198(261)	
PATIENT'S ADDRESS (No. Street)	6 PATIENT RELATIONSHIP TO	FX	7. INSURED'S	2.00000	OC Sin	Dienos:			***************************************	
23 Any Street	Self Spouse Child	potenting planting	1. SNOUPLED S	AUUME	ao (req.,	201940				
•	8 PATIENT STATUS	CALLED	CITY	generalization en cons				- y rit, Baseline ay day to		STATE
Any Town NC		7							1	DIMITE.
IF CODE TELEPHIONE (Include Area Code)	Single Married	Other	ZIP CCDE			1 -01	MALION S		JRA BOU.	A 2005)
2345 (919 \ 123-4567		- Part-Time-	2.7 0000			1.00	i i	I mor	JUL ARE	A 0000E)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initiati	10. IS PATIENT'S CONDITION	Student	11. INSURED	SP DATE SO	V OBOL	0.00.0	(j ameri		
OTHER INSUREDS NAME (LIST NAME, FIRST NAME, MICH.	IG. IS PATIENT SCORESTION	REDATED TO:	III. INSURED	2 FOUTU	TURNUL	ir Un r	SCA N	UMBEH		
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT	OR PREVIOUS)	a. INSURED'S	DATEO	F BIRTH	ŧ	n in talken y to y to y the project	*****	SEX	Taller and American School
	YES	NO		, , ,			14		F	- []
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER	R'S NAME	OR SC	HOOL I	NAME			Territories de la company
MM DO YY	YES	NO .								
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?		c. INSURANC	E PLAN I	AME O	R PRO	GRAM!	HAME	i for girth i artigeisi marel sa	NAME OF THE OWNER, THE
	YES []NO								
I INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL L	JSE	a. IS THERE	ANOTHE	RHEALT	HBEN	EFIT PE	AN?		anghamaninanagan-giganga-gigan
			YES		NO	if yes,	return i	io and c	omplete ite	sm3 a-d.
READ BACK OF FORM BEFORE COMPLETS 12. PAYIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize it	NG & SIGNING THIS FORM.		13. INSURED							
 PATIENTS ON AUTHORIZED PERSON'S SIGNATURE: I sometize to to process this claim. I also request payment of government benefits enti- below. 	er to myself or to the party who accep	pts assignment	payment o services d			i îp thê (undersig	ived bu	yscan or s	supplier for
SIGNED	DATE		SIGNED							
	S. IF PATIENT HAS HAD SAME OR	SIMEAR LLNESS.	16. DATES P	ni Shiburatan ka	NABLE	TO WO	FOC IN C	URRE	VT OCCUR	PATION
MM DD YY INJURY (Accom) OR PREGNANCY(LMP)	GIVE FIRST DATE MM : DD	1.83	FROM	1 00	1 83		TO	5,63,6	00	AA.
the same of the sa	2. 1.D. NUMBER OF REFERRING	PHYSICIAN	18. HOSPITAL	LIZATION	DATES	RELAT	TEO TO	CURRI	ENT SERV	ices
			FROM	00	; YY		TO		. 00	ΥY
9, RESERVED FOR LOCAL USE			20. OUTSIDE	LAB?		****	S:CHA	RGES.		
			TYES		80 I				1	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM	1,2,3 OR 4 TO ITEM 24E BY LINE		22 MEDICAL	RESUBI	MISSION	ý				
, 290		*	CODE		. 1	ORIG	SINAL FI	EF. NO		
1. Approximate a more	3. L.		23. PRIOR AL	THORIZ	TION N	UMBER	Ä.			.,,
9.1	4.1:		Wilderson							
2 L G C C C C C C C C C C C C C C C C C C	B B	ε	F	nanemento instru	G-	H			}	K
	LIRES, SERVICES, OR SUPPLIES lain Unusual Circumstanors)	DIAGNOSIS		com de		EPSDT Family				VED FOR
MM DD YY MM DD YY Sanical Service CPT/HC	PCS MODIFIER	CODE	\$ CHARG	,	UNITS	P)an	. EMG	009	LOG	AL USE
03 20 06 03 20 06 11 H202	2		190	00	1					
		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		h-n						
			1							
			<u></u>							
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			<u> </u>		3					
		8	E-							
	and the second s			-				*****		
		9	1							
and the state of t	and the second second second second		1							
S. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENTS	ACCOUNT NO. 27, ACCEP	T ASSIGNMENT?	28. TOTAL CH	ARGE	29	. AMGL	INT PA	ō.	30. SALA	NGE DUE
nn i	For govt	t clarms, see back) NO	§	190 0						190:00
	ADDRESS OF FACILITY WHERE		33. PHYSICIAI	VS, SUPI	Lieks	BRLIN	G NAME	E, ADDI	and the same of the same of	*******
	3 (If other than home or office)		& PHONE							
apply to this bill and are made a part thereof.)			2	Any E						
			Partition in the Control of the Cont	12 An Any t			1224	5		
. Provider 03/20/06			9700	-	- Wii,				00	
SIGNED DATE .			PBN# 8300	OUUH		1.6	impr 8	2000	UU	

PLEASE DO NOT STAPLE IN THIS AREA	Mobile Crisis	
FICA	HEALTH INSUR	RANCE CLAIM FORM
1. MEDICARE MEDICAID CHAMPUS	HAMPVA GROUP FECA OTHER 1a. 1	INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) X (Medicaid #) (Sportsor's SSN)	(VA File #) HEALTH PLAN BLK LUNG (SSN) (ID) 995	999999T
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE SEX 4. IN:	VSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Jane D.	07 13 1978 M F X	
5. PATIENT'S ACORESS (No., Street)	C1000 A0000 100000 A0000	VSURED'S ADDRESS (No., Street)
123 Any Street	Set Spouse Chid Other STATE 9 PATIENT STATUS	
Any Town	NC -	Y STATE
ZIP CODE TELEPHONE (Include Area C	Single Married Other	CODE TELEPHONE (INCLUDE AREA CODE)
12345 (919) 123-4567	Employed Full-Time Part-Time Student Student	( )
3. OTHER INSURED'S NAME (Last Name, First Name, Middle in	The state of the s	INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSUREO'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. IN:	NSURED'S DATE OF BIRTH SEX
AND TO LOCATE DATE OF BURNIA	LJYES LJWO	M L F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State) b. EM	MPLOYER'S NAME OR SCHOOL NAME
C EMPLOYER'S NAME OR SCHOOL NAME	manufactured based because of	VISURANCE PLAN NAME OR PROGRAM NAME
	YES NO	Country and a contract of a state of the country of
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE d. IS	S YHERE ANOTHER HEALTH BENEFIT PLAN?
	THE STATE OF THE S	YES NO If yes, return to and complete item 9 a.c.
READ BACK OF FORM BEFORE CO 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: 1 au to process this claim. I also request payment of government be below.	horize the release of any medical or other information necessary	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I sumprise payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14 DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) DR PREGNANCY (LMP).	SIVE PIRSTURIE THAT DU TT	DATER PATIENT LINARLE TO WORK IN CURSERT OCCUPATION  MM DD: YY  TO ::  TO ::
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM , DD , YY
19. RESERVED FOR LOCAL USE	***	FROM TO: OUTSIDE LAB? \$ CHARGES
19 RESERVES FOR LOUAL USE	120.0	TYES TNO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELAT	TEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 22. M	MEDICAD RESUBMISSION
1: 290	3	PRIOR AUTHORIZATION NUMBER
24 A 18 C	4	F G B L L J L K
DATE(S) OF SERVICE PIECE Type F	ROCEDURES, SERVICES, OR SUPPLIES DIAGNOSIS	S CHARGES OF Family DAG COB LOCAL USE
03 20 06 03 20 06 12	H2011	127 16 4
		The state of the s
25. PEOERAL TAX LO NUMBER SSN EN 26. PA	TENT'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT? 28, TO	THE CHARLES IN THE CONTRACT OF
ED PENERAL THA LU, RUMBER SON EN 26. PA	TENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TO [For gov: claims, see back) \$	OTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 127 16 \$ 25 00 \$ 102 16
31. SIGNATURE OF PHYSICIAN OR SUPPLIER S2. NA INCLUDING DEGREES OR CREDENTIALS RE II certify that the statements on the reverse	IE AND ADDRESS OF FACILITY WHERE SERVICES WERE   32. PA	127: 16 S 25 00 S 102 16  HYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #
apply to this tell and are made a part thereof.)	-	Any Provider
A. Provider 03/20/06		12 Any Street Any town, NC 12345 8300000F GREW 8300000
signed DATE	Piste	830000F GRP# 8300000

