North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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

Revised **May 2006**

Family Planning Waiver "Be Smart"

TABLE OF CONTENTS

Effective with date of service October 1, 2005, the North Carolina Division of Medical Assistance (DMA) has implemented a 5-year 1115 Medicaid demonstration waiver project for family planning services for the citizens of North Carolina.

FAMILY PLANNING WAIVER

The Family Planning Waiver is a Medicaid program designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending eligibility for family planning services to eligible women between the ages 19 through 55 and men ages 19 through 60 whose income is at or below 185% of the federal poverty level.

The name of the waiver program is the "BE SMART" program.

Objectives of the Family Planning Waiver are:

- Increase the number of reproductive age women and men receiving either Title XIX or Title X funded family planning services by improving access to and use of Medicaid family planning services.
- Reduce the number of inadequately spaced pregnancies by women in the target group thus improving birth outcomes and health of these women.
- Reduce the number of unintended and unwanted pregnancies among women eligible for Medicaid.
- Impact positively the utilization of and "continuation rates" for contraceptive use among the target population.
- Increase the use of more effective methods of contraception in the target population.

Key features of the Family Planning Waiver include:

- Providing comprehensive family planning services to eligible women and men who otherwise do not have access to these services.
- Providing screening, early detection, and education of sexually transmitted infections (STI), including Human Immunodeficiency Virus (HIV)/AIDS for women and men.
- Reducing the demand for abortions.
- Providing the opportunity for men to take the responsibility for being the primary contraceptor.
- Allowing women the opportunity to choose if and when to have children.

The Family Planning Waiver will also serve as the intervention and referral site for other health concerns for women and men.

There is no co-payment for any services received under the Family Planning Waiver.

Recipients have the freedom of choice in deciding to receive or reject any family planning service.

ELIGIBLE PROVIDERS

If your licensure and accreditation does not allow you to bill for family planning services under any other North Carolina Medicaid program, you will not be reimbursed for them under the Family Planning Waiver. If you are currently enrolled as a North Carolina Medicaid provider and your licensure and accreditation allows you to provide family planning services, then there are no additional enrollment requirements.

Family Planning Waiver services can be provided by:

- Ambulatory Surgery Centers
- Certified Registered Nurse Anesthetists
- Federally Qualified Health Centers
- Laboratories
- Local Health Departments
- Nurse Practitioners
- Nurse Midwives
- Outpatient Hospitals
- Physicians
- Rural Health Clinics

For information on enrolling as a North Carolina Medicaid provider, refer to the DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm.

NOTE:

Providers are also required to keep records necessary to disclose the extent of services rendered to recipients and billed to the waiver. Refer to the Basic Medicaid Billing Guide on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for additional information on Principles of Medical Record Documentation.

OUTREACH MATERIALS

Outreach materials are available to providers to display and/or distribute. Copies of the Family Planning Waiver outreach materials are available by completing Attachment A and returning it to the address on the order form.

Be Smart Brochure

Be Smart Small Poster English

Be Smart Large Poster English

Be Smart Brochure Spanish

Be Smart Small Poster Spanish

ELIGIBLE RECIPIENTS

A new Medicaid eligibility category, MAF-D, has been created for the waiver. The eligible recipient will be identified by a blue Medicaid card with the following statement **"FAMILY PLANNING WAIVER: RECIPIENT ELIGIBLE FOR LIMITED FAMILY PLANNING SERVICES ONLY" (Sample card page 4).** Only one name will be listed per Medicaid card. For households with multiple recipients receiving waiver services, each recipient will receive a separate Medicaid card for Family Planning Waiver services.

A recipient's eligibility may change from month to month. Therefore, a new Medicaid card is issued at the beginning of each month. The new card shows valid eligibility dates through the current calendar month. The "From" date may show eligibility for prior months in addition to the current calendar month.

Recipients eligible to receive waiver services are not eligible for Medicaid under any other current program. Eligible recipients are not limited to one specific Medicaid enrolled provider. A recipient may receive services from any qualified provider who is enrolled with Medicaid to provide the service. Family Planning Waiver services do not require enrollment in Carolina ACCESS. **There is no co-payment for services received under the Family Planning Waiver program.**

Eligible recipients are:

- Women age 19 through 55
- Men age 19 through 60
- Income at or below 185% of the federal poverty level
- U.S. citizens or documented immigrants
- Residents of North Carolina
- Not incarcerated
- Not pregnant
- Not permanently sterilized

Recipients can apply for the Family Planning Waiver by completing the DMA-5063, N.C. Health Check/Health Choice Application and DMA-5063A, Medicaid Family Planning Waiver (FPW) Application Addendum Attachment B. Applications are also available at the local department of social services (DSS), the local health department, and other locations throughout the community.

Applications are available in Spanish.

Applications must be submitted to the local DSS either in person or by mail to be processed. Applications are generally processed within 45 days.

Recipients eligible for the Family Planning Waiver are also eligible to apply for assistance with transportation to appropriate medical appointments from the local DSS.

There is no presumptive eligibility for the Family Planning Waiver.

Refer to the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/county.htm under County Link for the Medicaid Family Planning Waiver eligibility policy, Family and Children's Eligibility Manual MA-3265, Medicaid Family Planning Waiver and Aged, Blind, and Disabled Eligibility Manual MA-2170.

Contact your local DSS regarding eligibility questions.

THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE

MEDICAID IDENTIFICATION CARD

05-01-06 to 05-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

Family
Planning
Limited

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	08243 S	MAF	D	05-01-06	05-31-06

RECIPIENT ID	ELIGIBLES FOR MEDICAID	INS NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient *** Family Planning Waiver *** Recipient Eligible For Limited Family Planning Services Only		08-02-1971	F

INS NO	NAME CODE	POLICY NUMBER	TYPE

MAY 2006 MAF34 10847667 101
Jane Recipient
456 That Street
That City, NC 45678

RRECIPIENT (Not valid unless signed)
(Signature) _____

SERVICES

The Family Planning Waiver includes services, procedures, and supplies which enable individuals to freely determine the size of their families. Covered services include:

- Examination (including counseling and patient education) and treatment prescribed by a physician and furnished by or under the physician's supervision
- Laboratory procedures
- Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception through chemical, mechanical or other means
- Voluntary sterilization in accordance with sterilization guidance
- When providing services for the Family Planning Waiver, providers should perform services as clinically indicated by nationally recognized standards of care (e.g., American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control and Prevention (CDC), American Cancer Society (ACS), and the US Preventive Services Task Force (USPSTF).

NOTE:

All services eligible for reimbursement under the Family Planning Waiver program are listed in this Special Bulletin by the procedure code and description. Any services not listed in this Special Bulletin are not reimbursable under the Family Planning Waiver program.

NON-COVERED SERVICES

Recipients with Medicaid coverage through the Family Planning Waiver program are not eligible to receive the following services:

- Abortions
- Ambulance services
- Dental services
- Durable medical equipment (DME)
- Infertility services and related procedures
- Inpatient hospital services
- Optical services
- Treatment for AIDS
- Treatment for cancer
- Services required to manage or treat medical conditions/problems (not including STIs):
    - Discovered during a screening; and
    - Caused by or following a family planning procedure (i.e., UTIs, diabetes, hypertension, breast lumps.

NOTE:

If a medical condition/problem is identified and the provider is unable to offer free or affordable care, the provider should refer the recipient to one of primary care "safety net" providers listed in Attachment F. For more information on "Referrals," go to page 22.

BILLING THE RECIPIENT

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

ANNUAL EXAMINATION

An annual examination must be completed on all Family Planning Waiver recipients. **The annual examination must be performed for all waiver recipients before any other waiver services can be administered.** However, if emergent or urgent contraceptive services are needed, recipients are allowed limited emergency department visits prior to an annual examination. **One annual examination is allowed per 365 days.**

For family planning waiver purposes, it is **recommended** that the annual examination include the following components:

- Comprehensive history
- Information and education regarding contraceptive methods
- Physical examination including:
    - Thyroid palpation
    - Inspection and palpation of breasts, axillary glands and/or testicular, with instructions to the patient for self-examination
    - Auscultation of heart
    - Auscultation of lungs
    - Blood pressure
    - Weight and height
    - Abdominal examination
    - Pelvic, including speculum, bimanual, and rectovaginal or rectal examination
    - Extremities
    - Others as indicated
- Laboratory Services:
    - Hematocrit or hemoglobin
    - Urinalysis for sugar and protein
    - Papanicolaou smears (including repeat smears for insufficient cells)
    - Culture for N. gonorrhea
    - Serology for syphilis
    - Screening for other specified STIs
    - Screening for HIV
- Prescription of Contraceptive Method
- Post-Examination Interview Including:
    - Interpretation of clinical findings to patient
    - Instructions in the use of chosen method of contraception (preferably both oral and written instructions)
    - Scheduling appropriate follow-up visits
- Referrals to appropriate resources for other medical or social problems as indicated (including referrals to primary care “safety net” providers)

Annual Examination	
99203	Office/outpatient visit; new patient moderate, physician time approx 30 minutes
99204	Office/outpatient visit; new patient complex, physician time approx 40 minutes
99205	Office/outpatient visit; new patient complex, physician time approx 60 minutes
99214	Office/outpatient visit; established patient severe, physician time approx 25 minutes
99215	Office/outpatient visit; established patient severe, physician time approx 40 minutes
99385*	Initial comprehensive preventive medicine, new patient, 18-39 years
99386*	Initial comprehensive preventive medicine, new patient, 40-64 years
99395*	Periodic comprehensive preventive medicine, established patient, 18-39 years
99396*	Periodic comprehensive preventive medicine, established patient, 40-64 years
RC 510	Clinic, general classification
RC 519	Clinic, other clinic

NOTE:
*Providers must adhere to the age requirements outlined in the waiver. Women age 19 through 55 and men age 19 through 60.

ANNUAL EXAMINATION DATE

For Family Planning Waiver services, the annual examination date (AED) must be entered on all claims with an annual examination and laboratory procedure, except pregnancy test.

- Providers who bill on the CMS-1500 must enter the AED in block 15.
- Providers who bill on the UB-92 must use the occurrence form locators 32, 33, 34, or 35. Enter an "11" in the occurrence code field and then enter the AED in the corresponding "date" field.

NOTE:
The AED must be a valid month, day, and year (i.e., 05/01/06).

LABORATORY PROCEDURES

The following laboratory procedures are **only allowable for the Family Planning Waiver when performed "in conjunction with" an annual examination,** with the exception of pregnancy tests. For the purpose of the Family Planning Waiver, "in conjunction with" has been defined as the day of the procedure or 30 days after the procedure.

Providers must include the AED on all claims for an annual examination or laboratory procedures, except pregnancy test. The AED is the date of the annual examination.

The following laboratory procedures are allowed under the Family Planning Waiver:

Pregnancy Test	Pap Smear
Urinalysis	HIV Screening
Blood Count	STI Screening

PREGNANCY TEST

Pregnancy tests are only allowed during an annual examination, periodic visit, office "after hours" visit, emergency department visit, and sterilization consultation visit. One pregnancy test is allowed with an annual examination and up to an additional **six pregnancy tests are allowed with other visits per 365 days for a total of seven. The AED is not required on claims for pregnancy tests.**

Pregnancy Test	
84702	HCG quantitative
84703	HCG qualitative
81025	Urine pregnancy test

URINALYSIS

Urinalysis tests are allowed once per 365 days in conjunction with an annual examination. **The AED is required on claims for urinalysis tests.** The AED is the date of the annual examination.

Urinalysis	
81000	Urinalysis, by dip stick or tablet reagent; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent; automated with microscopy
81002	Urinalysis, by dip stick or tablet reagent; non-automated without microscopy
81003	Urinalysis, by dip stick or tablet reagent; automated without microscopy

BLOOD COUNT

Blood Count tests are allowed once per 365 days in conjunction with an annual examination. **The AED is required on claims for blood count tests.** The AED is the date of the annual examination.

Blood Count	
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85027	Blood count; complete (CBC), automated (Hgh, Hct, RBC, WBC and platelet count)

PAP SMEAR

Clinical Laboratory Improvement Amendments (CLIA) certified laboratories, hospitals, and physicians are allowed one pap smear procedure per 365 in conjunction with an annual examination. **The AED is required on claims for pap smear tests.**

COLLECTION OF PAP SMEARS
Pap smear CPT codes should not be used to bill collection of a specimen. Collection of the smear is included in the reimbursement for office visits and no separate fee is allowed. Providers who do not perform the lab test should not bill the pap smears. Only the provider who actually performs the lab test should bill the pap smear codes, except as noted below for physician interpretation.

PHYSICAN INTERPRETATION PROCEDURE CODE
CPT procedure code 88141 is the only code that physicians may use to bill the physician interpretation of Pap smear. Because 88141 has no components, it must be billed without modifier 26. Hospitals billing for physician interpretation should bill 88141 on CMS-1500 claim form using the hospital's professional provider number. If the physician and hospital bill on the same date of service for the interpretation and the technical component, both will be eligible for reimbursement.

PAP SMEAR TECHNICAL COMPONMENT PROCEDURE CODE
The provider who renders the technical service must choose a procedure code from one of the codes listed below. The codes do not include professional and technical components (TC) but are considered technical and should be billed as technical procedures without modifier TC. Use add-on code 88155 when appropriate in conjunction with codes 88142 through 88154 and 88164 through 88167.

REPEAT PAP SMEAR FOR INSUFFICIENT CELLS
One repeat pap smear is allowed due to insufficient cells. Providers must perform the repeat pap smear within 180 days of the first pap smear. Providers must include the ICD-9-CM diagnosis 795.08 as the secondary diagnosis on the appropriate claim.

Pap Smear	
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88142	Cytopathology, cervical or vaginal (any reporting system); manual screening under physician supervision
88143	Cytopathology, manual screening & rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	Cytopatholoy, slides, cervical or vaginal; with manual screening and rescreening under physician supervision

Pap Smear (con't)	
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer- assisted rescreening using cell selection and review under physician supervision
88164	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal; with manual screening and computer- assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under the physician supervision

HIV SCREENING

The Family Planning Waiver allows screening for HIV when performed in conjunction with an annual examination. **This is a recommended screening and should be completed as necessary and appropriate**. Providers must include the appropriate ICD-9-CM diagnosis on the appropriate claim**. The AED is required on claims for HIV Screening. The AED is the date of the annual examination.**

HIV Screening	
86689	HTLV or HIV antibody
86701	HIV-1
86702	HIV-2
86703	HIV-1&2
87390	HIV-1
87391	HIV-2
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique
87536	HIV-1, quantification
87537	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique
87539	HIV-2, quantification
• Providers are allowed one HIV screening per 365 days in conjunction with annual examination.	

