North Carolina
Medicaid Special Bulletin

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Attention:
All Health Check Providers

Effective July 1, 2007

Health Check
Billing Guide
2007

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Effective with date of service July 1, 2007, please replace the April 2006 Special Bulletin III, *Health Check Billing Guide 2006* with this special bulletin. For your convenience key words and phrases have been bolded or highlighted.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES (EPSDT)

Background

In the state of North Carolina, the EPSDT services program is administered under the name Health Check. Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act], requires state Medicaid programs to provide early and periodic screening, diagnosis, and treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening", whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this section.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and Medicaid must provide for arranging for these services. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient's condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient's conditions. EPSDT also covers personal care services, wheelchairs and other medical services or equipment which are needed to compensate for a health problem or maintain the child's health in the best condition possible. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. See the EPSDT Policy Instruction Update on DMA's website for further information about EPSDT.

EPSDT Features

Under EPSDT, there is:

1. **No Waiting List for EPSDT Services***
   EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and under 42 U.S.C. § 1396d (a) (43) (C) must provide for arranging for corrective treatment for recipients under 21 years of age.

   ***EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. See listing at the end of this section.**

2. **No Monetary Cap on the Total Cost of EPSDT Services**
   There are no monetary limits or caps on Medicaid services for recipients under 21 years of age as long as those services are medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. If a recipient is a participant in a Community Alternatives Program (CAP), it is important to remember that the recipient may receive **BOTH** waiver and EPSDT services. See DMA's EPSDT Policy Instruction Update for further information regarding waiver participation and EPSDT.

3. **No Upper Limit on the Number of Hours or Units under EPSDT**
   For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. **No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist or Other Licensed Clinician**
   To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. **No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered**
   Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes **MAY NOT APPLY** to requests for services for children under 21 years of age.

6. **No Co-payment or Other Cost to the Recipient**

7. **Coverage for Services that Are Never Covered for Recipients Over 21 Years of Age**
   Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act] can be covered under EPSDT. See

attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical and mental illness, or condition [health problem].

8. **Coverage for Services Not Listed in the N.C. State Medicaid Plan**
   Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. For example, rehabilitative services for developmental disabilities, mental health and substance abuse services, medical and adaptive equipment, transportation, in-home nursing, personal care, and specialized therapies, out-of-home residential, facility and hospital services, and other medically necessary care are a covered EPSDT service, even if the particular service requested is not listed in DMA clinical policies or service definitions.

2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

3. The requested service must be determined to be medical in nature.

4. The service must be safe.

5. The service must be effective.

6. The service must be generally recognized as an accepted method of medical practice or treatment.

7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service. For example, only a North Carolina Medicaid enrolled durable medical equipment (DME) provider may provide DME to a Medicaid recipient. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

Important Points about EPSDT Coverage

General

1. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child's condition regardless of eligibility for a CAP waiver.

2. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.

3. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

4. Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.

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

   When requesting prior approval for a covered service, refer to the Basic Medicaid Billing Guide, section 6. Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services for further detail about information to be submitted.

   Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, law that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination. It should be noted that CAP appeals will be considered

under both the CAP criteria and EPSDT. Specifically, the definition of amelioration is in effect and must be applied to pending appeals. **Please refer to the Basic Medicaid Billing Guide for further information regarding appeals.**

The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a re-authorization request.

6. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

7. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

8. Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

If a service is medically necessary and there are no in-state North Carolina Medicaid enrolled providers and if the service is to be provided by an out-of-state provider, the out-of-state provider must be enrolled with North Carolina Medicaid prior to providing the service, excluding emergent services. Requests for out-of-state services, excluding emergent services, delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility.

9. Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).

10. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do **NOT** have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this section.

11. Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance requesting a review

for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.

12. See DMA's EPSDT Policy Instruction Update for further information re waiver participation and EPSDT.

13. Information regarding EPSDT coverage and mental health/developmental delay/substance abuse services appears below.

- Staff employed by local management entities (LMEs) **CANNOT** deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.