OC NOT STAPLE N THIS SPEA	Multi-systemic Th	nerapy (MST)
FICA	HEALTH IN	SURANCE CLAIM FORM
I, MEDICARE MEDICAID CHAMPUS CHAM		R 1s. INSURED'S LD. NUMBER (FOR PROSPAM IN ITEM 1)
(Medicare #) X (Medicaid #) (Spontar's SSN) /VA	File #) (SSN or ID) (SSN) (ID)	99999999T
PAY(ENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4, INSURED'S NAME (Last Name, First Name, Mipdle Initial)
Recipient, Jane D.	07 13 1999 ₩ F X	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Street	Self Spouse Child Other	
STY	ATE B. PATIENT STATUS	CITY STATE
Any Town	NC Single Married Other	
TELEPHONE (Include Area Code)	Service Servic	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
12345 (919) 123-4567	Employed Full-Time Part-Time	
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
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)  VES NO	a. INSURED'S DATE OF SHITH SEX
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	B. EMPLOYER'S NAME OR SCHOOL NAME
MM DO YY	YES NO	I
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OF PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If year, return to and complete item 9 a-a.
READ BACK OF FORM BEFORE COMPLI 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorized process this claim. I also request payment of government benefits below.	te the release of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: authorize payment of medical banelits to the undereigned physician or supplier for services described below.</li> </ol>
SIGNED	DATE	SIGNED
4. DATE OF CURRENT: A RLINESS (First symptom) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	
MM DD YY RAILRY (Accident) DB PREGNANCY(LMP)	GIVE FIRST DATE MM   CD   YY	FROM: DD - YY
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17s. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
		FAOM DD YY MM DD YY
		FROM
R: RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES.
9. RESERVED FOR LOCAL USE	abush or arrange and make the committee what completions earlier amount consumer consultance and demonstrated	20. OUTSIDE LAB? . S CHARGES.
	EMS 1,2,3 OR 4 TO FIEM 24E BY LINE)	20. OUTSIDE LAB? S CHARGES  YES NO SOME SOURCES ON SOME SOURCES OF SOME SOURCES ON SOURCES
9: RESERVED FOR LOCAL USE  1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)  1. \( \sum_{290} \),	EMS 1.2.3 OR 4 TO FEM 24E BY LINE)	20. OUTSIDE LAB? . S CHARGES
B. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)		20. OUTSIDE LAB? S CHARGES.  TYES NO SOLUTION OF CODE OF THE CODE
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT) 1. 290 2 4. A B C	4	20. OLITSIDE LAB? S CHARGES.  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)     1. 290	3. L. E  BOURIES, SERVICES, OR SUPPLIES DIAGNOSIS Explain Unusual Circumstances	20. OUTSIDE LAB? S CHARGES.  YES MO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H J K DAYS [PSDR]  P CHARGES OR Family THE CORP. RESERVED FOR
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)     290	L	20. OUTSIDE LAB? \$ CHARGES.  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COS RESERVED FOR LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)   290	3. L. E  BOURIES, SERVICES, OR SUPPLIES DIAGNOSIS Explain Unusual Circumstances	20. OUTSIDE LABP S CHARGES  YES MO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H J K DAYS [PSDR] P GRANN THE COR RESERVED FOR
	L	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)     290	L	20. OUTSIDE LAB? S CHARGES.  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
290	L	20. OUTSIDE LAB? S CHARGES.  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)   290	L	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)   290	L	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)  290  1  A	L	20. OLITSIDE LAB? S CHARGES.  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB RESERVED FOR LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)   290	L	20. OLITSIDE LAB? S CHARGES.  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB RESERVED FOR LOCAL USE
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)   290	L	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
290	L	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)  2. L. S. C. PRICE TO SERVICE TO OF SERVICE SER	L	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)  2	3. L. E  EDURIES, SERVICES, OR SUPPLIES Explain Unusual Circumstances) MCPCS   MCDIFFER  0333   DAGNOSIS CODE  TS ACCOUNT NO. 27, ACCEPT ASSISHMENT?	20. OLITSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSDY S CHARGES OR Family EMG COB LOCAL USE
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)  2. L  4. A	3. L. E  EDURES, SERVICES, OR SUPPLIES  Explain Unusual Circumstances)  MODIFIER  033	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H J K DAYS EPSDT ENG COB RESERVED FOR LOCAL USE  94 16 4
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE TITLE 190)  2. L	3. L. E  EDURIES, SERVICES, OR SUPPLIES Explain Unusual Circumstances) MCPCS   MCDIFFER  0333   DAGNOSIS CODE  T'S ACCOUNT NO.   27, ACCEPT ASSIGNMENT? (For gov. Jelms. sea back) LYES   NO.	20. OUTSIDE LABP S CHARGES  YES NO  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K CAPTER S CHARGES  S CHARGES OR Family EMG COB LOCAL USE  94 16 4  28. TOTAL CHARGE 22. AMOUNT PAID 30. BALANCE DUE \$ 94 16 \$ \$ 94 16  30. PHYSICIAN'S, SUPPLIER 5 SELLING NAME, ADDRESS, ZIP CODE
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE TIT)  2. 1. 290  2. 1. 8 C PROC.  4. A B C PROC.  5. PORTE(S) OF SERVICE TO OR SUPPLIES SERVICE OF SE	3	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H J J K S CHARGES S CHARGES OR PRIME EMG COS RESERVED FOR LOCAL USE  94 16 4  28. TOTAL CHARGE 22. AMOUNT PAID 30. BALANCE DUE \$ 94 16 S S 94 16 39. PHYSICIAN'S, SUPPLIER'S SILLING NAME, ADDRESS, ZIP CODE 8 PHONE #
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE TY  2.	3. L. E  EDURIES, SERVICES, OR SUPPLIES Explain Unusual Circumstances) MCPCS   MCDIFFER  0333   DAGNOSIS CODE  T'S ACCOUNT NO.   27, ACCEPT ASSIGNMENT? (For gov. Jelms. sea back) LYES   NO.	22. MEDICAID RESUBMISSION OF CLINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H I J K DAYS EPSOD S CHARGES OR FAMILY EMG COB LOCAL USE  94 16 4  28. TOTAL CHARGE 22. AMOUNT PAID 30. BALANCE DUE \$ 94 16 5 S 94 16 5 S 94 16 S PHONE # ANY Provider
DAYE(S) OF SERVICE TO SERVICE SOLUTION SERVICE SERVICE TO SERVICE TO SERVICE TO SERVICE TO SERVICE SERVIC	3	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  F G H J J K S CHARGES S CHARGES OR PRIME EMG COS RESERVED FOR LOCAL USE  94 16 4  28. TOTAL CHARGE 22. AMOUNT PAID 30. BALANCE DUE \$ 94 16 S S 94 16 39. PHYSICIAN'S, SUPPLIER'S SILLING NAME, ADDRESS, ZIP CODE 8 PHONE #