STI SCREENING

STI screenings are also covered under the Family Planning Waiver when performed in conjunction with an annual examination. **The AED is required on claims for all STI screenings.** The AED is the date of the annual examination.

Gonorrhea	
87590	Neisseria gonorrhea, direct probe technique
87591	Neisseria gonorrhea, amplified probe technique
87592	Neisseria gonorrhea, quantification
87850	Neisseria gonorrhea
• Providers are allowed one gonorrhea screening per 365 days in conjunction with the annual examination.	

Syphilis	
86592	Syphilis test; qualitative
86593	Syphilis test; quantitative
• Providers are allowed one syphilis screening per 365 days in conjunction with the annual examination.	

General STI Screening	
87081	Culture, bacterial, screening only, for single organisms
87210	Smear, primary source, with interpretation; wet mount for infectious agents
• Providers are allowed one general STI screening per 365 days in conjunction with the annual examination.	

Chlamydia	
86631	Chlamydia
86632	Chlamydia, IgM
87110	Culture, Chlamydia
87270	Infectious agent antigen detection by immunofluorescent technique; adenovirus; Chlamydia trachomatis
87320	Infectious agent antigen detection by enzyme immunoassay technique; adenovirus; Chlamydia trachomatis
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis
• Providers are allowed one Chlamydia screening per 365 days in conjunction with the annual examination.	

Herpes	
86694	Herpes simplex, non-specific type test
86695	Herpes simplex, type 1
86696	Herpes simplex, type 2
87207	Smear, primary source, with interpretation; special stain for inclusion bodies or parasites
87273	Herpes simplex virus, type 2
87274	Herpes simplex virus, type 1
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87530	Herpes simplex virus, quantification
• Providers are allowed one Herpes screening per 365 days in conjunction with the annual examination.	

Treponema	
86781	Treponema pallidum, confirmatory test
87285	Treponema pallidum
• Providers are allowed one Treponema screening per 365 days in conjunction with the annual examination.	

STI TREATMENT

One course of STI (antibiotic treatment) from the approved list for each organism identified above is allowed per calendar year for the Family Planning Waiver. **All approved antibiotics must have the appropriate ICD-9-CM diagnosis on the prescription. Even though the waiver covers multiple STIs, all prescriptions for STI treatment must be filled on the same day. This day is not required to be the same day as the AED. The AED is not required on STI prescriptions.** For a complete list of ICD-9-CM diagnoses and medications, refer to Attachment C.

PERIODIC VISIT

Six periodic visits are allowed per 365 days. The purpose of the periodic visits is to evaluate the recipient's contraceptive program, renew or change the contraceptive prescription and to provide additional opportunities for counseling. **The AED is not required on claims for periodic visits.**

The periodic revisit with pelvic or "method problem" visit with pelvic should include:

- An interim medical history, including assessment of presenting problem(s) and general well-being with evidence that the following conditions were investigated according to oral contraceptive or IUD user:

Oral Contraceptive Users	**IUD Users**
Presence of headaches	Presence of abdominal pain
Visual disturbances	Unusual bleeding or vaginal discharge
Chest, abdominal or leg pain	Fever chills and other symptoms of infection
Depression or abnormal mood changes	

- Blood pressure and weight
- Pelvic examination, if appropriate
- Education – assessment that the patient is using the method correctly; follow-up health instructions
- Counseling and referral
- Scheduling of return visits, if appropriate

A scheduled revisit without pelvic or "method problem" visit without pelvic should include the above series except for the pelvic examination.

Periodic Visit	
99201	Office/outpatient visit; new patient physician time approx 10 minutes
99202	Office/outpatient visit; new patient moderate, physician time approx 20 minutes
99211	Office/outpatient visit; established patient minimal, physician time approx 5 minutes
99212	Office/outpatient visit; established patient minor, physician time approx 10 minutes
99213	Office/outpatient visit; established patient severe, physician time approx 15 minutes

RC 510	Clinic, general classification
RC 519	Clinic, other clinic

OFFICE "AFTER HOURS" VISITS

Office "after hours" visits are only covered when services are provided outside the posted office hours for emergency or urgent contraceptive care. It is appropriate to bill office "after hours" visit codes when the providers goes into the office before the posted opening hours or after the posted closing hours to provide emergent or urgent contraception.

Office "after hours" visits will be counted as one of the six periodic visits and are subject to the same 365 day limit. The AED is not required on claims for office "after hours" visits. Providers must bill using ICD-9-CM diagnosis V25.03 when providing office "after hours" visits.

Only established patients are eligible to receive emergency office "after hours" visits. Office "after hours" visits are not covered when routine family planning services are available to recipients. **Office "after hours" codes are not covered when the service is provided in a hospital emergency department.**

Refer to DMA's website http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information on the After Hours Office Visit policy.

Office After Hours Visit	
99050	Services requesed after posted hours in addition to basic service
• Providers must include an office visit CPT code along with an after office hours CPT code (i.e., 99211+99050=1 visit). • An FP modifier must be appended to both the office visit code and the office "after hours" code.	

EMERGENCY DEPARTMENT VISIT

Emergency Department and emergency room visits are not covered under Family Planning Waiver. Emergency department visits are counted as one of the six periodic visits and aresubject to the same 365 days limit. Providers must bill using ICD-9-CM diagnosis V25.03 when providing an emergency department visit. The AED is not required on claims for emergency department visits. Providers are encouraged to educate recipients on the appropriate use of an emergency room visit.

STERILIZATIONS

Sterilization procedures for women and men are covered under the Family Planning Waiver. **A sterilization procedure is limited to one per lifetime. The AED is not required on claims for sterilization consultation or procedures.** The North Carolina Medicaid program is bound by stringent federal guidelines in regard to coverage of sterilization procedures. The guidelines are as follows:

- The recipient is at least 21 years old at the time the sterilization consent is obtained.
- The recipient is not a mentally incompetent recipient.
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization except under the following circumstances:

    - **Premature delivery** - Informed consent must be given at least **30 days before the expected date of delivery** and at least 72 hours must have passed since the informed consent was given.
    - **Emergency abdominal surgery** - At least 72 hours must have passed since the informed consent was given.

    - The recipient has voluntarily given informed consent in accordance with all the requirements prescribed in 42 CFR 441.257 and 441.258. The recipient must be:

        - Given an opportunity to ask and receive answers to questions concerning the procedure and provided a copy of the consent form.
        - Advised that sterilization consent may be withdrawn at any time before the sterilization procedure without affecting the right to future care or treatment and without loss of or withdrawal of any federally funded program benefits to which the recipient might otherwise be entitled.
        - Counseled in alternative methods of family planning and birth control.
        - Advised that the sterilization procedure is considered to be irreversible.
        - Provided a thorough explanation of the specific sterilization procedure to be performed.

- Provided a full description of the possible discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- Provided a full description of the benefits or advantages that may be expected as a result of the sterilization.
- Provided suitable arrangements to ensure that information is effectively communicated if the recipient is blind, deaf, or otherwise handicapped.
- Provided an interpreter if the recipient does not understand the language used on the consent form or the language used by the person obtaining consent.
- Permitted to have a witness of his or her choice present when the consent is obtained.

NOTE:
North Carolina Medicaid does not cover sterilization reversals.

CONSENT FORM

The sterilization consent form is a federally mandated document. The form must be on file with Medicaid's fiscal agent, and all federal regulations pertaining to the completion of the form **must** be satisfied prior to payment of a sterilization claim. The consent form must be Health and Human Services approved.

The sterilization consent form is a three-copy form. The pink copy should be given to the recipient for their records; the physician should retain the yellow copy; and the white copy should be submitted to the address listed on the form**. Consent forms may be obtained by calling the fiscal agent at 1-800-688-6696 or refer to** Attachment D.

CONSULTATION FOR STERILIZATION

The Family Planning Waiver will cover consultation for a sterilization procedure. When a provider refers a recipient to **another provider** for a sterilization procedure, the provider performing the sterilization procedure must select one of the following codes when providing consultation to the recipient. **Recipients are allowed two consultations for sterilization per lifetime**.

Consultation	
99241	Office consultation; new or established patient minor, physician time approx 15 minutes
99242	Office consultation; new or established patient low, physician time approx 30 minutes
99243	Office consultation; new or established patient moderate, physician time approx 40 minutes
99244	Office consultation; new or established patient severe, physician time approx 60 minutes
99245	Office consultation; new or established patient complex, physician time approx 80 minutes
RC 510	Clinic, general classification
RC 519	Clinic, other clinic

Sterilization	
55250	Vasectomy, unilateral or bilateral (including postop semen examination(s))
55450	Ligation of vas deferens, unilateral or bilateral
58600	Ligation or transaction fallopian tubes abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by device vaginal or suprapublic approach
58670	Laparoscopy surgical; with fulguration of oviducts (with or without transaction)
58671	Tubal ligation by laparoscopic surgery with occlusion of device (band, clip or Falope ring)
RC 36X	Operating room services
RC 49X	Ambulatory surgical care

- Providers are allowed one permanent sterilization procedure per lifetime.

NOTE:

Sterilizations are not covered in an inpatient setting under the Family Planning Waiver program.

ADDITIONAL STERILIZATION SERVICES

The Family Planning Waiver also covers anesthesia, X-rays, EKGs, and surgical pathology when provided with a sterilization procedure. Providers must bill using ICD-9-CM diagnosis V25.2 when performing a sterilization procedure and additional sterilization services. **The AED is not required for additional sterilization services.**

Anesthesia	
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00851	Anesthesia intraperitioneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction
00921	Anesthesia for procedure on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
RC37X	Anesthesia

- **Providers are still required to bill with the appropriate anesthesia modifier.**
- The hospital's facility charges are billed on the UB-92 claim form with RC in the 37X range. Only the facility charges are included in the RC code. CRNA professional charges must not be included in the RC code.
- The surgeon bills for the surgical charges on the CMS 1500-claim form.

X-ray	
71010	Radiologic examination, chest; single view, frontal
RC 32X	Radiology-Diagnostic
• Providers are allowed one x-ray for the sterilization procedure per lifetime.	

EKG	
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
RC 73X	EKG/ECG
• Providers are allowed one EKG for the sterilization procedure per lifetime.	

Surgical Pathology	
88302	Surgical pathology, gross and microscopic examination
89310	Semen analysis; motility and count (not including Huhner test)
• CPT code 89302 and 89310 are each allowed twice per lifetime as part of a sterilization procedure.	

STERILIZATION MEDICATIONS

Post operative medications are covered for sterilizations in the Family Planning Waiver. All approved post-operative medications must have ICD-9-CM diagnosis V25.2 on the prescription. For a complete list of approved antibiotics and pain medications, refer to Attachment E. **The AED is not required on claims for post-operative medications for sterilization procedures.**

NOTE:
Once a recipient has had a permanent sterilization procedure and the necessary post-surgical follow-up has occurred, the recipient is no longer eligible for Family Planning Waiver services.

CONTRACEPTIVE SUPPLIES AND DEVICES

FDA approved and Medicaid covered pharmaceutical supplies and devices, such as oral contraceptive pills, intrauterine devices, and injections are covered under the Family Planning Waiver if provided for family planning purposes.

There is no co-payment for approved contraceptive supplies and devices. The AED is not required on claims for approved contraceptive supplies and devices.

Procedures	
11976	Removal, implantable contraceptive capsule
57170	Diaphragm-fitting with instruction
58300	Insert intrauterine device
58301	Removal of intrauterine device
RC 510	Clinic, general classification
RC 519	Clinic, other clinic

- Providers **should not** bill a separate periodic office visit code for CPT codes 57170, 58300, and 58301; an office visit component is included in the reimbursement.
- CPT codes 57170, 58300, and 58301 are included in the six periodic visit limitation.
- When diaphragm-fitting, intrauterine device insertion, or removal of an intrauterine device occurs during an annual examination, providers must only bill the appropriate annual examination procedure code.

Supplies and Devices	
J1055	Depo-provera (medroxyprogesterone acetate and estradiol cypionate, 0.5ml) injection
J7300	Para gard T380A (Intrauterine device)
J7302	Levonorgestrel-relesing Intrauterine system (Mirena)
RC 25X	Pharmacy
RC 27X	Medical/surgical supplies and devices

- Providers may bill a periodic visit code when administering Depo-provera; however, the use of a periodic visit code is subject to the 6 periodic visit limit.

PHARMACEUTICAL SUPPLIES

All eligible drugs for the Family Planning Waiver will have a family planning indicator on the drug file (including birth control pills, Depo-provera, Ortho Evra, Nuva Ring). The dispensing fee is based on regular Medicaid rules. **There is a six prescription limit per month with no override capability.** Providers are not allowed to distribute "brand medically necessary" (DAW1) drugs, if a generic is available. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-9-CM diagnosis code.

NOTE:

The AED is not required on Family Planning Waiver prescriptions.

BIRTH CONTROL PILLS

Birth control pills may be dispensed through a pharmacy. A recipient may receive up to a 3- month supply.

DIAPHRAGMS

Family Planning Waiver recipients can choose a diaphragm as a birth control method. A provider can fit the patient and bill using the appropriate CPT code for diaphragm fitting. However, the Medicaid program does not cover diaphragms.

EMERGENCY CONTRACEPTIVES

Emergency contraceptives are a covered service. The appropriate office visit code may be billed separately.

NORPLANT

The Family Planning Waiver covers the removal of Norplant. The global period for 11976 is one (1) pre-care day and ninety (90) post-operative days.

REFERRALS

When medical conditions/problems indicated by history, physical examination, or laboratory and clinical tests are discovered that are outside the scope of the Family Planning Waiver and the provider has no mechanism to make services financially affordable, a referral to a primary care "safety net" provider must be made. Primary care "safety net" providers offer services for free or on a sliding-fee scale basis.

If the provider offers free or affordable care for services outside the scope of the Family Planning Waiver, then no referral is necessary. The provider should continue medical care.

For a list of primary care "safety net" providers in your area, refer to Attachment F. This list is updated yearly and published in the General Medicaid Bulletin.

NOTE:

If a provider discovers that a recipient is pregnant, a referral to the local DSS for enrollment in the Medicaid for Pregnant Women program should be made.

QUALITY ASSURANCE

Quality assurance monitoring is a required component of the Family Planning Waiver. The goals of the monitoring are:

- To assure accessibility of family planning services to eligible recipients.
- To assure that enrolled providers follow the guidelines as outlined in the Family Planning Waiver clinical coverage policy.
- To measure the delivery of health care services through utilization monitoring, patient satisfaction surveys, complaint monitoring, focused care studies and quality improvement projects.

Outcome and summary reports will also be developed to evaluate the effectiveness of the Family Planning Waiver.