- LMEs may NOT use the Screening, Triage, and Referral (STR) process or DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.

- Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.

- If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.

- All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

14. North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower

cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

Procedure for Requesting EPSDT Services

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. If prior approval is required and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] to the appropriate vendor or DMA staff. In the event prior approval is not required for a service and the recipient needs to exceed the clinical coverage policy limitations, it is not necessary to obtain prior approval from a vendor or DMA staff. See the section entitled "Provider Documentation" for information re documentation requirements.

When requesting prior approval for a covered service, refer to the Basic Medicaid Billing Guide, section 6. Requests should be submitted to the appropriate vendor or DMA staff as specified in that section. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted.

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(r) of the Social Security Act for recipients under 21 years of age. See attached listing. **Medical and dental** service requests for non-covered state Medicaid plan services and requests for a review when there is no established review process for a requested service should be submitted to the Division of Medical Assistance, Assistant Director for Clinical Policy and Programs at the address or facsimile (fax) number specified on the form entitled "Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age". Requests for non-covered state Medicaid plan **mental health services** should be submitted to Value Options. The "Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age" is available on the DMA website at http://www.ncdhhs.gov/dma/EPSDTprovider.htm. To decrease delays in reviewing non-covered state Medicaid plan requests, providers are asked to complete this form. A review of a request for a non-covered state Medicaid plan service includes a determination by DMA that **ALL** EPSDT criteria specified in this section are met.

Requests for Medicaid prior approval of DME and orthotics and prosthetics under EPSDT that do not appear on DMA's lists of covered equipment, including pediatric home mobility aids and augmentative communication devices, should be submitted to Children's Special Health Care Services (CSHCS) at the address specified below.

POMCS (Purchase of Medical Care Services)
NC Division of Public Health
1904 Mail Service Center
Raleigh, NC 27699-1904
Telephone #: 919-855-3701
FAX #: 919-715-3848

Please specify that the request is for a Medicaid recipient under 21 years of age so that CSHCS will know that EPSDT applies. Medicaid due process procedures will be applied to the request.

Provider Documentation

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes a discussion about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure. Should additional information be required, the provider will be contacted.

For Further Information about EPSDT

- Important additional information about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the DMA EPSDT provider page. The web addresses are specified below.

  Basic Medicaid Billing Guide http://www.ncdhhs./dma/medbillcaguide.htm

  EPSDT Provider Page
  http://www.ncdhhs.gov/dma/EPSDTprovider.htm

- DMA and its vendors will conduct trainings in 2007 for employees, agents, and providers on this instruction. Details will be published as soon as available.

ATTACHMENTS:

- Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a)
- Non-Covered State Medicaid Plan Services Request Form

LISTING OF EPSDT SERVICES FOUND AT 42 U.S.C. § 1396d (a) [1905(a) OF THE SOCIAL SECURITY ACT]

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

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1- 440.170 at the website stated below.

http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html

North Carolina
Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Secretary Carmen Hooker Odom, Secretary

Allen Dobson, Jr., M.D., Assistant
for Health Policy and Medical Assistance

NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM
FOR RECIPIENTS *UNDER* 21 YEARS OF AGE

RECIPIENT INFORMATION: ***Must be completed by physician, licensed clinician, or provider.***

NAME:_____
DATE OF BIRTH:____/____/_____*(mm/dd/yyyy)* **MEDICAID NUMBER:**_____
ADDRESS: _____
_____

MEDICAL NECESSITY: ***ALL REQUESTED INFORMATION, including CPT and HCPCS codes, if applicable, as well as provider information must be completed. Please submit medical records that support medical necessity.***

REQUESTOR NAME:_____ **PROVIDER NAME:**_____
MEDICAID PROVIDER #:_____ **MEDICAID PROVIDER #:**_____
ADDRESS:_____ **ADDRESS:**_____
_____ _____
TELEPHONE #: (___)_____ **TELEPHONE #: (___)**_____
FAX #:_____ **FAX #:**_____

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT ***(incl. length of time you have cared for recipient and nature of the care):***_____
_____