PLEASE DO NOT STAPLE	Partial Hospital	
N THIS AREA		
TTTPICA	HEALTH IN	SURANCE CLAIM FORM
1. MEDICARE MEDICAID CHAMPUS CHAI	IPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	R 1a, INSURED'S LD. NUMBER   FOR PROGRAM IN ITEM 1)
	File #1 (SSN or ID) (SSN) (ID)	99999999T
2. PATIENTS NAME (Last Name, First Name, Middle Initial) Recipient, Jane D.	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Modile Instal)
S. PATIENT'S ACORESS INC., Street	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Street	Self Spause Child Other	c. modition and the transfer and the
STY	ATE 6. PATIENT STATUS	CITY STATE
Any Town	IC Single Married Other	1 10 1
TP CODE TELEPHONE (Include Area Code)	Employed Full-Yime Part-Filmer	ZIP GODE TELEPHONE (INCLUDE AREA CODE)
12345 (919) 123-4567	Student Student	
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
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a INSURED'S DATE OF BIRTH SEX
OTHER INSURED'S DATE OF BIRTH SEX	D. AUTO ACCIDENT? PLACE (State)	b EMPLOYER'S NAME OR SCHOOL NAME
MM DO YY	TYES TWO :	S. CHIPTEN OR OR GOTOLL NAME
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	[] YES [] NO	
DISURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH SENEFIT PLAN?
READ BACK OF FORM BEFORE COMPL	TIMA A PARINET THE PARIS	YES NO If yes, return to and complete item 9 a-c.
<ol> <li>PATIENTS OR AUTHORIZED PERSON'S SIGNATURE 1 authorities process this claim. I slee request playment of government benefits below.</li> </ol>	s the release of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED	DATE	SIGNED
4. DATE OF CURRENT: (ILLNESS (First symptom) OR MM DO YY (NEARY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMEAR ILLNESS. GIVE FIRST DATE MM : DD : YY	
7. 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
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES
21. DIAGNOSIS OF NATURE OF ILLNESS OF INJURY, (RELATE IT)	MS 1,2,3 OR 4 TO (TEM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
r. <u>L 290</u>	3. L	23. PRIOR AUTHORIZATION NUMBER
2. English and the second seco	4. Language de la company	
	D E  DURES, SERVICES, OR SUPPLIES DIAGNOSIS	F G H I J K DAYS EPSD RESERVED FOR
	Explain Unusual Circumstances) CODE HCPCS MODIFIER	S CHARGES OR Family EMG COS LOCAL USE
03 20 06 03 20 06 21 HO	35	121 69 1
		1
5 FEDERAL TAX LD. NUMBER SSN EN 26 PATIEN	PS ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28 YOTAL CHARGE 29 AMOUNT PAID 30 BALANCE DUE
	For govt planns, see back) YES NO	\$ 121 69 \$ 50 00 \$ 71 69
	ND ADDRESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
(I certify that the statements on the reverse	IED (If other than home or office)	& PHONE #
apply to filis bill and are made a part thereof?		Any Provider 12 Any Street
. Provider 03/20/06		Any town, NC 12345
		PMS# 8300000D GRP# 8300000

	Facility-Based Cr	·
PICA	HEALTH IN	SURANCE CLAIM FORM PICA
MEDICARE MEDICAID CHAMPUS CHAM	APVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	R 14. INSURED'S LD. NUMBER (FOR PROGRAM IN (TEM 1)
(Medicare #) X (Medicaid #) (Sponsor's SSN) (VA	File #) SSN or ID; (SSN) (ID)	99999999T
PATIENT'S NAME (Last Name, First Name, Middle Intial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ecipient, Jane D.	07 13 1978 M F X	as of the East
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
23 Any Street	Self Spouse Child Other	or expension
TY ST	ATE 8. PATENT STATUS	CITY STATE
ny Town	NC Single Married Other	and the state of t
P CODE   TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
2345 (919) 123-4567	Employed Pust Time Part Time	***
OTHER INSURED'S NAME (Last Name, First Name, Middle Inidel)	10, IS PATIENT'S CONDITION RELATED TO:	11 INSURED'S POLICY GROUP OR FECA NUMBER
OTHER PROPERTY OF THE GROUP IN THE PROPERTY OF		
AWARA WALLDOWN BOLLOV OF ADALOUS SILESCO	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	A RICHITETRO DAYE OF DIOYU
OTHER INSURED'S POLICY OR GROUP NUMBER		a, INSURED'S DATE OF BIRTH SEX
communication action continuous hardinastication training and accommon hardinastication and the continuous accommon training and the continuous accommon training and the continuous accommon to the continuous accommon training and the continuous accommon to the continuous accommon training and the continuous accommon to the continuous accommon training and the continuous accommon to the continuous accommon training and the continuous accommon training and the continuous accommon training and the continuous accommon training accommon training and the continuous accommon training acco		
OTHER INSURED'S DATE OF BIRTH SEX MM : DO : YY		V ST. CWILLITER S NAME OR SURJULI. NAME
M	YES LINO	
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OR PROGRAM NAME	100. 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 COMPU 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 24/horo	ETING & SIGNING THIS FORM. The thin telepase of any medical or other information necessary.	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for</li> </ol>
to process this claim. I also request payment of government benefits	either to myself or to the party who accepts assignment	services described below.
below.		
SIGNED	DATE	SIGNED
DATE OF CURRENT: A ILLNESS (First symptom) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	S. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM ; DD : YY
MM   D0 : YV   (NJURY (Accident) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY	FROM TO YY
7. NAME OF REFERRING PHYSICIAN OR OTHER SOLINCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
		FROM DD YY MM DD YY
9. RESERVED FOR LOCAL USE		20, OUTSIDE LAB? \$ CHARGES
		- Tyes Two
1. DIAGNOSIS OF NATURE OF ILLNESS OF INJURY. (FIGLATE (T	EMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION
290		CODE ORIGINAL REF. NO.
	3. Emperorant r trans	23. PRIOR AUTHORIZATION NUMBER
2 L	. 4- L	F IGIHIII K
DATE(S) OF SERVICE Place Type PROC	DEDURES, SERVICES, OR SUPPLIES DIAGNOSIS	DAYS EPSOT RESERVED FOR
	(Explain Unividal Circumstances) CODE	3 CHARGES UNITS Plan EMG COB LOCAL USE
03 20 06 03 20 06 21 89	484	300 48 16
THE RESERVE THE PROPERTY OF TH		
		And the second s
		- 1
		The state of the s
	THE ADDRESS OF THE STATE OF THE	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
5. PEDERAL TAX LD. NUMBER SSN EIN 26. PATIE?	(For govi. plants, see back)	
S. PEDERAL TAX LO. NUMBER SSN EIN 26. PATIE?	YT'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT? [For gov. clems, see back]  YES NO	s 300 48 s 50 00 s 250 48
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME.	YES NO AND ADDRESS OF FACILITY WHERE SERVICES WERE	\$ 300 48 \$ 50 00 \$ 250 48  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME INCLUDING DEGREES OR CREDENTIALS RENDE If certify that the statements of the reverte	YES NO	s 300 48 s 50 00 s 250 48  33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 3 PHONE #
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME. INCLUDING DEGREES OR CREDENTIALS RENDE	YES NO AND ADDRESS OF FACILITY WHERE SERVICES WERE	s 300 48 s 50 00 s 250 48  33 PHYSIGIANS, SUPPLIER'S BILLING NAME. ADDRESS, ZIP CODE 3 PHONE #  Any Provider
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME INCLUDING DEGREES OR CREDENTIALS RENDE If certify that the statements of the reverte	YES NO AND ADDRESS OF FACILITY WHERE SERVICES WERE	s 300 48 s 50 00 s 250 48  33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 3 PHONE #