FAMILY PLANNING WAIVER
ICD-9-CM DIAGNOSIS CODES LIST

V25.01	**Prescription of oral contraceptives**
V25.02	**Initiation of other contraceptive measures**
V25.03	**Encounter for emergency contraceptive counseling and prescription**
V25.09	**Other**
V25.1	**Insertion of intrauterine contraceptive device**
V25.2	**Sterilization**
V25.40	**Contraceptive surveillance, unspecified**
V25.41	**Contraceptive pill**
V25.42	**Intrauterine contraceptive device**
V25.43	**Implantable subdermal contraceptive**
V25.49	**Other contraceptive method**
V25.5	**Insertion of implantable subdermal contraceptive**
V25.8	**Other specified contraceptive management**
V25.9	**Unspecified contraceptive management**

TIPS FOR BILLING

PRIVATE PHYSICIAN PROVIDERS

- All services must be billed with the appropriate CPT/HCPCS code, ICD-9-CM diagnosis, and FP modifier.
- Providers must select the most appropriate codes for services rendered under the Family Planning Waiver and adhere to all the components of the code as defined by the American Medical Association.
- The AED must be entered in block 15 on the CMS-1500. **Providers must include the AED on all claims for an annual examination and laboratory procedures, except pregnancy test.**
- An ICD-9-CM diagnosis related to family planning services must be the primary diagnosis on the claim form. A complete list is located on page 23.
- All approved antibiotic treatment and pain medications must have the appropriate ICD-9-CM diagnosis written on the prescription.
- No "brand medically necessary" (DAW1) medications are allowed, if a generic is available.
- All applicable North Carolina Medicaid policies and procedures must be adhered to in addition to those listed in this special bulletin.

FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS

- All services must be billed with the appropriate CPT/HCPCS code, ICD-9-CM diagnosis, and FP modifier.
- Providers must select the most appropriate codes for services rendered under the Family Planning Waiver and adhere to all the components of the code as defined by the American Medical Association.
- The AED must be entered in block 15 on the CMS-1500. **Providers must include the AED on all claims for an annual examination and laboratory procedures, except pregnancy test.**
- An ICD-9-CM diagnosis related to family planning services must be the primary diagnosis on the claim form. A complete list is located on page 23.
- All FQHC/RHC providers must bill using the "C" suffix provider number.
- The core service code is not allowed with Family Planning Waiver services.
- All approved antibiotic treatment and pain medications must have the appropriate ICD-9-CM diagnosis written on the prescription.
- No "brand medically necessary" (DAW1) medications are allowed, if a generic is available.
- All applicable North Carolina Medicaid policies and procedures must be adhered to in addition to those listed in this special bulletin.

LOCAL HEALTH DEPARTMENTS

- All services must be billed with the appropriate CPT/HCPCS code, ICD-9-CM diagnosis, and FP modifier.
- Providers must select the most appropriate codes for services rendered under the Family Planning Waiver and adhere to all the components of the code as defined by the American Medical Association.
- The AED must be entered in block 15 on the CMS-1500. **Providers must include the AED on all claims for annual examination and laboratory procedures, except pregnancy test.**
- An ICD-9-CM diagnosis related to family planning services must be the primary diagnosis on the claim form. A complete list is located on page 23.
- Indicate "Yes" on the HSIS Service Screen data field for Family Planning Waiver Services.
- All approved antibiotic treatment and pain medications must have the appropriate ICD-9-CM diagnosis written on the prescription.
- No "brand medically necessary" (DAW1) medications are allowed, if a generic is available.
- All applicable North Carolina Medicaid policies and procedures must be adhered to in addition to those listed in this special bulletin.

OUTPATIENT HOSPITALS

- All services must be billed with the appropriate Revenue code, CPT code, and ICD-9-CM diagnosis.
- An ICD-9-CM diagnosis related to family planning services must be the primary diagnosis on the claim form. A complete list is located on page 23.
- All laboratories services must be billed with the appropriate laboratory revenue code and HCPCS code.
- Hospital providers must use the occurrence form locators 32, 33, 34, or 35. Enter an "11" in the occurrence code field and then enter the AED in the corresponding "date" field.
- All approved antibiotic treatment and pain medications must have the appropriate ICD-9-CM diagnosis written on the prescription.
- No "brand medically necessary" (DAW1) medications are allowed, if generic is available.
- All applicable North Carolina Medicaid policies and procedures must be adhered to in addition to those listed in this special bulletin.

PHARMACY (OUTPATIENT ONLY)

- All eligible drugs will have a family planning indicator on the drug file (including birth control pills, Depo-provera, Ortho Evra).
- All claims must be submitted via point of sale with the approved ICD-9-CM diagnosis written on the prescription.

- All approved antibiotic treatment and pain medications must have the appropriate ICD-9-CM diagnosis written on the prescription.
- No "brand medically necessary" (DAW1) medications are allowed, if a generic is available.
- Dispensing fee based on Medicaid rules.
- All applicable North Carolina Medicaid policies and procedures must be adhered to in addition to those listed in this special bulletin.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							111111111E		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M / F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Recipient, Jane			09 11 71						
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
123 Recipient Street			Self / Spouse / Child / Other						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
RecipientCity		NC	Single X / Married / Other						
ZIP CODE	TELEPHONE (Include Area Code)		Employed / Full-Time Student / Part-Time Student				ZIP CODE	TELEPHONE (INCLUDE AREA CODE)	
12345	(123) 456-7890							( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO				a. INSURED'S DATE OF BIRTH MM DD YY	SEX M / F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M / F		b. AUTO ACCIDENT? YES / NO	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES / NO				c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO *If yes, return to and complete item 9 a-d.*		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: 05 01 06	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____
19. RESERVED FOR LOCAL USE: 1234567		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. V25 01 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
05 01 06	05 01 06	11		99203	FP		88 00	1				

25. FEDERAL TAX I.D. NUMBER	SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $ 88 00	29. AMOUNT PAID $	30. BALANCE DUE $ 88 00
		12345				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS *(I certify that the statements on the reverse apply to this bill and are made a part thereof.)*	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED *(if other than home or office)*	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Signature on file 05-01-06 SIGNED DATE		PIN# 1111111 GRP# 222222c

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

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

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

PLEASE DO NOT STAPLE IN THIS AREA [redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID [X] (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							333333333A		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M [ ] F [X]		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Recipient, Jane			09 11 85						
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
123 Recipient Street			Self [ ] Spouse [ ] Child [ ] Other [ ]						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
RecipientCity		NC	Single [X] Married [ ] Other [ ]						
ZIP CODE	TELEPHONE (Include Area Code)		Employed [ ] Full-Time Student [ ] Part-Time Student [ ]				ZIP CODE	TELEPHONE (INCLUDE AREA CODE)	
12345	(123) 456-7890							( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO				a. INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]		b. AUTO ACCIDENT? [ ] YES [ ] NO	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? [ ] YES [ ] NO				c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes,* return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◄ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY: 05 01 06	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____
19. RESERVED FOR LOCAL USE: 1234567		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V25 01 2. 3. 4.		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
05 01 06	05 01 06	11		99212	FP		34 88	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO. 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO	28. TOTAL CHARGE $ 34 88
29. AMOUNT PAID $	30. BALANCE DUE $ 34 88		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Signature on file 05-01-06 SIGNED DATE	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# 1111111 GRP# 2222222

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)			
							222222222E				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
Recipient, Joe			09 11 71								
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)				
123 Recipient Street			Self	Spouse	Child	Other					
CITY		STATE	8. PATIENT STATUS				CITY			STATE	
RecipientCity		NC	Single	Married X	Other						
ZIP CODE	TELEPHONE (Include Area Code)		Employed	Full-Time Student	Part-Time Student		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)			
12345	(123) 456-7890							( )			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO				a. INSURED'S DATE OF BIRTH MM DD YY	SEX M F			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M F		b. AUTO ACCIDENT? YES NO	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES NO				c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.				

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 05 01 06	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____	
19. RESERVED FOR LOCAL USE: 1234567		20. OUTSIDE LAB? YES NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
1. V252 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
05 01 06	05 01 06	11		55450	FP		387 44	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 387 44	29. AMOUNT PAID $	30. BALANCE DUE $ 387 44
	12345				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Signature on file SIGNED 05-01-06 DATE		PIN# 1111111 GRP# 2222222

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 444444444M

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

3. PATIENT'S BIRTH DATE: 09 11 71 SEX: M X F

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: RecipientCity STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 456-7890

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 05 01 06

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 1234567

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V252 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
05 01 06	05 01 06	11		00921	FP QZ		225 00	111				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

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

28. TOTAL CHARGE: $ 225 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 225 00

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

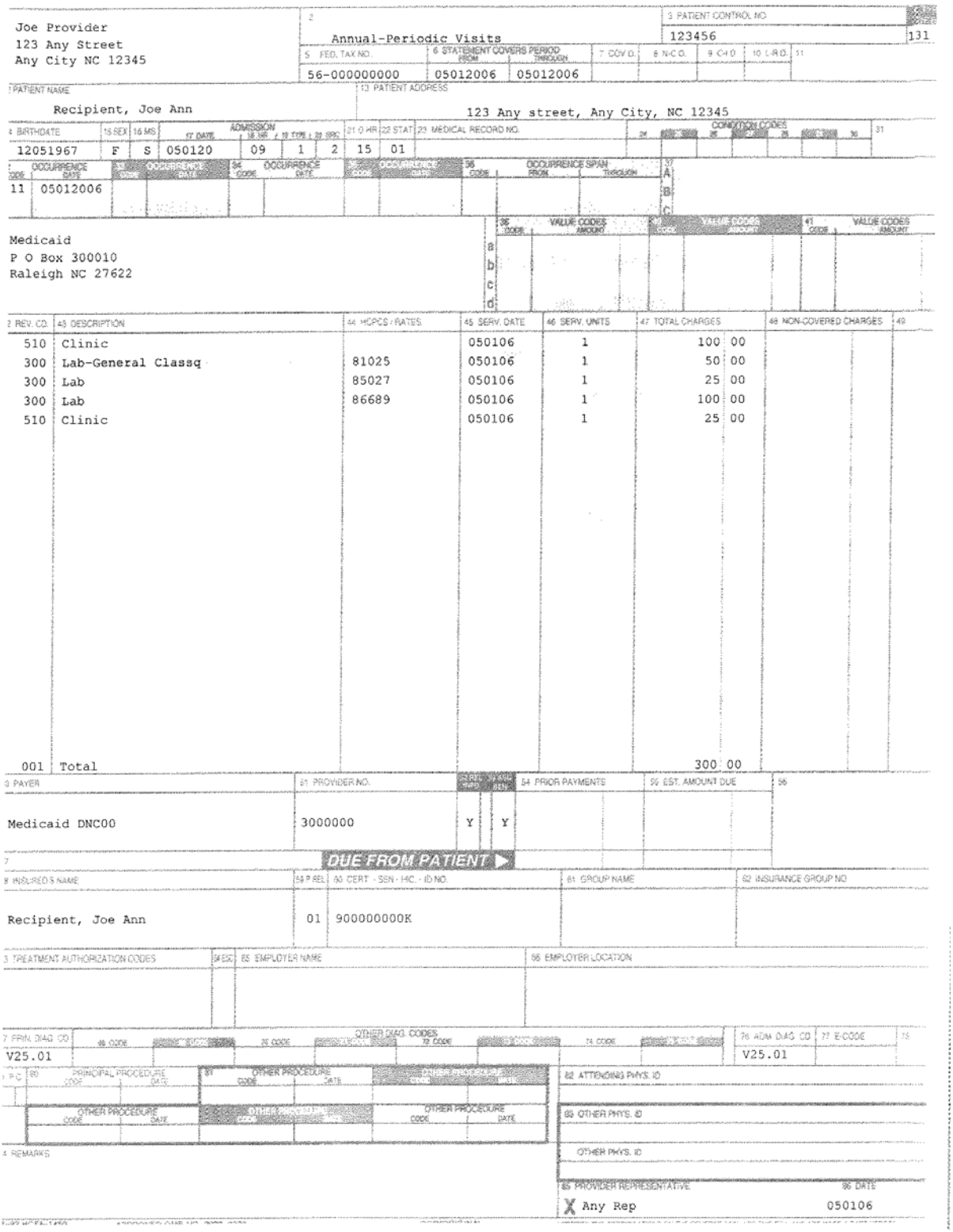
Signature on file 05-01-06

SIGNED DATE

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

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

PIN# 1111111 GRP# 2222222



Joe Provider
123 Any Street
Any City NC 12345

Annual-Periodic Visits

3 PATIENT CONTROL NO.: 123456

5 FED. TAX NO.: 56-000000000
6 STATEMENT COVERS PERIOD: FROM 05012006 THROUGH 05012006

7 COV'D. | 8 N-C'D. | 9 C-H'D. | 10 L-R'D. | 11

1 PATIENT NAME: Recipient, Joe Ann

13 PATIENT ADDRESS: 123 Any street, Any City, NC 12345

4 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	30	31
12051967	F	S	050120	09	1	2	15	01								

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
11	05012006										A B C

Medicaid
P O Box 300010
Raleigh NC 27622

38 CODE	38 VALUE CODES AMOUNT	39 CODE	39 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
510	Clinic		050106	1	100 00		
300	Lab-General Classq	81025	050106	1	50 00		
300	Lab	85027	050106	1	25 00		
300	Lab	86689	050106	1	100 00		
510	Clinic		050106	1	25 00		
001	Total				300 00		

50 PAYER	51 PROVIDER NO.	52 REL. TO EMP.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid DNC00	3000000	Y	Y			

DUE FROM PATIENT

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Recipient, Joe Ann	01	900000000K		

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD	77 E-CODE	78
V25.01					V25.01		

P/C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Any Rep | 86 DATE: 050106

UNIFORM BILL: NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.
9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