PAST HEALTH HISTORY ***(incl. chronic illness)*****:**_____
_____
_____

RECIPIENT DIAGNOSIS(ES) RELATED TO THIS REQUEST ***(incl. onset, course of the disease, and recipient's current status)*****:**_____
_____

TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE ***(incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)*****:**_____
_____
_____

1 of 3 **-OVER-**

NAME:	MID #:	DOB:

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE. (if *applicable, please include* *CPT AND HCPCS codes*). PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE RECIPIENT'S DEFECT, PHYSICAL OR MENTAL ILLNESS OR CONDITION [THE PROBLEM]. THIS DESCRIPTION *MUST* INCLUDE A DETAILED DISCUSSION ABOUT HOW THE SERVICE, PRODUCT, OR PROCEDURE WILL IMPROVE OR MAINTAIN THE RECIPIENT'S HEALTH IN THE BEST CONDITION POSSIBLE, COMPENSATE FOR A HEALTH PROBLEM, PREVENT IT FROM WORSENING, OR PREVENT THE DEVELOPMENT OF ADDITIONAL HEALTH PROBLEMS._____

_____

_____

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_____

_____

_____

_____

IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:
___YES ___NO IF YES, PROVIDE NAME AND PROTOCOL #_____

_____

IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE: ___YES ___NO IF NO, PLEASE EXPLAIN._____

_____

_____

_____

IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE:__YES ___NO IF NO, PLEASE EXPLAIN._____

_____

_____

ARE THERE ALTERNATIVE PRODUCTS, SERVICES, OR PROCEDURES THAT WOULD BE MORE COST EFFECTIVE BUT SIMILARLY EFFICIACIOUS TO THE SERVICE REQUESTED: ___YES ___NO IF YES, SPECIFY WHAT ALTERNATIVES ARE APPROPRIATE FOR THE RECIPIENT AND PROVIDE EVIDENCE BASE WITH THIS REQUEST, IF AVAILABLE._____

_____

_____

_____

_____

WHAT IS THE EXPECTED DURATION OF TREATMENT:_____

_____

NAME:	MID #:	DOB:

OTHER ADDITIONAL INFORMATION:_____

_____

_____

_____

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_____

_____ _____

REQUESTOR'S SIGNATURE AND CREDENTIALS **DATE**

INCLUDE EVIDENCE-BASED LITERATURE TO SUPPORT THIS REQUEST IF AVAILABLE.

MAIL OR FAX COMPLETED FORM TO:

Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

Health Check Overview

Health Check/EPSDT is important because it:

1. Provides for early and regular medical and dental screenings for all Medicaid recipients under the age of 21.
2. Is part of the Federal Medicaid EPSDT requirement that provides recipients with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.
3. Under EPSDT, North Carolina Medicaid has an explicit obligation to make available a variety of individual and group providers qualified and willing to provide EPSDT services.
4. DMA will enroll providers, set reimbursement rates, set provider qualification and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

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

Health Check Periodicity Schedule

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

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

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

Periodic and Interperiodic Health Check Screening Examinations

Periodic Health Check screening examinations require all age appropriate components including developmental screening, vision screening, hearing screening, dental screening, immunizations as needed and other necessary health care. Refer to the Periodicity Schedule located above for recommended age intervals for Periodic examinations.

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

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

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

Health Check Screening Examination Components

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

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

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

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

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

- **Measurements, blood pressure, and vital signs**
  To be performed as age appropriate and medically necessary at every Health Check screening examination. Height, weight, head circumference, growth chart, **BMI** (Body Mass Index), and vital signs as age appropriate. Blood pressure is recommended to become part of the preventive screening examination beginning at age 3 years old.

- **Developmental screening including mental, emotional, and behavioral**
  To be performed at Periodic screening examinations at ages 6 , 12, and 18 or 24 months, and 3 years, four years, and five years of age using a standardized and validated screening tool. A complete list of appropriate screening tools can be found at **www.dbpeds.org/ and www.brightfutures.org.** The American Academy of Pediatric's policy on Developmental Surveillance and Screening can be found at **http://aapolicy.aappublications.org/cgi/content/full/pediatrics;108/1/192.**

- **Immunizations**
  Immunizations must be provided at the time of a Periodic or Interperiodic screening examination if needed. **It is not appropriate for a Health Check screening examination to be performed in one location and a child referred to another location or office for immunizations**.