LEASE O NOT		
TAPLE TTHIS REA	Psychosocial Reha	bilitation
PICA	HEALTH IN	SURANCE CLAIM FORM PICA TOTAL
MEDICARE MEDICAID CHAMPUS CHAMP	PVA GROUP PEGA OTHER HEALTH PLAN BUK LUNG	1a. INSURED'S LD. NUMBER (FOR PROGRAM IN (TEM 1)
(Medicere #) X (Medicaid #) (Sponsor's SSN) (VA F.	## (SSN or ID) [SSN) [ID]	99999999T
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle India)
Recipient, Jane D.	07 13 1978 M F X	7. INSUREDS ADDRESS (No., Street)
PATIENT'S ADDRESS (No., Street)  123 Any Street	Set Spouse Child Other	7. INSUREI S ALUMEDS (NO., 58991)
•	TE E PATIENT STATUS	CITY
Any Town	Single Married Other	
P CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INGLUDE AREA CODE)
2345 (919) 123-4567	Employed Full-Time Part-Time Student Student	( )
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
OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	5. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY	TAER NO	
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER AGGIDENT?	c, INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLET	THIC & GIGNING THIC ECOM	YES NO If yes, return to and complete item 9 s.s.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize to process this claim. Lateo request payment of government benefits el below.</li> </ol>	the release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for services described believe.
SKINED	DATE	SIGNED
4. DATE OF CURRENT:   ILLNESS (First symptom) OR   SMM   DD   YY   INSURY (Accessed OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM OD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM. DD YY TO YY FROM DD YY
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. LD. NUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? & CHARGES
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITE)	MS 1,2,3 OR 4 TO ITEM 246 BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1	3. Industriance - succession	23. PRIOR AUTHORIZATION NUMBER
2 <u>                                    </u>	4. L	F G H I J J K
DATE(S) OF SERVICE TO Place Type PROCE	DURES, SERVICES, OR SUPPLIES DIAGNOSIS xplain Unusual Circumstancial) CODE CODE	S CHARGES DAYS EPSD OR FAMING COB LOCAL USE
03 20 06 03 20 06 11 H20	17	9 36 4
3		
A AND THE STATE OF		
5. FEDERAL TAX LO. NUMBER SSN EIN 26. PATIENT	rs account no. 27 accept assignment? (For govi. dalms, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	(For govi. dialine, see eack)  YES NO	s 9 36 s s 9 36
INCLUDING DEGREES OR CREDENTIALS RENDER IT contily that the statements on the reverse	ND ADDRESS OF FACILITY WHERE SERVICES WERE IEO (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 3. PHONE 9
apply to this bill and are made a part thereof?		Any Provider 12 Any Street
A. Provider 03/20/06		Any town, NC 12345
SGNED DATE		PRKE 8300000S GRP# 8300000

PLEASE DO NOT STAPLE IN THIS AREA	Substance Abuse C Outpatient Treatm	
PICA	HEALTH IN:	SURANCE CLAIM FORM PICA
1. MEDICARE MEDICAID CHAMPUS CHAM	HEALTH PLAN BLK LUNG	R 18. INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)
A best	File #) (SSN or ID) (SSN) (ID)	99999999T
2. PATIENTS NAME (Last Name, First Name, Meddle initial)  Recipient, Jane D.	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Street	Self Spouse Child Other	The state of the s
CITY	ATE 8. PATIENT STATUS	CITY STATE
Any Town	IC Single Married Other	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
12345 (919) 123-4567	Employed Full-Time Part-Time Student Student	( )
OTHER INSURED S NAME (Last Name, First Name, Middle Initiel)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OF FECA NUMBER
II. OTHER INSURED'S POUCY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NÓ	a INSURED'S DATE OF BIRTH SEX
B. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	6 EMPLOYER'S NAME OR SCHOOL NAME
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	G. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
I, INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM SEFORE COMPL	TTING & CICARRIO THE COSTA	YES NO # yes, return to and complete item 9 a-d.
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I subtions to process this claim: I also request payment of government benefits below.</li> </ol>	is the release of any medical or other information necessary	<ol> <li>HISURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorized payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNEO	DATE	SIGNED
14, DATE OF CURRENT: (ILINESS (First symptom) DR  MM DD YY (Accident) DR  PREGNANCYCUP:	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   CO   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. MUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DD YY MM DD YY FROM TO
19, RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT)	MS 1,2,3 OR 4 TO ITEM 24E BY LINE)	122 MEDICAID RESUBMISSION
1 290	3. Europeanous a sone	CODE ORIGINAL REF, NO. 23. PRIOR AUTHORIZATION NUMBER
2 tunner i ven	4. L	
From To of of	EDURES, SERVICES, OR SUPPLIES DIAGNOSIS Explain Unusual Circumstances) CODE HCPCS MODIFIER CODE	F G H I J K  DAYS EPSDT S CHARGES OR Family EMG COB LOCAL USE
	235	45 76 1
1 1 1 1 1		
S FEDERAL TAX D. NUMBER SSN EIN 26 PATIEN	T'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see 5sck)	28. TOTAL CHARGE 29. AMOUNT PAID 35. BALANCE DUE
	YES NO	s 45 76 s 20 00 s 25 76
NOLUDING DEGREES OR CREDENTIALS RENDER (I certify that the statements on the reverse .	ND ADDRESS OF FACILITY WHERE SERVICES WERE RED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 3. PHONE #
apply to this bill and are made a part thereof.)		Any Provider 12 Any Street
A. Provider 03/20/06		Any town, NC 12345
IGNED DATE		PRNS 8300000P GEPE 8300000