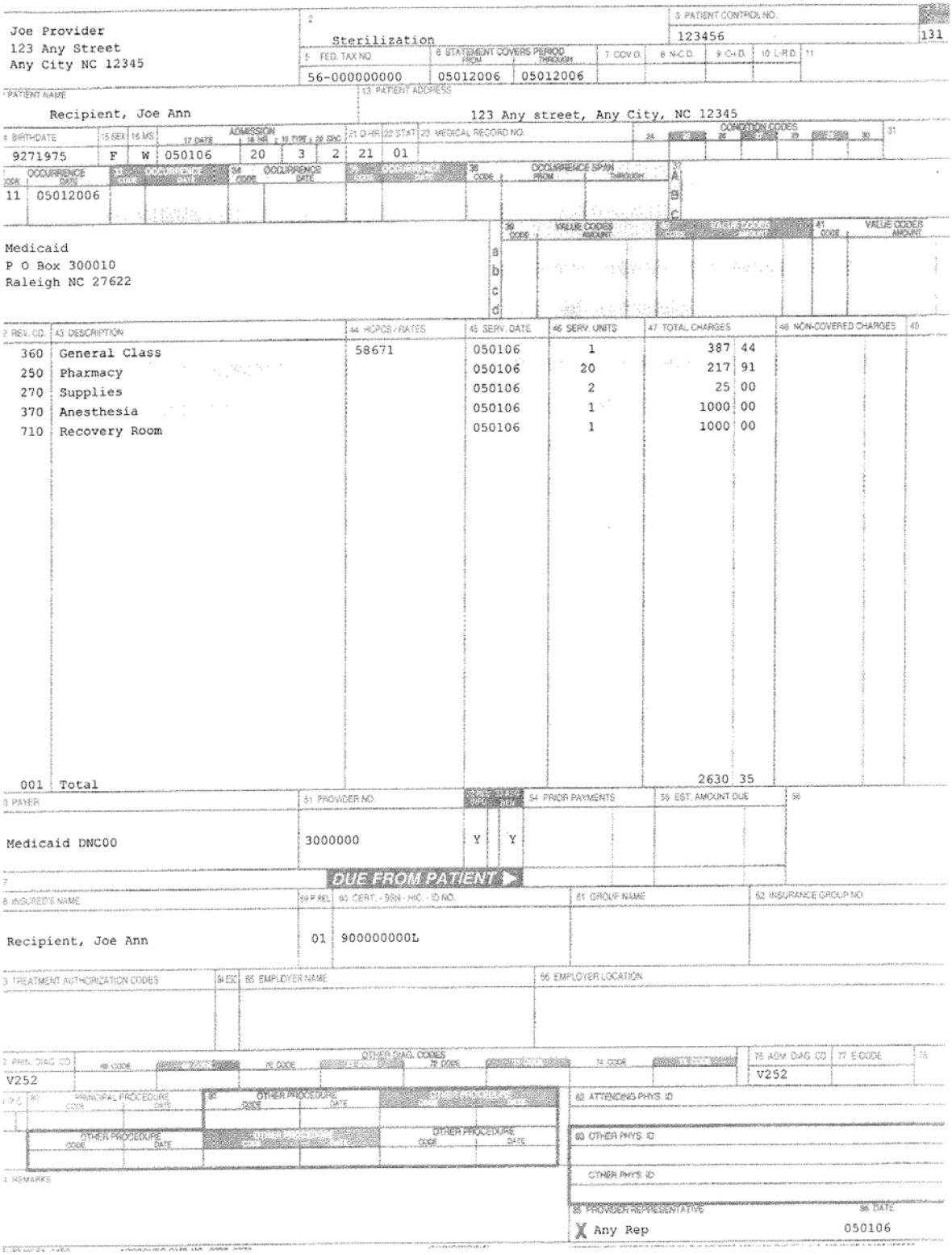
   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) Based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) If CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS



Joe Provider
123 Any Street
Any City NC 12345

2 Sterilization

3 PATIENT CONTROL NO. 123456

5 FED. TAX NO. 56-000000000

6 STATEMENT COVERS PERIOD FROM 05012006 THROUGH 05012006

PATIENT NAME: Recipient, Joe Ann

13 PATIENT ADDRESS: 123 Any street, Any City, NC 12345

8 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 CHR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
9271975	F	W	050106	20	3	2	21	01									

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
11	05012006											A
												B
												C

Medicaid
P O Box 300010
Raleigh NC 27622

38 CODE	38 VALUE CODES AMOUNT	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a							
b							
c							
d							

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
360	General Class	58671	050106	1	387 44		
250	Pharmacy		050106	20	217 91		
270	Supplies		050106	2	25 00		
370	Anesthesia		050106	1	1000 00		
710	Recovery Room		050106	1	1000 00		
001	Total				2630 35		

50 PAYER	51 PROVIDER NO.	52 REL. ASSIGN.	53 ASSIGN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid DNC00	3000000	Y	Y			

DUE FROM PATIENT

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Recipient, Joe Ann	01	900000000L		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 ADM. DIAG. CD	74 E-CODE	75
V252						V252		

76	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID

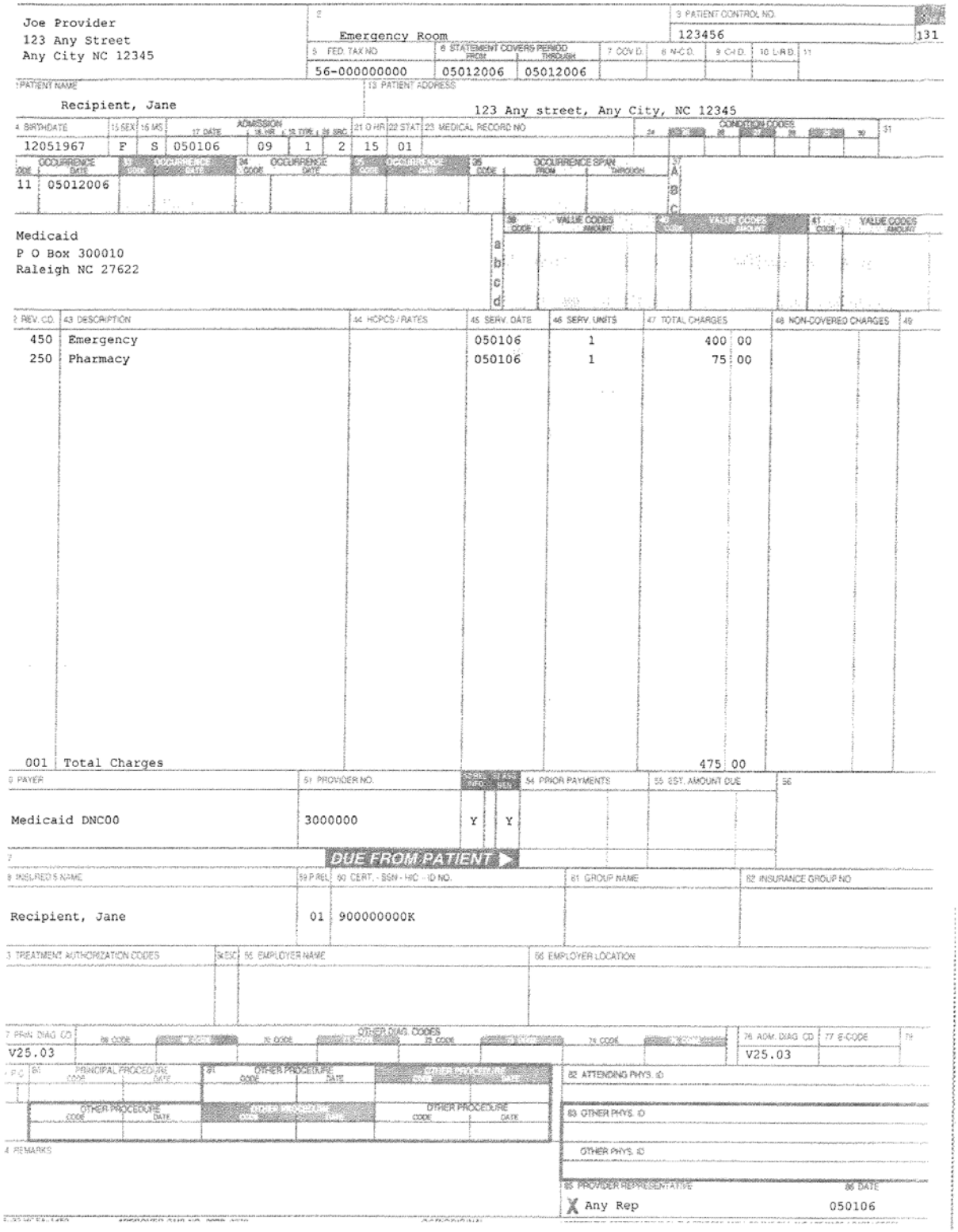
83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Any Rep

86 DATE: 050106



Joe Provider
123 Any Street
Any City NC 12345

Emergency Room

3 PATIENT CONTROL NO.: 123456

5 FED. TAX NO.: 56-000000000
6 STATEMENT COVERS PERIOD FROM: 05012006 THROUGH: 05012006

1 PATIENT NAME: Recipient, Jane

13 PATIENT ADDRESS: 123 Any street, Any City, NC 12345

4 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO
12051967	F	S	050106	09	1	2	15	01	

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH
11	05012006									

Medicaid
P O Box 300010
Raleigh NC 27622

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
450	Emergency		050106	1	400 00	
250	Pharmacy		050106	1	75 00	
001	Total Charges				475 00	

50 PAYER	51 PROVIDER NO.	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Medicaid DNC00	3000000	Y	Y		

DUE FROM PATIENT

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO
Recipient, Jane	01	900000000K		

67 PRIN. DIAG. CD	70 OTHER DIAG. CODES	76 ADM. DIAG. CD	77 E-CODE
V25.03		V25.03	

74 PRINCIPAL PROCEDURE CODE DATE
74 OTHER PROCEDURE CODE DATE
74 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE: X Any Rep
86 DATE: 050106

ATTACHMENT A

Be Smart.
Be Ready.

◆ **Family Planning Medicaid Waiver**

To order any other NCHSF materials, please use July 2005 materials order form.

Ordering Tips
- Specify both the # of packs and total quantity, for example: for A5E, 5 packs = 500 total
- No orders outside NC
- Keep a copy of your order
- Allow 3 weeks for delivery

October 2005 Order Form For Free Materials

Duplicate form as needed — Example: A5 5 packs = 500 total

Item	Title	Quantity	# Packs	Total
A5E	Be Smart Brochure English	100 / pk		
A6E	Be Smart Small Poster English	***		
A7E	Be Smart Large Poster English	***		
D6E	HC/NCHC Application English limit 500	100 / pk		
D6S	HC/NCHC Application Spanish limit 300	100 / pk		

The Be Smart brochure and small poster will be available in Spanish in December.

◆ **Health Check (Medicaid) NC Health Choice applications include the Family Planning Waiver application.**

◆ **Mail To:** North Carolina Healthy Start Foundation
1300 St. Mary's St., Suite 204
Raleigh, NC 27605

◆ **FAX To:** 919-828-7470 ◆ **Phone:** 919-828-1819, ask for shipping

NORTH CAROLINA Healthy Start FOUNDATION
www.nchealthystart.org

Name _____

Agency _____

Dept _____ Phone _____

Street Address _____

City _____ State _____ Zip _____ County _____

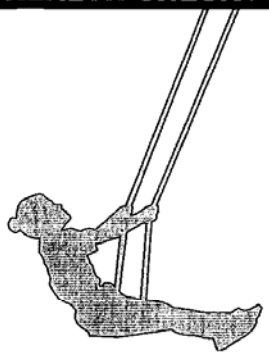
No delivery without street address. This is a: ☐ business address ☐ residential address

PO Box _____ City _____ Zip _____

Email _____ Order Date _____ Date Needed _____

ATTACHMENT B

HEALTH CHECK / NC HEALTH CHOICE FOR CHILDREN APPLICATION



Health Check NC Health Choice for children

Better health for your children, peace of mind for you.

Free or Low-Cost Health Insurance for Children and Teens up to 21 Years Old
(Pregnant women, parents, or other adults may also use this application to apply for Medicaid as a caretaker or for Family Planning Services).

Si usted desea obtener la forma DMA-5063, solicitud en español para seguro medico para niños, comuníquese con el departamento de servicios sociales de su localidad. También puede llamar a la línea de Recursos de Salud Familiar al 1-800-367-2229. Se le atenderá en español. (You can get a Spanish application at your local department of social services or call 1-800-367-2229.)

WHAT ARE HEALTH CHECK AND NC HEALTH CHOICE FOR CHILDREN?

Health Check (Children's Medicaid Insurance) and Health Choice are two similar health insurance programs for children. Your family's income, the number of people in your family and the age of the children determine if your children qualify. This information will also be used to determine in which program the children will be enrolled.

WHAT ARE THE BENEFITS?

- **Sick visits**
- **Checkups**
- **Hospital care**
- **Counseling**
- **Prescriptions**
- **Dental care**
- **Eye exams and glasses**
- **Hearing exams and hearing aids**
- **And more!**

Transportation - If your children are enrolled in Health Check, transportation to medical appointments may be provided through your department of social services. If the children are enrolled in Health Choice, you must provide your own transportation.

Children with Special Health Care Needs may be eligible for additional services.

HOW DO I APPLY?

It's easy. Just mail or drop off the completed application at the department of social services in the county where you live. If you would like help filling out the application, call or visit your department of social services. You can find the address and phone number in your phone book under "County Government" or by calling the North Carolina Family Health Resource Line at 1-800-367-2229.

Be careful to answer all the questions completely so we can process your application more quickly. If you need more space, please attach additional pages. It can take 45 days or less to process your application. If we need additional information, we will contact you by mail. The sooner we get the information, the sooner we can let you know if your children qualify.

DMA-5063 06/01/05 Questions about Health Check/Health Choice? Call 1-800-367-2229. Page 1

WHAT ELSE DO I NEED TO KNOW ABOUT HEALTH CHECK AND HEALTH CHOICE?

Will My Children Get Insurance Cards?
YES! Your children will receive insurance cards in the mail. Please keep the card handy so you can show it at medical appointments and when you fill prescriptions.

How Do I Choose a Doctor?
The department of social services will help you choose your doctor if your children are enrolled in Health Check (Children's Medicaid Insurance). If your children are enrolled in Health Choice, you may contact the doctor of your choice.

Will I Need to Re-enroll My Children?
YES! You will need to re-enroll to continue benefits. For most children this is done once a year. You will be contacted when it is time to re-enroll.

Will I Have to Pay Enrollment Fees and a Co-pay?
Depending on your income, you may have to pay an enrollment fee of $50 to $100 per family per year. In some cases, you also may have a small co-pay for doctor visits and prescriptions. If the fee and/or co-pay apply to you, you will be notified.

Will My Children Be Enrolled Immediately?
Health Check (Children's Medicaid Insurance) has no funding limits, so there is no waiting list. If your children are eligible for Health Choice, they may have to go on a waiting list before being enrolled if federal or state funds are not sufficient to serve more children.

WHAT ARE MY RESPONSIBILITIES?