Health Check Screening Examination Components, continued

The *Recommended Immunization Schedule for Persons ages 0 – 18---United States, 2007,* approved by the Advisory Committee on Immunization Practices (ACIP), AAP, and the American Academy of Family Physicians (AAFP) may be found at **http://cdc.gov/mmwr/preview/mmwrhtml/mm5551a7.htm.**

Note: Please refer to pages 21 - 30 in this guide for additional immunization information.

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

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

Note: If the required vision and/or hearing screenings cannot be performed during a periodic visit due to blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

- **Dental screenings**
  An oral screening is to be performed at every Health Check screening examination**. In addition, referral to a dentist is required for every child by the age of 3 years old.** An oral screening performed during a physical examination is not a substitute for examination through direct referral to a dentist. The initial dental referral **must** be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. When any screening indicates a need for dental services at an earlier age (such as baby bottle caries), referrals must be made for needed dental services and documented in the child's medical record. The periodicity schedule for dental examinations is not governed by the schedule for regular health examinations.

Note: Although not a requirement of a Health Check screening examination, providers who perform a Health Check screening examination and dental varnishing may bill for both services. Refer to the January 2007 general Medicaid Bulletin on DMA's website at **http://www.ncdhhs.gov/dma/bulletin/0107revisedbulletin.pdf** for billing codes and guidelines.

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

Note: Medicaid will not reimburse separately for these routine laboratory tests when performed during a Health Check screening examination.

Health Check Screening Examination Components, continued

Hemoglobin or Hematocrit

Hemoglobin or hematocrit **must** be measured once during infancy **(preferably** between the ages of 9 and 12 months) for all children and once during adolescence for menstruating adolescent females. An annual hemoglobin or hematocrit for adolescent females (ages 11 to 21 years) **must** be performed if any of the following risk factors are present: moderate to heavy menses, chronic weight loss, nutritional deficit or athletic activity.

If there is a documented normal result of a hemoglobin or hematocrit preformed by another provider within three months prior to the date of the Health Check examination, repeating the hemoglobin or hematocrit is not required as part of the Health Check examination unless the provider feels that this test is needed. The result and source of the test must be documented in the child's medical record.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has specific guidelines for hemoglobin/hematocrit testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged provided the appropriate release of information requirements are met. For more information on requirements and time frames, call the local WIC office.

Urinalysis

Urinalysis **must** be performed during the 5 year old Periodic screening examination as well as during Periodic screening examinations for all sexually active males and females.

Sickle Cell

North Carolina hospitals are required to screen all newborns for sickle cell disease prior to discharge from the hospital. If a child has been properly tested, this test need not be repeated. **Results must be documented in the child's medical record.** If the test result of the newborn sickle cell is **not** readily available, contact the hospital of birth. An infant without documentation of being tested at birth should receive a sickle cell test prior to 3 months of age. If the child is 3 months of age or older, and there is no sickle cell test result in the record, the test should be repeated if the provider feels it is indicated.

Tuberculin Testing (TB)

Reviewing perinatal histories, family and personal medical histories, significant events in life, and other components of the social history will identify children/adolescents for whom TB testing is indicated. **If none of the screening criteria listed below are present, there is no recommendation for routine TB screening.**

TB testing should be performed as clinically indicated for children/adolescents at increased risk of exposure to tuberculosis **via Purified Protein Derivative (PPD) intradermal injection/Mantoux method** – not Tine Test.

Criteria for screening children/adolescents for TB (per the NC TB Control Branch) are:

1. Children/adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.
2. Perform a **baseline screen** when these children/adolescents present for care.
   a. Foreign-born individuals arriving within the *last five years* from Asia, Africa, Caribbean,

Health Check Screening Examination Components, continued

Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand and countries in Western Europe.

b. Children/adolescents who are migrants, seasonal farm workers or are homeless.
c. Children/adolescents who are HIV-infected.
d. Children/adolescents who inject illicit drugs or use crack cocaine.