PLEASE DO NOT STAPLE N THIS AREA	Substance Abuse I Outpatient Progra	m (SAIOP)
PICA		SURANCE CLAIM FORM PICA TITLE
the state of the s	HEALTH PLAN BLK LUNG	1s. INSURED'S LD, NUMBER (FOR PROGRAM IN ITEM 1)
X	4 File #) [ ISSN or ID] [ ISSN) [ ID]	999999997
2. PATIENT'S NAME (Last Name, First Name, Middle indial)	3. PATIENT'S BIRTH DATE SEX	4, INSURED'S NAME (Last Warre, First Name, Middle Indian)
Recipient, Jane D.	07 13 1978 M F X	? INSURED'S ADDRESS (No., Street)
5. PATIENT'S ADDRESS (No., Street) 123 Any Street	Set Spouse Child Other	F. MOUREU S MUNTELS TRUE STORY
	TATE IS PATIENT STATUS	CITY STATE
Any Town	NC Single Married Other	
ZIP CODE TELEPHONE (Include Area Cude	manned that had been	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
12345 (919 ) 123-4567	Employed Full-Time Part-Time Student Student	The state of the s
OTHER INSURED'S NAME (Last Name, First Name, Middle Install		11. INSURED'S POLICY GROUP OR FECA NUMBER
		arrange -
LOTHER INSURED'S POLICY OR GROUP NUMBER	4. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
, OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY	YES NO	
EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
L INSURANCE PLAN NAME OR PROGRAM NAME	10s. RESERVED FOR LOCAL USE	O. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		. YES NO If yes, return to and complete item 9 a.d.
READ BACK OF FORM BEFORE COMP 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorities to process this claim. I also request payment of government benefi- below.	rize the release of any midical or other information necessary	<ol> <li>Insured's on authorized PERSon's Signatyrie lauthorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED	CATE	SIGNED
14. DATE OF CURRENT:   ILLNESS (First symptom) OR INJURY (Accident) DR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	16. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD W NUMPY (Accident) DR PREGNANCY(LMP)	GIVE FIRST DATE MM. OD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 10 YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17g. I.O. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM : DO
IS RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE	TEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CHIGHNAL REF NO.
1, 290	3	23. PRIOR AUTHORIZATION NUMBER
2 1	4: [	
24. A 8 C	D E CEDURES, SERVICES, OR SUPPLIES PARAMETERS	F G H J J K DAYS EPSOTI DECEMBED END
From of of	(Explain Unusual Circumstances) DIAGNOSIS (Explain Unusual Circumstances) CODE THOPOS   MODIFIER	S CHARGES OR Family EMG COB LOCAL USE
03 20 06 03 20 06 11 H	0015	131 93 1
25. FEDERAL TAX LD. NUMBER SSN EN 26. PATS	ENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	YES NO	\$ 131 93 \$ \$ 131 93
	AND ADDRESS OF FACILITY WHERE SERVICES WERE SERED (If other than home or office)	33: PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
il centry that the statements on the reverse		Any Provider
apply to this bill and are made a part thereof?		12 Any Street
		Any town, NC 12345
A. Provider 03/20/06		PIN# 8300000Q GRP# 8300000

PLEASE DO NOT STAPLE N THIS SPEA	Substance Abuse M Monitored Residen	tial Treatment
TPCA		SURANCE CLAIM FORM PICA TITLE
MEDICARE MEDICAID CHAMPUS CHAMP	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) X (Medicaid #) (Sponsor's SSN) (VA F	(SSN or ID) (SSN) (IU)	99999999T
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Jane D.	07 13 1978 M F X	7 INSURED'S ADDRESS (No., Street)
5, PATIENT'S ADDRESS (No., Street)	ferror young proving proving	F. REDUCEUS PEUCIESS (RES. SHORE)
123 Any Street	Self Spouse Child Other TE 8 PATIENT STATUS	CITY STATE .
Any Town NO	· promp promp profes	3
ZIP CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
12345 (919 ) 123-4567	Employed Futi-Time Part-Time	4
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Indial)	10, IS PATIENT'S CONDITION RELATED TO:	11 INSURED'S POLICY GROUP OR FECA NUMBER
		1
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
	YES NO	MD FO
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY	YES NO	
C. EMPLOYER'S NAME OR SCHOOL NAME	c: OTHER ACCIDENT?	E. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH SENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLE	Tree Tree Tools	YES NO # yes, return to and complete item 9 a-d.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. Lalso request payment of government benefits a below.</li> </ol>	this reliance of mor medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14, DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY NLURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DO YY	FROM DB YY TO MM QD YY
17: NAME OF REFERRING PHYSICIAN OR CTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM , DD , YY FROM , TO , YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITE	MS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
290 7. Laurence	* · · · · · · · · · · · · · · · · · · ·	
T. bassiniarium v. namn	A banaciones a sour	23. PRIOR AUTHORIZATION NUMBER
2	4. [	
24: A B C	D E	DAYS EPSOTI RESERVED FOR
From of of (E	EXPLAIN LINUSUAL CIRCUMSTANCES) DIAGNOSIS EXPLAIN LINUSUAL CIRCUMSTANCES) CODE HCPCS   MODIFIER	5 CHARGES OR Family EMS COB LOCALUSE
03 20 06 03 20 06 21 H00		265 25 1
Management of the second secon		
1		
25. FEDERAL TAX LO. NUMBER SSN EIN 26. PATIEN	TIS ACCOUNT NO. 27. ACCEPT ASSIGNMENT? [For gov. daims, see back]	28. TOTAL CHARGE 29. AMOUNT PAID 80. BALANCE QUE \$ 265, 25 \$ \$ 265, 25
	YES NO  IND ADDRESS OF FACILITY WHERE SERVICES WERE RED If other than home or office)	
HANNAGLAD SAFOLSTON PLANTAGED LIGHTED LIGHTED		Any Provider
(f certify that the sistements on the reverse apply to this bit and are made a part thereof.)		
it certify that the statements on the feverine epoly to this bit and are made a part thereof.)  a. Provider 03/20/06		12 Any Street Any town, NC 12345