- ✓ You agree to tell the department of social services within 10 days if there are any changes in the information you provided on your application.
- ✓ A state or federal reviewer may check the information on this form. You agree to participate in the review and will cooperate with the reviewer.
- ✓ If you knowingly provide false information or if you withhold information and your children get health insurance for which they are not eligible, you can be lawfully punished for fraud and may be asked to repay the programs for any medical bills and/or premiums that were paid incorrectly.
- ✓ You agree to tell the department of social services if anyone with Health Check (Children's Medicaid Insurance) is in an accident.
- ✓ If Health Check (Children's Medicaid Insurance)/Health Choice pays for health care for your children, you give permission to the state of North Carolina to collect payments from anyone who is supposed to pay for that care. You also agree to share medical information about your children with any insurance company to get the medical bills paid.
- ✓ For a person to be enrolled in Health Check (Children's Medicaid Insurance)/Health Choice, you must provide his/her social security number or apply for a number. Please know that these numbers will be matched by computer with other government agency records (but not the Bureau of Citizenship and Immigration Services) to verify information. If you decide not to give the numbers, the person cannot be enrolled.

WHAT ARE MY RIGHTS?

- ✓ Health Check (Children's Medicaid Insurance)/Health Choice cannot discriminate because of race, color, nationality, sex, religion, age, disability or political belief.
- ✓ By law, all information that you provide remains private.
- ✓ You can ask for a hearing if you think any decisions are unfair, incorrect or are made too late.

WHO CAN ANSWER MY QUESTIONS?

Contact the department of social services in the county where you live or call the NC Family Health Resource Line at 1-800-367-2229.

Before you return the application, please make sure to do the following:

Read pages 1 and 2. Tear them off and keep for your records.
Complete the questions on pages 3 through 6.
Sign the application on page 5.

DMA-5063 06/01/05 Questions about Health Check/Health Choice? Call 1-800-367-2229. Page 2

Health Check NC Health Choice for children

APPLICATION

For Office Use Only
County DSS: _____
Date Received: _____
Case #: _____
☐ Mail in ☐ DSS ☐ Health Dept

Please complete. Then send pages 3-6 to your local department of social services. If this application is being completed by or for a pregnant woman who has no other children living with her, complete this application as if the pregnant women is already a parent.

Tell Us About the Family

1. Who are *all* the children under age 21 who live in the home?

*Fill out this information **even** for children who will not be applying for Health Check/Health Choice. Social Security number and citizenship status are required **only** for those applying for health insurance.*

Name of child (first, middle initial, last)	Applying for this child (Y, N)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes below. List all that apply.)	**Hispanic/Latino (Y, N) If yes, specify using codes below.	Child a U.S. citizen (Y, N)	Social Security Number (SSN)

***Asian= A American Indian or Alaska Native= I Native Hawaiian or other Pacific Islander= P Caucasian or White= W Black or African-American= B**
**** Hispanic Puerto Rican= P Hispanic Cuban= C Hispanic Mexican= M Hispanic Other= H**

2. Where do you & the children live? (If different, please put your address on a separate paper and return with this application.)

Address:	Mailing address (if different):
City: State: Zip Code:	City: State: Zip Code:
Home phone: ( )	Daytime phone: ( )

3. Who are the parents living with the children? If the children do not live with their parents, who are the adults living in the home who care for the children?

Name of parent or adult (first, middle initial, last)	Date of birth (mo/day/yr)	Sex (M, F)	*Race (Use codes in 1. above. List all that apply.)	**Hispanic/Latino (Y, N) If yes, use codes in 1. above.	Children's names and parent or adult relationship to the children (John – Mother, Mary - Stepmother)

a. Do you want to apply for pregnancy coverage for any of the people listed above? ☐ Yes ☐ No
If you are applying for pregnancy assistance, you need to provide a statement from the doctor that includes the delivery date and the number of babies expected. However, send in the application form even if you do not have the statement from the doctor yet.
If yes, for whom? _____ SSN# _____

b. Do you want to apply for Medicaid for any of the people listed above? If you want to apply, you will be contacted for information about bank accounts, real and personal property, cash value of life insurance, stocks, bonds, etc. The total of these must be less than $3,000. Also, if you are eligible, you may be responsible for some of your medical bills. ☐ Yes ☐ No
Applicants must provide their Social Security numbers and may have to give information to the child support office.
If yes, for whom: _____ SSN# _____

c. Do you want to apply for family planning services for any people ages 19 and older listed above? ☐ Yes ☐ No
Applicants must provide their Social Security numbers.
If yes, for whom: _____ SSN# _____

DMA-5063 06/01/05 Questions about Health Check/Health Choice? Call 1-800-367-2229. Page 3

4. Is there a family member living away from the home for less than 12 months (Example: military service, attending school)? ☐ **Yes** ☐ **No**
   If yes, please give information below:

Full name (first, middle initial, last)	Reason for absence	Expected date of return

Tell Us About the Family's Health Insurance and Medical Needs

5. Is there currently a parent **not** living in the home? ☐ **Yes** ☐ **No**
   If yes, what is that parent's name? (optional) _____
   Is that parent required by an agreement to pay for health insurance? ☐ **Yes** ☐ **No**

6. Does anyone applying have another health insurance plan? ☐ **Yes** ☐ **No**
   If yes, please give information below:

Name (first, middle initial, last)	Insurance company name	Insurance company address	Insurance company phone number	Group/policy number

7. Does anyone applying need help paying medical bills from the past three months? ☐ **Yes** ☐ **No**
   If yes, please give the information below: *We may be able to help pay those bills.*

Name of person(s) with bill (first, middle initial, last)	Name of doctor, clinic and/or hospital where person was treated	Date of medical treatment

8. Has anyone applying been in an accident in the past three months? ☐ **Yes** ☐ **No**
   Did he/she receive medical care because of the accident? ☐ **Yes** ☐ **No**
   If yes, please tell us who. _____ When was the accident? ____/____/____

Tell Us About the Parent's and Children's Income

9. Who are the parents and children in the home who work, and what are their wages?

Name of working person (first, middle initial, last)	Employer's name and phone number	Amount earned before deductions	Tips earned	How often paid (monthly, weekly, etc.)
		$	$	
		$	$	
		$	$	

Please provide copies of all of last month's paycheck stubs for everybody listed. Send in the application even if you do not have your stubs.

10. Is there a parent or child in the home who is self-employed? ☐ **Yes** ☐ **No**
    For example, does anyone earn money from farming, own his or her own business, or have rental property income?
    If yes, please attach business records showing income and expenses for the last 6 months or the number of months in business if less than 6 months. If the income is annual, please attach business records for the last 12 months.

11. Has a parent or child in the home lost a job in the past three months? ☐ **Yes** ☐ **No**
    If yes, please complete the following:

Name of person(s) who lost a job	Date job lost	Former employer's name	Former employer's address & phone number

DMA-5063 06/01/05 Questions about Health Check/Health Choice? Call 1-800-367-2229. Page 4

12. If the parent or child receives income from any other source please complete the blocks below.

Type of Income	Name of the person who receives other income	Amount received	How often received (monthly, weekly, etc.)
Child Support:		$	
Social Security:		$	
Unemployment:		$	
Other (Please explain):		$	

Tell Us About the Parent's and Children's Expenses

Some of these expenses may be used to reduce the income that we count to determine enrollment in Health Check/Health Choice.

13. Does a working parent living in the home pay for childcare, a babysitter or care for dependent adult? ☐ **Yes** ☐ **No**
If yes, please fill in the information:

Name, address & phone number of sitter or childcare provider	Name of person cared for	Name of person paying for care	Amount paid	How often paid (monthly, weekly, etc.)
			$	
			$	

14. Does a parent living in the home pay child support for a child who is not living in the home? ☐ **Yes** ☐ **No**
If yes, please fill in the information.

Who pays the support	Who is the support paid to	Is it court ordered (Y, N)	Amount paid	How often paid (monthly, weekly, etc.)
			$	
			$	

Tell Us If You Would Like Help With Child Support

The Child Support Agency can help get financial and medical help for the child from the child's absent parent. If you seek assistance from the Child Support Agency, the courts can establish paternity and establish and enforce child support obligations.

There are other benefits to working with the Child Support Agency. For example, your child may be eligible for other financial benefits, including Social Security, pension benefits, veteran's benefits and possible inheritance. Also, your child may benefit by having a bond between parent and child. Finally, your child may benefit by getting important medical history information.

If you want the Child Support Agency's help in establishing paternity or in getting a support order through the court, check the "Yes" box. If you check the box, someone will contact you. ☐ **Yes, I would like help from the Child Support Agency.**

- ✓ I attest that all statements recorded on this document are true and correct to the best of my knowledge.
- ✓ I have either read or had read to me all attachments to this application, and I understand my rights and responsibilities as an applicant/recipient.
- ✓ I authorize the release of any information necessary to establish my family's eligibility. I understand that this information may include medical information about the individuals applying for health insurance and/or nonmedical information about individuals applying and others. This might include information from doctors, hospitals, employers and insurance companies.
- ✓ I have received or understand that I will receive a copy of the "Medicaid Notice of Privacy Practices."
- ✓ I authorize the copying of this release form to verify information. It shall remain valid and in force until revoked by me in writing.
- ✓ I understand that if Medicaid pays for nursing facility care, in-home health services, or services provided under the Community Alternatives Program (CAP), Medicaid may become a creditor of my estate and my estate may be subject to recovery to repay Medicaid.

Signature of parent or other adult: _____

Date: ____/____/_____

DMA-5063 06/01/05 Questions about Health Check/Health Choice? Call 1-800-367-2229. Page 5

Health Check Health Choice for children

Language Preference and Special Needs
(Optional)
You may still apply for Health Check/Health Choice even if you don't answer the questions on this page.

What Language Does the Family Prefer to Speak?

The federal government requires the State to provide information about the languages the family speaks. Please help us by providing the information for the parent/other adult and those applying for health insurance.

Name of person (first, middle initial, last)	Language person prefers to speak (circle one)
1.	English Spanish Other (Specify_____)
2.	English Spanish Other (Specify_____)
3.	English Spanish Other (Specify_____)
4.	English Spanish Other (Specify_____)
5.	English Spanish Other (Specify_____)
6.	English Spanish Other (Specify_____)

Does Your Child Have Special Health Care Needs?

Please help us improve services for children with special health care needs and meet federal reporting requirements by answering these questions.

1. Does your child (or children) currently need medicine prescribed by a doctor other than vitamins? ☐Yes ☐No
   Does your child (or children) need this medicine because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐No
   If yes, please list the child (or children):_____

2. Does your child (or children) need more medical care, mental health or education services than usual or routine for most children of the same age? ☐Yes ☐No
   Does your child (or children) need these services because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months? ☐Yes ☐ No
   If yes, please list the child (or children): _____

3. Is your child (or children) limited or prevented in **any way** in his or her ability to do the things most children the same age can do? ☐ Yes ☐ No
   Is this limitation because of *any* medical, behavioral or health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐ No
   If yes, please list the child (or children): _____

4. Does your child (or children) need special therapy, such as physical, occupational, or speech therapy? ☐ Yes ☐ No
   Does your child (or children) need this therapy because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐ No
   If yes, please list the child (or children):_____

5. Does your child (or children) currently have any kind of emotional, developmental or behavioral difficulty for which they need treatment or counseling? ☐ Yes ☐ No
   Does your child (or children) need this treatment or counseling because of *any* medical, behavioral or other health condition that has lasted or is expected to last *at least* 12 months? ☐ Yes ☐ No
   If yes, please list the child (or children):_____

DID YOU SIGN THE APPLICATION ON PAGE 5?

ATTACHMENT C

STI MEDICATION LIST

Medications for the Family Planning Waiver program will only be provided by prescription through the pharmacy drug program. **All prescriptions for STI medications must include the appropriate ICD-9 CM diagnosis code.**

STI DIAGNOSIS	ICD-9-CM CODE	REIMBURSED ANTIBIOTICS
HERPES		Acyclovir 200mg, 400mg, 800 mg
Genital herpes	54.10	Famciclovir 125mg, 250mg, 500mg
Herpetic vulvovaginitis	54.11	Valacyclovir 500mg, 1.0gm
Herpetic ulceration of vulva	54.12	
Herpetic infection of penis	54.13	
Other	54.19	
CHLAMYDIA		Azithromycin , 250mg, 500mg, 1gm
Other specified diseases due to Chlamydia	78.88	Doxycycline 100mg
Chlamydia trachomatis	99.41	Erythromycin 250mg, 400mg, 500mg, 800mg
	99.53	Ofloxacin 200mg, 300mg, 400mg
		Levofloxacin 500mg
		Tetracycline 250mg
SYPHILIS		Azithromycin 1gm
Genital syphilis (primary)	91.0	Benzathine penicillin G 2.4 million units
Primary anal syphilis	91.1	Ceftriazone 250mg
Other primary syphilis	91.2	Ciprofloxacin 500mg
Early syphilis, latent, serological relapse after treatment	92.0	Doxycycline 100mg
		Erythromycin 500mg
Early syphilis, latent, unspecified	92.9	Tetracycline 500mg
GONORRHEA		Azithromycin 250mg, 500mg, 1gm
Acute, of lower GU tract	98.0	Cefixime 400mg
Gonococcal infection (acute) of upper GU tract, site unspecified	98.10	Ceftriaxone 125 mg, 250mg, 500mg
		Ceftizoxime 500mg
Gonococcal cystitis (acute)	98.11	Cefotaxime 500mg

GONORRHEA (CONT)		Cefoxitin 2gm with probenecid 1gm Ciprofloxacin 250mg, 500mg Cefpodoxime 200 mg Gatifloxacin 400mg Levofloxacin 250mg Lomefloxacin 400mg Norfloxaxin 800mg Ofloxacin 400mg Spectinomycin 2gm Sulfamethoxazole/TMP
Gonococcal prostatitis (acute)	98.12	
Gonococcal epididymo-orchitis (acute)	98.13	
Gonococcal seminal vesiculitis (acute)	98.14	
Gonococcal cervicitis (acute)	98.15	
Gonococcal endometritis (acute)	98.16	
Gonococcal salpingitis, acute	98.17	
Other	98.19	
Chronic, of lower GU tract	98.2	
Chronic, gonococcal infection of upper GU tract, site unspecified	98.30	
Gonococcal cystitis, chronic	98.31	
Gonococcal prostatitis, chronic	98.32	
Gonococcal epididymo-orchitis, chronic	98.33	
Gonococcal seminal vesiculitis, chronic	98.34	
Gonococcal cervicitis, chronic	98.35	
Gonococcal endometritis, chronic	98.36	
Gonococcal salpingitis (chronic)	98.37	
Other	98.39	
Gonococcal arthritis	98.50	
Gonococcal synovitis and tenosynovitis	98.51	
Gonococcal bursitis	98.52	
Gonococcal spondylitis	98.53	
Other	98.59	
Gonococcal infection of pharynx	98.6	
Gonococcal infection of anus and rectum	98.7	
OTHER VENEREAL DISEASE		Azithromycin 250mg, 500mg, 1gm Doxycycline 100mg Erythromycin 500mg, 800mg Gatifloxacin 400mg Levofloxacin 250mg, 500mg Ofloxacin 200mg, 300mg, 400mg
Non-gonococcal urethritis, unspecified	99.40	

CANDIDIASIS		Butoconazole 2% cream
Of vulva and vagina	112.1	Miconazole 200mg suppository
Of other urogenital sites	112.2	Terconazole 80mg suppository Terconazole cream 0.4%, 0.8%
TRICHOMONIASIS		Metronidazole 250mg, 500mg, 750mg, 2gm
Urogenital trichomoniasis, unspecified	131.00	Tinidazole 2000mg
Trochomonal vulvovaginitis	131.01	
Trichomonal urethritis	131.02	
Trichomonal prostatitis	131.03	
Other	131.09	
Other specified sites	131.8	
Trichomoniasis, unspecified	131.9	
PUBIC LOUSE		Permethrin 5% cream
Phthirus pubis	132.2	Lindane 1% shampoo

NOTE:

For additional information regarding STI infections and diagnosis, refer to the Center for Disease Control (CDC) Sexually Transmitted Diseases Treatment Guidelines.