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

The North Carolina TB Control Branch is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. The North Carolina TB Control Branch contact number is 919-733-7286. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

- **Lead testing**
  Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should also perform lead testing when otherwise clinically indicated.

  Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial testing. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

Blood Lead Concentration	Recommended Response
<10 ug/dL	**Rescreen at 24 months of age**
10 through 19 ug/dL	**Confirmation (venous) testing should be conducted within three months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on two consecutive tests (venous or finger stick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered.
20 through 44 ug/dL	**Confirmation (venous) testing should be conducted within 1 week.** If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on two consecutive tests (venous or finger stick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years of age with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	**The child should receive a venous lead test for confirmation as soon as possible**. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Testing

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results from specimens of children outside this age group should contact the State Laboratory of Public Health at 919-733-3937.

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

IMMUNIZATIONS

Immunization Administration CPT Codes with the EP Modifier

Note: Effective with date of service August 1, 2006, the N.C. Medicaid program covers CPT codes 90467, 90468, 90473, and 90474 for the intranasal and oral administration of vaccines/toxoids. Refer to the March 2007 general Medicaid Bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin/0307bulletin.pdf for more information

Medicaid reimburses providers for injectable and oral/intranasal administration of immunizations to Medicaid-enrolled children birth through 20 years of age. Always use the EP modifier when billing for **immunization administration CPT codes.**

EPSDT PROVISION: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes EPSDT coverage of additional codes/procedures as it relates to immunization administration. Documentation must show how the service product or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Private Sector Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check examination or an office visit.

- Administration of one injectable immunization is billed with the administration CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier and is reimbursed at $17.25.
- Additional injectable immunizations are billed with the administration CPT code 90472 or 90466 with the **EP** modifier and are reimbursed at $9.71.
- Administration of one intranasal/oral immunization is billed with the administration CPT code 90467 with EP modifier and is reimbursed at $11.27 or 90473 with the EP modifier and is reimbursed at $11.60. **Note: CPT codes 90467 or 90473 can only be billed if the intranasal/oral vaccine is the**

only immunization provided on that date of service. Either code cannot be billed with another immunization administration code on that date of service. A second intranasal/oral immunization cannot be billed at this time.

- An intranasal or oral immunization provided in addition to one or more injectable immunizations is billed with the administration CPT code 90468 or 90474 with the EP modifier. CPT code 90468 is reimbursed at $8.56. CPT code 90474 is reimbursed at $7.89.

Federally Qualified Health Center or Rural Health Clinic Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check visit. **Health Check visits and the immunization administration fees are billed using the provider's Medicaid number with the "C" suffix. When billing for immunizations with a Core visit, use the provider's Medicaid number with the "A" suffix.**

- Administration of one immunization is billed with the CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier and is reimbursed at $17.25.
- Additional injectable immunizations are billed with the administration CPT code 90472 or 90466 with the **EP** modifier and are reimbursed at $9.71.
- Administration of one intranasal/oral immunization is billed with the administration CPT code 90467 with the EP modifier and is reimbursed at $11.27 or 90473 with the EP modifier and is reimbursed at $11.60. **Note: CPT codes 90467 or 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. Either code cannot be billed with another immunization administration code on that date of service. A second intranasal/oral immunization cannot be billed at this time.**
- An intranasal or oral immunization provided in addition to one or more injectable immunizations is billed with the administration CPT code 90468 or 90474 with the EP modifier. CPT code 90468 is reimbursed at $8.56. CPT code 90474 is reimbursed at $7.89.

An immunization administration fee cannot be billed in conjunction with a core visit. Report the immunization given during the core visit without billing the administration fee.

Local Health Department Providers

An immunization administration fee may **not** be billed if the immunization(s) is provided in addition to a Health Check screening visit. The immunization administration CPT codes 90465, 90467, 90468, 90471, 90473 or 90474 with the EP modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit**.