PLEASE 30 NOT STAPLE N THIS							ance Abuse No nity Resident							
AREA .														
TTPICA						F	EALTH INS	URANCE	CL	AIM	FOI	RM		PICA
. MEDICARE MI	EDICAID	CHAMPUS		CHAMPVA	GROU	P FE TH PLAN BL	CA OTHER	ta. INSURED'S	LD. NUN	RER	interest Action	announnement.	FOR PE	OGRAM (NITEM 1)
(Medicare #) X	ledicaid #) (	Sponsor's S	SN)	EVA File	8) (SSN	er iDj	SSN) [ ((D)	999999999	T					
PATIENT'S NAME LIN	st Name, First Nar	ne, Middle i	ntial)	Samuel and the second	3 PATIENTS		SEX	4. INSURED'S	RAME (L)	est Nac	ne, First	Name,	Micidia	(neiat)
Recipient, Jan	e D.		and the last transfer was		07 1	3 1978 ₩	auchtivitiefune in der nur von nur die Welter verne	inerana. Notice en este este Priorit	an the desire of the second			******	n 'n Tan Inna' angharan	
5. PATIENT'S ADDRESS						ELATIONSHIP 1	percent grown	7. INSURED'S A	4DORES!	S (No.	Streeti			
123 Any Street		described to the Control of the Control		- magazini programa di magazini di magazin	Land .	Spouse Chris	d Other			eres es con		and the second second		
CITY				NC	8. PATIENT S		posses,	CITY						STATE
Any Town	L wint or mi	APA (P. C) - 1	de Arres E		Singla	Married	Other	ZIP CODE	APPROXIMATE AND	Adams and the second	Test	COLON	E ONO.	UDE AREA CODE)
ZIP CODE 12345		HONE (Inclu 9 \ 123		(50%)	Employed -	Pas-Time ;		ZIP CODE			100	ephon (	E IMOL	GUE AREA (GUE)
12345 BOTHER INSURED'S N	1.3	7		rigiali	TO IS DATE	Student L	Student	11. (NSURED'S	POSICV	gaor	IP OB S	FCA N	/ WRER	
OTHER Wounder on	HAME (Last Name)	, FIRST NUKE	r, endute tr	14(21)	10.1017416	nt doombind	A TRUENTED TO	11. 14501455		1,21 11,21	// (111)	# AV 131	STREET, LT	
OTHER INSURED'S P	OLICY OF GROU	IP NUMBER	۹		a, EMPLOYM	ENT? (CURREN	T OR PREVIOUS)	a, INSURED'S I	DATE OF	BIATI	K	ì.s		SEX F [ ]
OTHER INSURED'S 0	ATE OF BIRTH	SE:	y		b. AUTO ACC		PLACE (State)	b. EMPLOYER:	S NAME	OR SC	HOOL	NAME	Jani	-
MM DD YY		AL TOTAL	, F{	1		YES	NO .							
EMPLOYER'S NAME				Ĺ	c. OTHER AC	CIDENT?	wel browned	c. INSURANCE	PLAN N	AME C	R PRO	GRAW (	KAME	nem nemicrosis neikonskinski komponente nemen nemen en e
						YES	NO							
INSURANCE PLAN N	AME OR PROGR	ala name			10d RESER	ED FOR LOCAL	. USE	d. IS THERE A!	WOTHER	HEAL	TH SEN	EFIT PL	AN?	
								YES	□ N	40	It yes	return t	e and c	omplete item 9 a-c.
12. PATIENTS OR AUTI to process this claim, below.	READ BACK O HORIZED PERSO I also request pay	M'S SIGNA	TURE (a	ethorize the	retease of any	medical or other in	elomation necessary		medicai t	yenefiti				TURE I authoriza rsician or supplier for
SIGNED					DA	TE		SIGNED						
14. DATE OF CURRENT	· A ILLNESS (	Firet sympto	m) OR	15.	IF PATIENT H	AS HAD SAME O	A SIMILAR ILLNESS.	16. DATES PAT	TENT US	ABLE	TOWO	PAC IN C	UAREI	T OCCUPATION
MM DD YY	INJURY (A	coident) OR		į	GIVE FIRST D	ATE MM STA	D 1/4	FROM	00	. XA		70	1/01/	DD YY
17. NAME OF REFERRI			SOURCE	17a	I.D. NUMBER	OF REFERRING	PHYSICIAN	18, HOSPITALI MM FROM	ZATION	DATES	RELAT	TED TO	1466	NT SERVICES DD YY
19. RESERVED FOR LO	XCAL USE							20. OUTSIDE L	AB?	0.		\$ CHA	RGES	
21. DIAGNOSIS OR NA	TURE OF ILLNES	SORIKJU	RY. (RELA	TE TEMS	1,2,3 OR 4 TO	TEM 24E BY LIN	(E)	22. MEDICAID	RESUBM	ilesio	ORK	SINAL R	EF. NO	
290					3. L	NOW.	<b>y</b>	23: PRIOR AUT	HORIZA	TION	WUMBE)	A.		
2					4. L		~					,	,	
24. A DATE(S) OF	CERNACE .	B Piece	C			S. OR SUPPLIE	E DIAGNOSIS	F			EPSD?		1 1	RESERVED FOR
From PY	MM DD	et	of eServices	CPT/HCP	sin Unusual Ciri CS MOE	ournstances) HREA	CODE	\$ CHARGE	s ,	OR UNITS	Family Plan	EMG	COB	LOCAL USE
03 20 06	03   20   0	06 21	0.000	н0012	НВ			145	50	1				
										hammen of the state of	ļ		Andrew Services	the second of the contribution of the contribu
1 1	5		000000					ž.						
	and the second									general control of				
		Ī	SERVICE		-									
			1000	Š.	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9								-
	1 1	B. 10000	200000		1	200								
			900						1					
			9500					<u> </u>						
	,	200	- Anna			1		ESCALARIA .	1					
			1	ATION TO	1000	107.400	DT ACCOMMENTATION	An Tava		nongeri	A	1617 -		AND THE EXCHANGE OF THE
25. FEOERAL TAX LD. I	NUMBER S	ISN EN	26. 8	MIRNIS	ACCOUNT NO.	(For go	PT ASSIGNMENT? out claims, see back)	28. TOTAL CHA				UNT PA	SLJ .	30. BALANCE DUE
describer of the second second	LANGE CO.			LABATT ALOT	ADDDESE OF	YES	E SERVICES WERE	L	45. 50	سليبي	5 : 66 : 10	ri sisar	0 4000	\$ 145:50 RESS, ZIP CODE
31. SIGNATURE OF PH INCLUDING DEGRE	ES OR CREDEN	TIALS			(if other than h		P ATTLEMENT SECURE	& PHONE #		No. Of Contract Contr	r unusuit	na mati		WAS ELL PANE
if certify that the state apply to this bill and	aments on the rav are made a part th	rersie nareof.)							Any P					
									12 An Any t			1004	15	
A. Provider		3/20/06						PINS 83000	-	own,		1234 8 4485		nn
A. FIOVIDER SIGNED		ATE						12200 03000	VUN		1.6	CATALAN C		