ATTACHMENT D

Completing the Sterilization Consent Form

Instructions

Following is the list of fields included in the federal consent form requirements for sterilization. All areas are required to be completed except area 9 (race) and areas 10, 11, 12, if not applicable. ***Fields in bold print cannot be altered.*** This guide will assist in correct completion of consent forms and should help to decrease the number of denials related to errors in completing the form.

1. Person or facility that provided information concerning sterilization.
2. Type of sterilization procedure to be performed.
3. Recipient date of birth (must be at least 21 years of age when the consent form is signed), Date of birth must match recipient files.
4. Name of recipient as it appears on the MID card.
5. The full name of the physician scheduled to do the surgery (abbreviations, initials, or "doctor on call" are unacceptable). May use "Physician on call for Any Provider OB/GYN clinic."
6. Type of sterilization procedure to be performed.
7. ***Recipient's signature (must be dated) cannot be altered, traced over, or corrected. Initials are not acceptable. Signature must be legible. If not, the recipient's name may be typed or printed under the signature.***
8. ***Date the consent form was signed. The date of the recipient's signature must be at least 30 days and no more than 180 days prior to the date of the sterilization. The count begins the day following the recipient's signature date.***
9. Race and ethnicity (not required).
10. Language in which the form was read to the recipient, if an interpreter was used.
11. ***Signature of the interpreter.***
12. ***Signature date of the interpreter (same as # 8 and # 16).***
13. Name of recipient.
14. Name of sterilization procedure.
15. ***Signature of person witnessing consent must be dated (see # 16). Must be legible. If not legible, the witness' name may be typed or printed above or below the signature.***
16. ***Date (this date must be the same as the recipient signature date). Note: the doctor can also be the witness.***
17. The full name and address of the facility, including street name and number, city, state, and zip code where the consent was obtained and witnessed.
18. Name of recipient.
19. Actual date of sterilization. Date of surgery may be changed on consent form with submission of operative records verifying date of service.
20. Type of sterilization procedure performed.
21. The box is to be checked if the delivery was premature (write the recipient's expected delivery date in the space provided).
22. The box is to be checked if emergency abdominal surgery was performed. Claim must be submitted with operative records.
23. Physician's signature must be legible or name must be printed below the signature. A signature stamp may be used. Signature cannot be initials.
24. Date must be on or after the date of service.

ATTACHMENT D

Copy of the Sterilization Consent Form

MID#_____

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____(1)_____. When I first asked for *(doctor or clinic)* the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____(2)_____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded program.

I am at least 21 years of age and was born on _____(3)_____ *Month Day Year*

I, _____(4)_____, hereby consent of my own free will to be sterilized by _____(5)_____ *(doctor)* by a method called _____(6)_____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health, Education, and Welfare or
Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.
I have received a copy of this form.

_____(7)_____ Date: _____(8)_____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

_____(9)_____
Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized)
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____(10)_____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____(11)_____ _____(12)_____
Interpreter *Date*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____(13)_____ *name of individual* signed the consent form, I explained to him/her the nature of the sterilization operation _____(14)_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____(15)_____ _____(16)_____
Signature of person obtaining consent *Date*

_____(17)_____
Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____(18)_____ on _____(19)_____
Name of individual to be sterilized *Date of sterilization*

_____(19 cont'd)_____ I explained to him/her the nature of the *operation* sterilization operation _____(20)_____, the fact that *specify type of operation* it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at an any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(21) ☐ Premature delivery
(22) ☐ Individual's expected date of delivery:
☐ Emergency abdominal surgery:

(describe circumstances):

_____(23)_____ _____(24)_____
Physician *Date*

372-116 **White:** PATIENT **Yellow:** PHYSICIAN **Pink:** STATE AGENCY

ATTACHMENT E

POSTOPERATIVE STERILIZATION MEDICATION LIST

Medications for the Family Planning Waiver program will only be provided by prescription through the pharmacy drug program. **All prescriptions for postoperative sterilization medications must include a V25.2 diagnosis.**

STERILIZATION PROCEDURE	CPT CODE	REIMBURSED ANTIBIOTICS
VASECTOMY		Amox TR-K CLV 500-125mg, 1000-62.5 Amoxicillin 250mg, 500mg Cephalexin 250mg, 500mg Ciprofloxacin HCL 250mg, 500mg Doxycycline 100mg Erythromycin ES 400mg Levofloxacin 500mg Metronidazole 500mg Penicillin VK 500mg Sulfamethoxazole/TMP DS Azithromax 250mg
Vasectomy, unilateral or bilateral (including postop semen examination(s))	55250	
Ligation of vas deferens, unilateral or bilateral	55450	
TUBAL LIGATION		
Ligation or transaction fallopian tubes abdominal or vaginal approach, unilateral or bilateral	58600	
Occlusion of fallopian tube(s) by device vaginal or suprapublic approach	58615	
Laparoscopy surgical; with fulguration of oviducts (with or without transaction)	58670	
Tubal ligation by laparoscopic surgery with occlusion of device (band, clip or Falope ring)	58671	

STERILIZATION PROCEDURE	CPT CODE	REIMBURSED ANALGESICS
VASECTOMY		Acetaminophen/Cod #2, #3 Hydrocodone/Apap 2.5/500, 5/325, 5/500, 7.5/325, 7.5/500, 7.5/650, 7.5/750, 10/325, 10/500, 10/650,, 10/660, 10/750 Ibuprofen 400mg, 600mg, 800mg Ketorolac 10mg Naproxen 500mg Naproxen Sodium 550mg Oxycodone 5mg Oxycodone w/Apap 2.5/325, 5/325, 5/325, 7.5/325, 7.5/500, 10/325, 10/650 Propoxy-N/Apap 65/650, 100-650
Vasectomy, unilateral or bilateral (including postop semen examination(s))	55250	
Ligation of vas deferens, unilateral or bilateral	55450	
TUBAL LIGATION		
Ligation or transaction fallopian tubes abdominal or vaginal approach, unilateral or bilateral	58600	
Occlusion of fallopian tube(s) by device vaginal or suprapublic approach	58615	
Laparoscopy surgical; with fulguration of oviducts (with or without transaction)	58670	
Tubal ligation by laparoscopic surgery with occlusion of device (band, clip or Falope ring)	58671	

STERILIZATION PROCEDURE	CPT CODE	REIMBURSED ANTIEMETIC
VASECTOMY		Promethazine 25mg
Vasectomy, unilateral or bilateral (including postop semen examination(s))	55250	
Ligation of vas deferens, unilateral or bilateral	55450	
TUBAL LIGATION		
Ligation or transaction fallopian tubes abdominal or vaginal approach, unilateral or bilateral	58600	
Occlusion of fallopian tube(s) by device vaginal or suprapublic approach	58615	
Laparoscopy surgical; with fulguration of oviducts (with or without transaction)	58670	
Tubal ligation by laparoscopic surgery with occlusion of device (band, clip or Falope ring)	58671	

ATTACHMENT F

PRIMARY CARE "SAFETY NET" PROVIDERS LIST

The following list includes contact information on health care providers (federally qualified health centers, free clinics, local health departments, and rural health clinics) which provide primary care services to recipients regardless of their ability to pay; free or a sliding-fee scale; or otherwise help make services financially affordable. **This list is not inclusive of all the health care providers in your county.** If there is no primary care provider in your county, providers are encouraged to make referrals to primary care "safety net" providers in surrounding counties.

This information may change over time, so it is important to call the provider to find out more information about the availability or services, hours of operation, eligibility criteria (if any), and fee schedules.

A	**ALAMANCE**	**Charles Drew Community Health Center** 221 N Graham – Hopedale Road Burlington, NC 27217 (336)570-3739 **Frye Regional Medical Center Alexander Campus** 226 NC Hwy 165 Taylorsville, NC 28681 (828)635-4200 **Open Door Clinic of Alamance County** 221 N. Graham-Hopedale Road Burlington, NC 27217 (336)570-9800 **Scott Clinic** 5270 Union Ridge Road Burlington, NC 27217 (336)421-3247
	ALLEGHANY	**Alleghany County (Appalachian) District** 157 Health Services Road Sparta, NC 28675 (336)372-5641
	ANSON	**Anson Community Hospital** 500 Morven Road Wadesboro, NC 28170 (704)694-5131 **Anson County Health Department** 110 Ashe Street Wadesboro, NC 28170 (704)694-5188 **Anson Regional Medical Services** Hwy 52 South Morven, NC 28119 (704)851-9331

		Anson Regional Medical Services 203 Salisbury Street Wadesboro, NC 28170 (704)694-6700
	ASHE	**Ashe County (Appalachian) District** 413 McConnell Jefferson, NC 28640 (336)246-9449 **Ashe Memorial Hospital, Inc.** 200 Hospital Avenue Jefferson, NC 28640 (336)246-7101
	AVERY	**Appalachian HealthCare Project** 155 Furman Road, Suite 7 Boone, NC 28607 (828)263-9493 **Charles A. Cannon, Jr. Memorial Hospital, Inc.** PO Box 767 Linville, NC 28646 (828)737-7000
B	**BEAUFORT**	**Agape Community Health Clinic** 118 Fourth Street Washington, NC 27889 (252)940-0602 **Beaufort County Hospital** 628 East Twelfth Street Washington, NC 27889 (252)975-4100 **Pungo District Hospital Corporation** 202 East Water Street Belhaven NC 27810 (252)943-2111
	BERTIE	**Bertie Memorial Hospital** PO Box 40 Windsor, NC 27983 (252)794-6600 **Lewiston-Woodville Family Medical Center** 307 South Main Street Lewiston, NC 27849 (252)348-2545 **Windsor Medical Center** 306 Winston Lane Windsor, NC 27983 (252)794-3042
	BLADEN	**Bladen County Hospital** PO Box 398 Elizabethtown, NC 28337 (910)862-5179

		Bladen Lakes Community Health Center 6777 Albert Street Dublin, NC 28332 (910)879-1020 **Bladen Medical Associates** 211 4th Street Bladenboro, NC 28320 (910)863-3138 **Bladen Medical Associates** 88 East Green Street Clarkton, NC 28433 (910)647-0083 **Bladen Medical Associates** 16 Third Street Dublin, NC 28332 (910)862-3528 **Bladen Medical Associates** 300A East McKay Street Elizabethtown, NC 28337 (910)862-5500
	BRUNSWICK	**Brunswick Community Hospital** PO Box 139 Supply, NC 28462 (910)755-8121 **J.Arthur Dosher Memorial Hospital** 924 Howe Street Southport, NC 28461 (910)457-3800 **New Hope Clinic** 4705 Southport Supply Road, SE Southport, NC 28461 (910)278-6705
	BUNCOMBE	**ABCCM Medical Ministry** 155 Livingston Street Asheville, NC 28801 (828)259-5339 **Asheville Specialty Hospital** 428 Biltmore Avenue Asheville, NC 28801 (815)727-3355 **Barnardsville Medical Services** 540 Dillingham Road Barnardsville, NC 28709 (828)626-3965 **Buncombe County Health Department** 35 Woodfin Street Asheville, NC 28801 (828)250-5214

		Emma Family Resource Center 37 Brickyard Road Asheville, NC 28806 (828)252-4810 **Minnie Jones Family Health Center** 1 Granada Street Asheville, NC 28806 (828)251-2455 **Three Streams Family Health Center, Inc.** 2 Sulpher Springs Raod Asheville, NC 28806 (828)285-9725 **Western North Carolina Community Health Services** 10 Ridgelawn Road Asheville, NC 28806 (828)285-0622 **WNCCHS Ridgelawn Health Center** 10 Ridgelawn Road Asheville, NC 28806 (828)285-0622
	BURKE	**Good Samaritan Clinic** PO Box 3601 Morganton, NC 28680 (828)439-9948 **Grace Hospital, Inc.** 2201 South Sterling Street Morganton, NC 28655 (828)580-5000 **Valdese General Hospital Inc.** PO Box 700 Valdese, NC 28690 (828)874-2251
C	**CABARRUS**	**The Community Free Clinic** 528A Lake Concord Road, NE Concord, NC 28025 (704)782-0650 **NorthEast Medical Center** 920 Church Street, N Concord, NC 28025 (704)783-3000
	CALDWELL	**Caldwell County Health Department** 1966 B Morganton Blvd SW Lenior, NC 28645 (828)426-8415 **Caldwell Memorial Hospital, Inc.** PO Box 1890 Lenoir, NC 28645 (828)757-5100

	Helping Hands Clinic of Caldwell County 810 Harper Avenue Lenior, NC 28645 (828)754-8565 **West Caldwell Health Council, Inc.** 4329 Collettsville Road Collettsville, NC 28611 (828)754-2409
CARTERET	**Broad Street Clinic Foundation, Inc.** 500 N 35th Street Morehead City, NC 28557 (252)726-4562 **Carteret County Health Department** 3820 Bridges Street, Suite A Morehead City, NC 28557 (252)728-8550 **Carteret General Hospital** PO Drawer 1619 Morehead City, NC 28557 (252)808-6000
CASWELL	**Caswell County Health Department** 189 County Park Road Yanceyville, NC 27379 (336)694-4129 ext 157 **Caswell Family Medical Center** 439 US Highway 158 West Yanceyville, NC 27379 (336)694-9331 **Prospect Hill Community Health Center** 140 Main Street Prospect Hill, NC 27314 (336)562-3311
CATAWBA	**Catawba Valley Medical Center** 810 Fairgrove Church Road Hickory, NC 28602 (828)326-3800 **Cooperative Christian Ministries Health Care Center** 31 First Street Hickory, NC 28603 (828)327-0979 **Frye Regional Medical Center** 420 North Center Street Hickory, NC 28601 (828)322-6070
CHATHAM	**Chatham County Health Department** 80 East Street Pittsboro, NC 27312 (919)542-8215