- Administration of one or more injectable immunizations is billed with the CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier and is reimbursed at $27.42. These immunization administration codes are reimbursed at $27.42 regardless of the number of immunizations given.
- Administration of one intranasal/oral immunization is billed with CPT code 90467 with the EP modifier and reimbursed at $11.98 or 90473 with the EP modifier and is reimbursed at $12.64. **Note: CPT codes 90467 or 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. Either code cannot be billed with another immunization administration code on that date of service. A second intranasal/oral immunization cannot be billed at this time.**
- One intranasal or oral immunization provided in addition to one or more injectable immunizations is billed with the administration CPT code 90468 or 90474 with the EP modifier. CPT code 90468 is reimbursed at $9.27. CPT code 90474 is reimbursed at $8.94.

Immunization procedure codes must be reported even if the immunization administration fee is not being billed.

NOTE: Please refer to the North Carolina Medicaid Bulletins at www.ncdhhs.gov/dma/cptclickbulletin.htm and the appropriate fee schedule at www.ncdhhs.gov/dma/fee/fee.htm **for updates and rate changes for immunizations and administration codes.**

Immunization Billing Guidelines for Recipients Birth through Age 20

Vaccine: Injectable	**Provider Type: Private Sector Providers**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90465EP. For two or more vaccines, bill 90465EP and 90466EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	For one vaccine bill 90471EP. For two or more vaccines bill 90471EP and 90472EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP. For two or more vaccines, bill 90465EP and 90466EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP. For two or more vaccines, bill 90471EP and 90472EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP. For two or more vaccines, bill 90465EP and 90466EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	For one vaccine, bill 90471EP. For two or more vaccines, bill 90471EP and 90472EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.

Vaccine: Intranasal/Oral	**Provider Type: Private Sector Providers**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.

Vaccine: Injectable with Intranasal/Oral Provider Type: Private Sector Providers		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP, and 90468EP. Report CPT vaccine code(s) Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP, and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP, and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP, and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP, and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP, and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.

Vaccine: Injectable	**Provider Type: FQHC/RHC**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90471EP and 90472EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90465EP and 90466EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90465EP or 90466EP. Report CPT vaccine code(s). Immunization diagnosis code(s) are **not** required.	Cannot bill 90471EP or 90472EP. Report CPT vaccine code(s). Immunization diagnosis code(s) are **not** required.

Vaccine: Intranasal/Oral	**Provider Type: FQHC/RHC**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A at this time.. Immunization diagnosis code is **not** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90467EP. Report vaccine CPT code. Immunization diagnosis code is **not** required.	Cannot bill 90473EP. Report vaccine CPT code. Immunization diagnosis code is **not** required.

Vaccine: Injectable with Intranasal/Oral	**Provider Type: FQHC/RHC**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP, and 90468EP. Report vaccine CPT codes. Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP, and 90474EP. Report vaccine CPT codes. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP, 90466EP, and 90468EP. Report vaccine CPT codes. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP, 90472EP, and 90474EP. Report vaccine CPT codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90465EP, 90466EP, or 90468EP. Report vaccine CPT codes. Immunization diagnosis code(s) are **not** required.	Cannot bill 90471EP, 90472EP, or 90474EP. Report vaccine CPT codes. Immunization diagnosis code(s) are **not** required.

Vaccine: Injectable	**Provider Type: Local Health Departments**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	Cannot bill 90465EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	Cannot bill 90471EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP. For two vaccines or more, bill 90465EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP. For two vaccines or more, bill 90471EP. Report CPT vaccine code(s). One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP. For two or more vaccines, bill 90465EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.	For one vaccine, bill 90471EP. For two or more vaccines, bill 90471EP. Report CPT vaccine code(s). Immunization diagnosis code(s) **not** required.

Vaccine: Intranasal/Oral	**Provider Type: Local Health Departments**	
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	Cannot bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code is **not** required.	Cannot bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90467EP. Report vaccine CPT code. Two vaccines or more – N/A. at this time. Immunization diagnosis code **not** required.	For one vaccine, bill 90473EP. Report vaccine CPT code. Two vaccines or more – N/A. at this time. Immunization diagnosis code **not** required.