PLEASE DO NOT STAPLE N THIS AREA	Ambulatory Detoxi	
PICA	HEALTH IN:	SURANCE CLAIM FORM PICA [TITE]
1. MEDICARE MEDICAID CHAMPUS CHAM	FVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	R 18. INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)
(Madicare #) X (Medicaid #) (Sponsor's SSN) (VA	File #) (SSN or ID) (SSN) (ID)	99999999T
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Jane D.	07 13 1978 M F X	***
5. PATIENT'S ADDRESS (No., Strest)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Street	Self Spouse Child Other	
CITY	ITE I 8. PATIENT STATUS	CITY STATE
Any Town N	C Single Married Other	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (NICLUDE AREA CODE)
12345 (919) 123-4567	Employed Fus. Time Part Time Student Student	
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
		7 E
A. OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (CURRENT OR PREVIOUS)  YES NO	a. INSURED'S DATE OF BIRTH SEX
D. OTHER INSURED'S DATE OF BIRTH SEX	b AUTO ACCIDENT? PLACE (State)	5. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY	YES NO	
C. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If yes, resum to and complate item 9 a-d.
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE 1 authorized by process this claim. 1 also request payment of government benefits below.	e the release of any madical or other information necessary.	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED	DATE	SIGNED
14, DATE OF CURRENT: ILINESS (First symptom) OR MM DO YY RUURY (Accident) OR PREGNANCY(LMP)	15. & PATIENT HAS HAD SAME OR SMILAR ILLNESS GIVE FIRST DATE MM CD YY	16. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION  MM
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE.	17a. (.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM 100 YY  FROM TO TO
19. RESERVED FOR LOCAL USE	to a second the second	20. OUTSIDE LAB? S CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITS	IMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 1. 290	3	23. PRIOR AUTHORIZATION NUMBER
2	4. 1	
24. A B C	D E	F G H I I J K
From of of (	EDURES, SERVICES, OR SUPPLIES DIAGNOSIS Explain Unusual Circumstancies) CODE HCPCS MODIFIER	S-CHARGES OR Family EMG COB LOCAL USE
06 01 06 06 01 06 11 HO	014	81 72 4
	, ;	
		28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
25. FEDERAL TAX LD. NUMBER SSN EIN 26. PATIEN	T'S ACCOUNT NO. 27, ACCEPT ASS:GNMENT? (Fox gov., claims, see back)	
	(Fox govt, deline, see back)  YES NO	s 81 72 s s 81.72
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME A	(Fox gox), claims, see back)  YES NO  NO ADDRESS OF FACILITY WHERE SERVICES WERE	\$ 81 72 \$ \$ 81 72 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME A INCLUDING DESREES OR CREDENTIALS (Loanty that the statements on the reverse	(Fox govt, deline, see back)  YES NO	s 81 72 s s 81 72 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME. ADDRESS, ZIP CODE 8 PHONE 9
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME A NOCLUDING GEGREES OF CREDENTIALS RENDEL	(Fox gox), claims, see back)  YES NO  NO ADDRESS OF FACILITY WHERE SERVICES WERE	\$ 81 72 \$ \$ 81 72 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME A INCLUDING DESREES OR CREDENTIALS (Loanty that the statements on the reverse	(Fox gox), claims, see back)  YES NO  NO ADDRESS OF FACILITY WHERE SERVICES WERE	\$ 81 72 S S 81 72  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 8 PHONE #  Any Provider

OO NOT STAPLE N THIS SREA	Medically Sup Stabilization	ervised Detoxification/Crisis			
PICA	HEALTH	INSURANCE CLAIM FORM PICA TIT			
	VPVA GROUP FECA ( HEALTH PLAN BLK LUNG	THER 18. INSURED'S LD NUMBER (FOR PROGRAM IN ITEM 1)			
(Medicara #) X (Medicara #) (Sponsor's SSN) (VA	File #) (SSN or (D) (SSN)	(D) 99999999T			
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4, INSURED'S NAME (Last Name, First Name, Middle Instali)			
Recipient, Jane D.	07 13 1978 M	(A)			
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. NSURED'S ADDRESS (No., Street)			
123 Any Street	Self Spouse Child Other				
	TATE 8. PATIENT STATUS	CITY STATE			
	Single   Married   Uther	ZIP CODE TELEPHONE (INCLUDE AREA CODE)			
TELEPHONE (Include Area Code) 12345 (919 \ 123-4567	Employed - FoS-Time - Part-Time				
OTHER INSUREO'S NAME (Last Name, First Name, Middle India)	Student Student	2: 11 INSURED'S POLICY GROUP OR FECA NUMBER			
OTHER SECURED & RAME (LASS RISHS, FIRST REINE, MILLURE HALLS)	TO STATION OF CONTRACT TO STATE OF THE STATE	11, INSURED STOLEN GROUP CONTROLLER			
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIO	JS) a INSURED'S DATE OF BIRTH SEX			
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE	State) b. EMPLOYER'S NAME OR SCHOOL NAME			
MM DD YY	YES NO	_			
EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME			
	YES NO				
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
		YES NO Wyes, resum to and-complete item 9 a-d.			
READ BACK OF FORM BEFORE COMPL 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 author to process this citim. I also request payment of government benefit below.	ize the release of any medical or other information nece	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	DATE	SIGNED			
MM   DD   YY   MUURY (Accident) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILL GIVE FIRST DATE: MM   DD   YY	NESS. 16, DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MAN DD YY			
PREGNANCY(LMP)  17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17s. LO. NUMBER OF REFERSING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
, index of the Emole of the Control		MM DD YY MM DD YY			
9. RESERVED FOR LOCAL USE:		20. DUTSIDE LAB? S CHARGES			
		YES NO			
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE I	TEMS 1,2,3 OR 4 TO ITEM 24E BY LINE}	22. MEDICAID PESUBMISSION CODE ORIGINAL REF. NO.			
, 290	3	COURT CONTROL NO.			
1. Landaumer a raum	The footpoons and a service	23. PRIOR AUTHORIZATION NUMBER			
2. 1	4. Improvementation & Street	,			
4. A 8 C  OATE(S) OF SERVICE Place Type PRO	D E  CEDURES, SERVICES, OR SUPPLIES MACKET  DESCRIPTION OF SUP	F G H I J K  SES DAYS EPSOT RESERVED FOR			
From of of of	(Explain Unusual Circumstances) DAAGNC	SIS   DR Samily   NEOCHYED FOR			
1	2036	100 00 1			
00 01 00 00 01					
		TO THE REAL PROPERTY OF THE PARTY OF THE PAR			
S FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIE	NT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT (For govt. claims, see	back)			
	YES NO	s 100 00 s 20 00 s 80 00			
	AND ADDRESS OF FACILITY WHERE SERVICES V ERED (If other than home or office)	VERE 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			
(I partity that the statements on the reverse apply to this bill and are made a part thereof.)		Any Provider			
solding an early one on the during transfer of Books study and a		12 Any Street			
		Any town, NC 12345			
A. Provider 06/01/06		PRM# 8300000U GRF# 8300000			