		Chatham Hospital, Inc. PO Box 649 Siler City, NC 27344 (919)663-2113 **Moncure Community Health Center** 7228 Moncure Road-Pittsboro Moncure, NC 27559 (919)542-4991 **Siler City Health Center** 401 – B N Ivey Avenue Siler City, NC 27344 (919)663-1635
	CHEROKEE	**District Medical Center, Inc.** 415 Whitaker Lane Andrews, NC 28901 (828)321-1291 **Murphy Medical Center, Inc.** 4130 US Hwy 64 Murphy, NC 28906 (828)837-8161
	CHOWAN	**Chowan Hospital** PO Box 629 Edenton, NC 27932 (252)482-6156
	CLAY	**Clay Comprehensive Health Services, Inc.** PO Box 1309 Hayesville, NC 28904 (828)389-6347 **Clay County Health Department** 1 Riverside Circle Hayesville, NC 28904 (828)389-8052
	CLEVELAND	**Cleveland County Health Department** 315 East Grover Street Shelby, NC 28150 (704)484-5200 **Cleveland Regional Medical Center** 201 East Grover Street Shelby, NC 28150 (704)487-3245 **Crawley Memorial Hospital, Inc.** PO Box 996 Boiling Springs, NC 28017 (704)434-9466 **Kings Mountain Hospital** 706 West King Street Kings Mountain, NC 28086 (704)739-3601

COLUMBUS	**Columbus County Community Health Center, Inc.** 209 W Virgil Street Whiteville, NC 28472 (910)641-0202 **Columbus County Health Department** 304 Jefferson Street, Miller Building Whiteville, NC 28472 (910)641-3914 **Columbus County Hospital, Inc.** 500 Jefferson Street Whiteville, NC 28472 (910)642-8011
CRAVEN	**Craven Regional Medical Center** PO Box 12157 New Bern, NC 28561 (252)633-8880 **MERCI Clinic** 1315 Tatum Drive New Bern, NC 28561 (252)633-1599 **Moore Free Care Clinic** 1315 Tatum Drive New Bern, NC 28561 (910)947-6550
CUMBERLAND	**Cape Fear Valley Medical Center** PO Box 2000 Fayetteville, NC 28302 (910)609-4000 **The CARE Clinic, Inc.** 239 Robeson Street Fayetteville, NC 28305 (910)485-0555 **Cumberland County Health Department** 227 Fountainhead Lane Fayetteville, NC 28301 (910)433-3700 **Highsmith-Rainey Memorial Hospital** 150 Robeson Street Fayetteville, NC 28301 (910)609-1434 **Wade Family Medical Center** 7118 Main Street Wade, NC 28395 (910)483-6694
DARE	**The Outer Banks Hospital, Inc.** 4800 S Croaton Highway Nags Head, NC 27959 (252)449-4500

DAVIDSON	**Davidson Medical Ministries Clinic, Inc.** 420 N. Salisbury Street Lexington, NC 27293 (336)249-6215 **Lexington Memorial Hospital** PO Box 1817 Lexington, NC 27293-1817 (336)248-5161 **Thomasville Medical Center** PO Box 789 Thomasville, NC 27360 (336)472-2000
DAVIE	**Davie County Hospital** PO Box 1209 Mocksville, NC 27028 (336)751-8100 **Storehouse for Jesus Free Medical Clinic** PO Box 216 Mocksville, NC 27028 (336)751-1060
DUPLIN	**Community Health Services** 325 NC Hwy 55 West Mt. Olive, NC 28365 (919)658-5900 **Duplin County Health Department** 340 Seminary Street Kenansville, NC 28349 (910)296-2130 **Duplin General Hospital, Inc.** 401 North Main Street Kenansville, NC 28349 (910)296-2602 **Duplin Medical Association, Inc.** 107 North Center Street Warsaw, NC 28398 (910)293-3401 **Goshen Medical Center** 444 South West Center Street Faison, NC 28341 (910)267-0421 **Plainview Health Services** 360 East Charity Road Rose Hill, NC 28458 (910)289-3086
DURHAM	**Duke University Health System** Erwin Road Durham, NC 27710 (919)684-8111

		Durham Regional Hospital 3643 North Roxboro Road Durham, NC 27704 (919)470-4000 **Lincoln Community Health Center, Inc.** 1301 Fayetteville Street Durham, NC 27707 (919)956-4000 **North Carolina Specialty Hospital, LLC** PO Box 15819 Durham, NC 27704 (919)956-9300 **Select Specialty Hospital – Durham** 3643 N Roxboro Road Durham, NC 27704 (919)470-9011
	EDGECOMBE	**Heritage Hospital** 111 Hospital Drive Tarboro, NC 27886 (252)641-7700
F	**FORSYTH**	**Community Care Center** 2135 New Walkertown Road Winston-Salem, NC 27101 (336)723-7904 **Downtown Health Plaza,** **Wake Forest University Baptist Medical Center** 1200 Martin Luther King, Jr. Drive Winston-Salem, NC 27101 (336)713-9700 **Forsyth Memorial Hospital** 3333 Silas Creek Parkway Winston-Salem, NC 27103 (336)718-5000 **Medical Park Hospital, Inc.** 1950 South Hawthorne Road Winston-Salem, NC 27103 (336)718-0600 **North Carolina Baptist Hospital** Medical Center Boulevard Winston-Salem, NC 27157 (336)716-4750 **Northwest AHEC-Wake Forest University Health Sciences** Medical Center Boulevard Winston-Salem, NC 27157 (336)713-7700 **SemperCare Hospital of Winston-Salem, Inc.** 3333 Silas Creek Parkway Winston-Salem, NC 27103 (336)718-6500

	FRANKLIN	**Franklin County Volunteers in Medicine Clinic** 108 Bickett Blvd Louisburg, NC 27549 (919)496-0492 **Franklin Regional Medical Center** PO Box 609 Louisburg, NC 27549 (919)496-5131
G	**GASTON**	**Bessemer City Health Care Clinic** 540 ED Wilson Road Bessemer City, NC 28016 (704)629-3465 **Gaston County Health Department** 991 West Hudson Blvd Gastonia, NC 28052 (704)853-5262 **Gaston Family Health Services** 991 West Hudson Blvd Gastonia, NC 28052 (704)853-5267 **Gaston Memorial Hospital** PO Box 1747 Gastonia, NC 28053 (704)834-2121
	GATES	**Gates County Rural Medical Services, Inc.** 501 Main Street Gatesville, NC 27938 (252)357-1226
	GRANVILLE	**Granville Medical Center** PO Box 947 Oxford, NC 27565 (919)690-3000
	GREENE	**Greene County Health Department** 227 Kingold Blvd, Suite B Snow Hill, NC 28580 (252)747-8183 **Kate B. Reynolds Medical Center** 205 Martin Luther King Jr. Parkway Snow Hill, NC 28580 (252)747-4199 **Snow Hill Medical Center** 302 N Greene Street Snow Hill, NC 28580 (252)747-2921 **Walstonburg Migrant Resource Center** 204 S Main Street Walstonburg, NC 27888 (252)753-5525

	GUILFORD	**Community Clinic of High Point, Inc.** 904 N Main Street High Point, NC 27262 (336)841-7154 **Greensboro AHEC-Moses Cones Health System** 1200 N Elm Street Greensboro, NC 27401 (336)832-8025 **Guilford County Health Department** 1100 E Wendover Street Greensboro, NC 27405 (336)641-7777 **High Point Regional Adult Health Center** 624 Quaker Lane, Suite 100C High Point, NC 27260 (336)878-6027 **High Point Regional Health System** PO Box HP5 High Point, NC 27261 (336)878-6000 **Kindred Hospital – Greensboro** 2401 Southside Boulevard Greensboro, NC 27406 (336)271-2800 **Moses Cone Health System** 1200 N Elm Street Greensboro, NC 27401 (336)832-7000
H	**HALIFAX**	**Halifax Regional Medical Center, Inc.** PO Box 1089 Roanoke Rapids, NC 27870 (252)535-8011 **Lake Gaston Medical Center** 201 N Mosby Avenue Littleton, NC 27850 (252)586-5411 **Our Community Hospital, Inc.** PO Box 405 Scotland Neck, NC 27874 (252)826-4144 **Roanoke Valley Medical Ministries Clinic** 536 Jackson Street Roanoke Rapids, NC 27870 (252)308-1261 **Rural Health Group of Roanoke Rapids** 2066 Highway 125 Roanoke Rapids, NC 27870 (252)536-5000

	Scotland Neck Family Medical Center, Inc. 919 Junior High School Road Scotland Neck, NC 27874 (252)826-3143 **Twin County Rural Health** 204 Evans Road Hollister, NC 27844 (252)586-5151
HARNETT	**Anderson Creek Medical Center** 6750 Overhills Road Spring Lake, NC 28390 (910)436-2900 **Angier Medical Center** 84 Medical Drive Angier, NC 27501 (919)639-2122 **Benhaven Medical Center** 985 NC 87 South Cameron, NC 28326 (919)499-9422 **Betsy Johnson Regional Hospital** PO Drawer 1706 Dunn, NC 28335 (910)891-7161 **Boone Trail Medical Center** 1000 Medical Center Road Mamers, NC 27552 (910)893-3063 **Good Hope Hospital, Inc.** 410 Denim Drive Erwin, NC 28339 (910)897-6151
HAYWOOD	**Good Samaritan Clinic of Haywood County** 112 Academy Street Waynesville/Canton, NC 28716 (828)648-8676 **Haywood Christian Ministry** 150 Branner Avenue Waynesville, NC 28786 (828)456-4838 **Haywood Regional Medical Center** 262 Leroy George Drive Clyde, NC 28721 (828)456-7311
HENDERSON	**Blue Ridge Community Health Services, Inc.** Hwy 64 E & Howard Gap Road Hendersonville, NC 28793 (828)692-4289

		The Free Clinic 506 Park Hill Court Hendersonville, NC 28793 (828)697-8422 **Margaret R. Pardee Memorial Hospital** 800 North Justice Street Hendersonville NC 28791 (828)696-1000 **Park Ridge Hospital** PO Box 1569 Fletcher, NC 28732 (828)684-8501
	HERTFORD	**Helping Hands Clinic** 828 Academy Street Ahoskie, NC 27910 (252)358-7833 **Roanoke-Chowan Hospital** PO Box 1385 Ahoskie, NC 27910 (252)209-3000
	HOKE	**Hoke County Health Department** 429 East Central Avenue Raeford, NC 28376 (910)875-3717
	HYDE	**Engelhard Medical Center, Inc.** 34575 US 264 Engelhard, NC 27824 (252)925-7000 **Ocracoke Health Center, Inc.** Highway 12, Back Road Ocracoke, NC 27960 (252)928-1511
I	**IREDELL**	**Davis Regional Medical Center** PO Box 1823 Statesville, NC 28687 (704)873-0281 **Iredell Memorial Hospital, Inc.** PO Box 1828 Statesville, NC 28677 (704)878-4500 **Lake Norman Regional Medical Center** PO Box 3250 Mooresville, NC 28117 (704)660-4010 **Mooresville South Iredell Health Assistance Clinic** 400 E Statesville Ave., Suite 300 Mooresville, NC 28115 (704)663-1992

		Open Door Clinic 1421 Wilmington Avenue Statesville, NC 28677 (704)838-1108
J	**JACKSON**	**Good Samaritan Clinic of Jackson County** 538 Scotts Creek Drive Sylva, NC 28144 (828)586-3146 **Harris Regional Hospital, Inc.** 68 Hospital Road Sylva, NC 28779 (828)586-7000
	JOHNSTON	**Johnston County Health Department** 517 N Bright Leaf Blvd Smithfield, NC 27577 (919)989-5200
	JONES	**Jones County Health Department** 401 Highway 58 South Trenton, NC 28585 (252)448-9111
L	**LEE**	**Central Carolina Hospital** 1135 Carthage Street Sanford, NC 27330 (919)774-2100 **Helping Hand Clinic** 507 N Steele Street Sanford, NC 27330 (919)776-4359 **Lee County Health Department** 106 Hillcrest Drive Sanford, NC 27331 (919)718-4640 ext 5388
	LENOIR	**Kinston Community Health Center** 324 N Queen Street Kinston, NC 28502 (252)522-9800 **Lenoir Memorial Hospital, Inc.** PO Drawer 1678 Kinston, NC 28503 (252)522-7797
	LINCOLN	**Helping Hands Health Clinic** PO Box 2031 Lincolnton, NC 28093 (704)735-7145 **Lincoln County Health Department** 151 Sigmon Road Lincolnton, NC 28092 (704)736-8634

		Lincoln Medical Center PO Box 677 Lincolnton, NC 28093 (704)735-3071
M	**MACON**	**Angel Medical Center, Inc.** PO Box 1209 Franklin, NC 28744 (828)524-8411 **Highlands-Cashiers Hospital, Inc.** PO Drawer 190 Highlands, NC 28741 (828)526-1200
	MADISON	**Hot Springs Health Program, Inc.** 66 NW Highway 25-70 Hot Springs, NC 28743 (828)622-3245
	MARTIN	**Martin General Hospital** PO Box 1128 Williamston, NC 27892 (252)809-6179 **Martin-Tyrell-Washington Health District** 210 West Liberty Street Williamston, NC 27892 (252)792-7811
	MCDOWELL	**The McDowell Hospital** PO Box 730 Marion, NC 28752 (828)659-5000
	MECKLENBURG	**C. W. Williams Office** 3333 Wilkinson Blvd Charlotte, NC 28208 (704)393-7720 **Carolinas Medical Center Mercy/Pineville** 2001 Vail Avenue Charlotte, NC 28207 (704)379-5000 **Carolinas Medical Center Biddle Point** 1801 Rozelles Ferry Road Charlotte, NC 28208 (704)446-9987 **Carolinas Medical Center Eastland Family Practice** 5516 Central Avenue Charlotte, NC 28212 (704)446-1000 **Carolinas Medical Center Northpark** 251 Eastway Drive Charlotte, NC 28213 (704)446-9991

		Carolinas Medical Center-University 8800 N Tryon Street Charlotte, NC 28256 (704)548-6000 **Carolina Specialty Hospital** Seventh Floor, South Charlotte, NC 28207 (704)379-5117 **Charlotte AHEC-Carolinas HealthCare System** PO Box 32861 Charlotte, NC 28232 (704)697-6523 **Charlotte Community Health Clinic** 3040 A Eastway Drive Charlotte, NC 28205 (704)316-6561 **Charlotte Institute of Rehabilitation** 1100 Blythe Boulevard Charlotte, NC 28203 (704)355-4300 **Charlotte Volunteers in Medicine Free Clinic** 1330 Spring Street Charlotte, NC 28206 (704)350-1330 **Community Health Services** 1401 E 7th Street Charlotte, NC 28204 (704)375-0172 **Free Clinic of Our Towns** PO Box 1842 Davidson, NC 28036 (704)896-0471 **Lake Norman Free Clinic** 119 Olds Statesville Road Huntersville, NC 28078 (704)947-1350 **Metrolina Comprehensive Health** Midtown Medical Plaza 1918 Randolph Rd, Suite 670 Charlotte, NC 28207 (704)393-7720 **Nursing Center for Health Promotion** UNC-Charlotte 9201 University City Blvd Charlotte, NC 28223 (704)334-0000 **Presbyterian Hospital** PO Box 33549 Charlotte, NC 28233 (704)384-4000

		Presbyterian Hospital Matthews PO Box 3310 Matthews, NC 28106 (704)384-6370 **Presbyterian Specialty Hospital** PO Box 33549 Charlotte, NC 28233 (704)384-6050 **Shelters Health Services** 534 Spratt Street Charlotte, NC 28206 (704)334-0000
	MITCHELL	**Bakersville Community Medical Clinic, Inc.** 86 N Mitchell Avenue Bakersville, NC 28705 (828)688-4970 **Spruce Pine Family Medical Center** 496 Altapass Road Spruce Pine, NC 28777 (828)765-0330
	MONTGOMERY	**FirstHealth Montgomery Memorial Hospital** PO Box 486 Troy, NC 27371 (910)572-1301 **Montgomery County Health Department** 217 South Main Street Troy, NC 27371 (910)572-1393
	MOORE	**FirstHealth Moore Regional Hospital and Pinehurst Treatment** PO Box 3000 Pinehurst, NC 28374 (910)215-1000 **Moore Regional Hospital, FirstHealth of the Carolinas** 155 Memorial Drive Pinehurst, NC 28374 (910)215-1000
N	**NASH**	**Harvest Family Health Center, Inc.** 9088 Old Bailey Highway Spring Hope, NC 27882 (252)237-9383 **LifeCare Hospitals of North Carolina** 1031 Noell Lane Nashville, NC 27804 (252)451-2300 **Nash General Hospital** 2460 Curtis Ellis Drive Rocky Mount, NC 27804 (252)443-8070

	NEW HANOVER	**New Hanover Community Heath Center, Inc.** 925 N Fourth Street Wilmington, NC 28401 (910)343-0270 **New Hanover Regional Medical Center** 2228 S 17th Street Fiscal Services Wilmington, NC 28401 (910)343-7040 **Tileston Outreach Health Center** 320 South 5th Street Wilmington, NC 28401 (910)343-8736
	NORTHAMPTON	**Rural Health Group** 9425 NC Highway 305 Jackson, NC 27845 (252)534-1661 **Roanoke Amaranth Community Health Care** 1213 North Church Street Extension Jackson, NC 27845 (252)534-1661
O	**ONSLOW**	**Caring Community Clinic** 215 B Station Street Jacksonville, NC 28546 (910)577-2295 **Onslow Memorial Hospital** PO Box 1358 Jacksonville, NC 28541 (910)577-2345
	ORANGE	**Carrboro Community Health Center** 301 Lloyd Street Carrboro, NC 27510 (919)942-8741 **Orange County Health Department** 300 West Tryon Street Hillsborough, NC 27278 (919)245-2411 ext 2412 **Piedmont Women's Health Center (Birthing Center)** 930 Airport Road Chapel Hill, NC 27514 (919)933-3301 **Student Health Action Coalition** UNC School of Medicine CB#7000 065 McNider Chapel Hill, NC 27599 (919)843-6841 **University of North Carolina Hospitals** 101 Manning Drive Chapel Hill, NC 27514 (919)966-4131

P	**PAMLICO**	**HOPE Clinic** 203 N Street Bayboro, NC 28515 (252)745-5760 **Pamlico County Health Department** 203 North Street Bayboro, NC 28515 (252)745-5111
	PASQUOTANK	**Albemarle Hospital** PO Box 1587 Elizabeth City, NC 27906 (252)384-4600 **Community Care Clinic** 501 Catalina Avenue Elizabeth City, NC 27909 (252)384-4735
	PENDER	**Black River Health Services** 126 W Main Street Atkinson, NC 28421 (910)259-6973 **Pender County Health Department** 803 S Walker Street Burgaw, NC 28425 (910)259-1230 **Pender Memorial Hospital, Inc.** 507 E Fremont Street Burgaw, NC 28425 (910)259-5451
	PERSON	**Person Family Medical Center** 702 North Main Street Roxboro, NC 27573 (336)599-9271 **Person Memorial Hospital** 615 Ridge Road Roxboro, NC 27573 (336)599-2121
	PITT	**Greenville Community Shelter Clinic** 1600 Chestnut Street Greenville, NC 27834 (252)758-9244 **Grimesland Community Resource Center** 550 River Street Grimesland, NC 27837 (252)758-2698 **JR Harvey Health Resource Center** 202 Queen Street Grifton, NC 28530 (252)524-3475

		HealthAssist PO Box 6028 Greenville, NC 27835 (252)816-7016 **Pitt County Indigent Care Clinic** 550 River Road Grimesland, NC 27837 (252)758-2678 **Pitt County Memorial Hospital** 2100 Stantonsburg Road Greenville, NC 27835 (252)816-4100
	POLK	**Saluda Medical Center, Inc.** 86 Greenville Street Saluda, NC 28773 (828)749-4411 **St. Luke's Hospital** 101 Hospital Drive Columbus, NC 28722 (828)894-3311
R	**RANDOLPH**	**Mercy Medical Clinic** 1831 N Fayetteville Street Asheboro, NC 27204 (336)672-1300 **Randolph Hospital, Inc.** PO Box 1048 Asheboro, NC 27204 (336)625-5151
	RICHMOND	**FirstHealth Richmond Memorial Hospital** 925 Long Drive Rockingham, NC 28379 (910)417-3000 **Sandhills Regional Medical Center** PO Box 1109 Hamlet, NC 28345 (910)205-8000
	ROBESON	**Greenbrier** 703 S Walnut Street Fairmont, NC 28340 (910)628-9021 **Hope Retirement Village** 104 Hope Lane Red Springs, NC 28377 (910)843-5461 **Julian T. Pierce Health Center** East Wardell Drive Pembroke, NC 28372 (910)521-2816

		Leisure Living Germone Street Lumberton, NC 28358 (910)739-7592 **Lumberton Health Center** 901 North Chestnut Street Lumberton, NC 28358 (910)739-1666 **Maxton Medical Center** 610 E Martin Luther King Jr. Drive Maxton, NC 28364 (910)844-5253 **Sampson's Rest Home** 901 Goins Road Pembroke, NC 28372 (910)521-8544 **Southeastern Regional Medical Center** PO Box 1408 Lumberton, NC 28359 (910)671-5000 **South Robeson Medical Center** 1212 South Walnut Street Fairmont, NC 28340 (910)628-6711
	ROCKINGHAM	**Annie Penn Hospital** 618 South Main Street Reidsville, NC 27320 (336)951-4000 **Free Clinic of Reidsville & Vicinity, Inc.** 315 S Main Street Reidsville, NC 27323 (336)349-3220 **Morehead Memorial Hospital** 117 East Kings Highway Eden, NC 27288 (336)623-9711 **Rockingham County Health Department** 371 NC 65, Suite 204 Wentworth, NC 27375 (336)342-8143
	ROWAN	**Community Care Clinic of Rowan County** 315-G Mocksville Avenue Salisbury, NC 28144 (704)636-4523 **The Good Shepard's Clinic** 223 N Fulton Street Salisbury, NC 28144 (704)636-7200

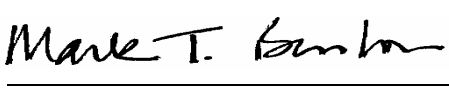
		Rowan County Health Department 1811 East Innes Street Salisbury, NC 28146 (704)638-2900 **Rowan Regional Medical Center** 612 Mocksville Avenue Salisbury, NC 28144 (704)210-5000
	RUTHERFORD	**Rutherford Hospital, Inc.** 288 South Ridgecrest Avenue Rutherfordton, NC 28139 (828)286-5000 **St. Gabriel's Wellness Center** 330 N Ridgecrest Rutherfordton, NC 28139 (828)286-0228
S	**SAMPSON**	**Carolina Pines Community Health Center** 500 S Fayetteville Street Salemburg, NC 28382 (910)525-5515 **Roseboro Medical Clinic, Sampson Regional Medical Center** 304 W Fayetteville Street Roseboro, NC 28382 (910)525-5055 **Rural Health Group, Inc.** PO Box 640 Newton Grove NC 28366 (919)594-1063 **Sampson Regional Medical Center** PO Box 260 Clinton, NC 28329 (910)592-8511 **Tri-County Community Health Center** 3331 Easy Street Dunn, NC 28334 (910)567-6194
	SCOTLAND	**Scotland Memorial Hospital and Edwin Morgan Center** 500 Lauchwood Drive Laurinburg NC 28352 (910)291-7000
	STANLY	**Community Care Clinic** 220 Yadkin Street Albemarle, NC 28001 (704)982-6640 **Stanly County Health Department** 1000 N First Street, Suite 3 Albemarle, NC 28001 (704)986-3000

		Stanly Memorial Hospital PO Box 1489 Albermarle, NC 28002 (704)984-4347
	STOKES	**Stokes County Health Department** Highways 8 & 89 North Danbury, NC 27016 (336)593-2400 **Stokes-Reynolds Memorial Hospital, Inc.** PO Box 10 Danbury, NC 27016 (336)593-2831
	SURRY	**Hugh Chatham Memorial Hospital, Inc.** PO Bo 560 Elkin, NC 28621 (336)527-7000 **Northern Hospital of Surry County** PO Box 1101 Mount Airy, NC 27030 (336)719-7100 **Surry County Health and Nutrition Center** 118 Hambry Raod Dobson, NC 27017 (336)401-8411 **Surry Medical Ministries Clinic** 813 Rockford Street Mount Airy, NC 27030 (336)789-5058
	SWAIN	**Swain County Hospital** 45 Plateau Street Bryson City, NC 28713 (828)488-2155
T	**TRANSYLVANIA**	**Transylvania Community Hospital and Bridgeway** PO Box 1116 Brevard, NC 28712 (828)883-5302 **Transylvania County Volunteers in Medicine** 203 E Morgan Street Brevard, NC 28712 (828)883-4454
	TYRELL	**Columbia Medical Center** 208 North Broad Street Columbia, NC 27925 (252)796-0689
U	**UNION**	**HealthQuest of Union County** 412 East Franklin Street Monroe, NC 28112 (704)226-2050

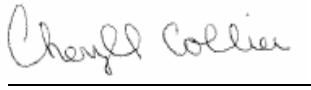
		Union Regional Medical Center PO Box 5003 Monroe, NC 28111 (704)283-3100
V	**VANCE**	**Maria Parham Hospital Medical Center** PO Box 59 Henderson, NC 27536 (252)436-1100
W	**WAKE**	**Apex Family Medicine** 212 South Salem Street Apex, NC 27502 (919)362-5201 **Carolina Women's Medical Clinic** 3301 Executive Drive Raleigh, NC 27611 (919)954-3000 **Horizon Health Center** 102 N Tarboro Road Raleigh, NC 27610 (919)743-3315 **The Open Door Clinic** Urban Ministries of Wake County 840 Semart Drive Raleigh, NC 27604 (919)832-0820 **Rex Hospital** 4420 Lake Boone Trail Raleigh, NC 27607 (919)784-3111 **Rock Quarry Road Family Medicine** 1001 Rock Quarry Road Raleigh, NC 27610 (919)833-3111 **Southern Wake Family Medicine** 130 N Judd Parkway NE Fuquay-Varina, NC 27526 (919)557-1110 **Western Wake Medical Center** 1900 Kildaire Farm Road Cary, NC 27511 (919)350-2550
	WARREN	**HealthCo, Inc.** 1 Opportunity Drive Soul City, NC 27553 (252)456-2181 **Norlina Medical Clinic, Maria Parham Medical Center** 1010 Division Street Norlina, NC 27563 (252)438-4143

WASHINGTON	**Washington County Hospital, Inc.** PO Box 707 Plymouth, NC 27962 (252)793-4135
WATAGUA	**Blowing Rock Hospital** PO Box 148 Blowing Rock, NC 28605 (828)295-3136 **Watagua County (Appalachian) District** 126 Poplar Grove Connector Boone, NC 28607 (828)264-4995 **Watauga Medical Center, Inc.** PO Box 2600 Boone, NC 28607 (828)262-4100
WAYNE	**Mt. Olive Family Medicine Center, Inc.** 238 Smith Chapel Road Mount Olive, NC 28365 (919)658-4954 **Wayne Memorial Hospital, Inc.** PO Box 8001 Goldsboro, NC 27533 (919)736-1110
WILKES	**Boomer Medical Center, Inc.** 156 Boomer Community Center Road Boomer, NC 28606 (336)291-2273 **West Wilkes Medical Center, Inc.** 171 West Wilkes Medical Center Ferguson, NC 28624 (336)973-7050 **Wilkes County Health Department** 306 College Street Wilkesboro, NC 28697 (336)651-7450 **Wilkes Regional Medical Center** PO Box 609 North Wilkesboro, NC 28659 (336)651-8100
WILSON	**Carolina Family Health Centers, Inc.** 303 East Green Street Wilson, NC 27893 (252)293-0013 **WATCH Mobile Unit** c/o Wayne Memorial Hospital PO Box 8001 2700 Goldsboro, NC 27533 (919)731-6653

		Wilson Medical Center 1705 South Tarboro Street Wilson, NC 27893 (252)399-8040
Y	**YADKIN**	**Hoots Memorial Hospital, Inc.** 624 West Main Street Yadkinville, NC 27055 (336)679-2041 **Yadkin County Health Department** 217 E Willow Street Yadkinville, NC 27055 (336)679-4203
	YANCEY	**Celo Health Center** 200 Seven Mile Ridge Road Burnsville, NC 28714 (828)675-4116 **Yancey Community Medical Center** 320 Pensacola Road Burnsville, NC 28714 (828)682-0200 **Yancey County (Toe River District) Health Department** 10 Swiss Avenue Burnsville, NC 28714 (828)765-2239



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



Cheryll Collier
Executive Director
EDS