EASE DNOT YAPLE	Non-Hospital Me	dical Detoxification
THIS		
REA	DEALTH	NSURANCE CLAIM FORM PICA
POA		HER 1a. INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)
MEDICARE MEDICARD GIVEN	HEALTH PLAN BLK LUNG (IL)	
Desdicate by [X] (Moderne a)	The second secon	d. INSURED'S NAME (Last Name, First Name, Middle Initial)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	MM DD YY	
ecipient, Jane D.	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
PATIENT'S ADDRESS (No., Street)	Self Spouse Child Other	
23 Any Street	TATE B. PATIENT STATUS	COTY STATE
11	NC CT	
ny 10mi	Single   Marine [ ] One [	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
CODE TELEPHONE (Include Area Code	Employed - Full-Time Part-Time	- ( )
2345 (919) 123-4567	Student Studen	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S NAME (Last Name, First Name, Middle Inkla)	SV. IS PRINCES SCORUMON TOWN TO	T. Heavilla of Sang College
OTHER INSURED'S POLICY OR GROUP NUMBER	EMPLOYMENT? (CURRENT OR PREVIOUS     TO VES    TO NO	a. INSURED'S DATE OF BIRTH SEX
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE IS	MAY ENV. POLICE O GAME AN ENGINEER
M	c. OTHER ACCIDENT?	Id. INSURANCE PLAN NAME OF PROGRAM NAME
EMPLOYER'S NAME OR SCHOOL NAME	TYES TNO	See Stand Business 1 Properties and a second second second second
A SE ON PROCENCES STATES	10d RESERVED FOR LOCAL USE	IO, IS THERE ANOTHER HEALTH BENEFIT PLAN?
INSURANCE PLAN NAME OR PROGRAM NAME	TOUR CREATITION OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OWNE	YES NO If yest, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMP	FTING & SIGNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
READ SACK OF FORM BEFORE COMP 2: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authors to process this claim. I also request payment of government benef- below.		<ul> <li>payment of medical benefits to the undersigned of hysician or supplier for services described below.</li> </ul>
	DATE	SIGNED
SIGNEO	15, IF PATIENT HAS HAD SAME OR SIMILAR ILLN	ESS THE DATES PATIENT INVASUE TO WORK IN CURRENT OCCUPATION
4. DATE OF CURRENT:   ILLNESS (First symptom) OR MM   DD : YY   AUJURY (Accident) OR	GIVE FIRST DATE MM   DD   YY	FROM DD YY MM DD YY
PREGNANCY(LMP)  7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
P. RAME OF REPERBING FRI GROWN CO. D. T. C.	-	FROM TO YY
RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
S RESERVED FOR COOK COOK		TYES NO.
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE	ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22 MEDICAID RESUBMISSION OFIGINAL REF. NO.
		CODE OHIGHAL HEP. NO.
5. 1290	3. leasurement a servi	23. PRIOR AUTHORIZATION NUMBER
	2.1	
2 L 8 C L	D E	F G H I J K
DATE(S) OF SERVICE Place Type PR	OCEDURES, SERVICES, OR SUPPLIES DIAGNOS (Explain Unusual Directmentances)	
NIM DD YY MAN DD YY Service Service CI	PTAICPCS.   MODIFIER CODE	SCHANGES UNITS Plan 2005 ECO-C 65E
06 01 06 06 01 06 21	H0010	325 88 1
The state of the s		
	7.5	
		MTZ DO TOTAL CHARGE 29 AMOUNT PAID 30 BALANCE DUE
5. FEDERAL TAX LD. NUMBER SSN EBI 26. PAT	PENT'S ACCOUNT NO. 27. ACCEPT ASSIGNME (For govt, claims, see	back)
3. PERETAL INV. S.D. GUMBLET	YES NO	s 325 88 s s 325 88
ПП	RE AND ADDRESS OF FACILITY WHERE SERVICES W	ERE 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
signature of Physician or Supplier 32 Nan		8 PHONE #
SIGNATURE OF PHYSICIAN OR SUPPLIER     NCLUDING DEGREES OR CAEDENTIALS     It contributes the statement on the reverse.	IDERED (If other than home or office)	
11. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAN NICLUDING DEGREES OR CREDENTIALS RES		Any Provider 12 Any Street
II. SIGNATURE OF PHYSICIAN OR SUPPLIER 12. NAM NCLUDING DEGREES OR CREDENTIALS REN Conflict the statements on the reverses		Any Provider

EASE NOT		
APLE THIS EA	Outpatient Opio	id Treatment
- Total	HEALTH	NSURANCE CLAIM FORM PICA TOTAL
PICA MEDICARE MEDICAID CHAMPUS CHAMP	VA GROUP FECA OT	HER! 1a. INSURED'S LD NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) X (Medicarid #) (Sponsor's SSN) (VA F	HEALTH PLAN BLK LUNG (SSN) (III	999999999T
PATIENT'S NAME (Last Name, First Name, Middle Intial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ecipient, Jame D.	07 13 1978 M F	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Streit)
23 Any Street	Self Spouse Child Other	
TY STA	E 8. PATIENT STATUS	CITY STATE
ny Town	Single Married Other	
P CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
2345 (919) 123-4567	Employed Full-Time Pan-Time Student Student	
OTHER INSURED'S NAME (Last Name, First Name, Middle Indel)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS	a. INSURED'S DATE OF BIRTH  MM.: DD: YY  MM.: DD: YY  MM.: F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE IS	ale) b. EMPLOYER'S NAME OR SCHOOL NAME
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME.
MARKET MAN S. S. M. AND AND AND STREET AND S	YES NO	15-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	THE STATE OF THE S	YES NO If year, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLE 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I sutholize to process this claim. I also request payment of government benefits e below.	this releases of the medical or other information neces-	INSURED'S DR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described balaw.
SIGNED	DATE	SIGNED
DATE OF CURRENT: / ILLNESS (First symptom) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLA	ESS. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	GIVE FIRST DATE MM 00 VY	FROM TO YY NAM DD YY
7. 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 : YY
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? SCHARGES
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITS	MS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1. 290	3. Lumanum :	23. PRIOR AUTHORIZATION NUMBER
1.	4.1	2
2 <u>1</u>	D E	F G H I J K
DATE(S) OF SERVICE TO PAGE Type PROCE	EDURES, SERVICES, OR SUPPLIES DIAGNOS Exclain Unusual Circumstances) CODE (CPCS   MODIFIER	SIS S CHARGES OR FAMILY EMG COB LOCAL USE
03 20 06 03 20 06 11 HO	20	19 17 1
5. FEOERAL TAX LO. NUMBER SSN EIN 26. PATIEN	T'S ACCOUNT NO. 27. ACCEPT ASSIGNATE (For gov. claims, see) YES NO	NT? 28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 19 17 \$ \$ 19 17
INCLUDING DEGREES OR CREDENTIALS RENDE	OND ADDRESS OF FACILITY WHERE SERVICES WIREO (If other than home or office)	& PHONE #
(I certify that the statements on the reverse apply to this bill and are made a part thereof;		Any Provider 12 Any Street
•		Any town, NC 12345

Mark T. Embru

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

Change Collies