Vaccine: Injectable with Intranasal/Oral Provider Type: Local Health Departments		
Service Type	**With Physician Counseling**	**Without Physician Counseling**
Health Check Screening with Immunization(s)	Cannot bill 90465EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.	Cannot bill 90471EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.
Immunization(s) Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP and 90468EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP and 90474EP. Report CPT vaccine codes. Immunization diagnosis code(s) **not** required.

Universal Childhood Vaccine Distribution Program/Vaccines for Children Program

The Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program provides, at no charge, all required (and some recommended) vaccines to North Carolina children birth through 18 years of age according to the recommendations of the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Due to the availability of these vaccines, Medicaid does not reimburse for UCVDP/ VFC vaccines for children ages birth through 18. The only exception is noted with an asterisk (*) in the table below.

If a vaccine is provided at no charge for a recipient over 18 years of age, as noted in the table below, the administration fee CPT code may be billed. The CPT code for the vaccine provided at no charge must be reported. **The asterisk beside the CPT procedure code for the vaccines in the table below indicates that providers should refer to the Immunization Branch website at www.immunizenc.com for detailed information regarding vaccines that are provided for those recipients over 18 years of age through the UCVDP/VFC program or call the Immunization Branch at 1-877-873-6247.**

For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the UCVDP program vaccines, Medicaid will reimburse providers for Medicaid-covered vaccines.

The following is a list of UCVDP/VFC vaccines:

Codes	Vaccines	Diagnosis Codes
90633	Hepatitis A Vaccine (12 months through 18 years of age)	V05.3
90636*	Hepatitis A and B (Twinrix) (18 years of age only in local health departments or UCVDP/VFC prior-approved non-traditional sites)	V06.8
90647	Hib 3-dose PRP-OMP (PedvaxHib)	V03.81
90648	Hib 4-dose PRP-T (ActHib)	V03.81
90649	Human papilloma virus, HPV, (Females 9 through 18 years of age) If the first dose of HPV is administered prior to age 19, UCVDP/VFC vaccine can be used to complete the series prior to age 20.	V04.89
90655	Influenza , preservative free (6 through 35 months of age)	V04.81
90656	Influenza, preservative free (3 years and older) **Refer to ACIP Guidelines for children over 5 years of age.**	V04.81
90657	Influenza (6 to 35 months of age)	V04.81
90658	Influenza (3 years of age and above) **Refer to ACIP Guidelines for children over 5 years of age.**	V04.81
90660	Influenza, live intranasal (FluMist) (5 through 18 years of age) Refer to ACIP guidelines.	V04.81
90669	Pneumococcal - PCV7 (2 through 59 months of age)	V03.82

90680	Rotavirus (6 to 32 weeks of age)	V04.89
90700	DTaP	V06.1
90702	DT	V06.5
90707*	MMR	V06.4
90710	MMRV (12 months through 6 years of age)	V06.8
90713	IPV	V04.0
90714	Td (7 through 18 years of age)	V06.5
90715*	Tdap (11 through 18 years of age)	V06.1
90716	Varicella	V05.4
90723	Combination DTaP, IPV, and Hepatitis B (> 2 months through 6 years of age)	V06.8
90732	Pneumococcal - PPV23 **High Risk for children age 2 through 18.**	V03.82
90734	Meningococcal (11 through 18 years of age) Must be in ACIP recommended coverage groups.	V01.84
90744*	Hepatitis B Vaccine – Pediatric/Adolescent **If the first dose of Hepatitis B vaccine is administered prior to age 19, UCVDP vaccine can be used to complete the series prior to age 20.**	V05.3

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

North Carolina Medicaid providers who are not enrolled in the UCVDP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-877-873-6247.

Out-of-state providers (within the 40-mile radius of North Carolina) may obtain VFC vaccines by calling their state VFC program. VFC program telephone numbers for border states are listed below:

- **Georgia** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-532-8513
- **Virginia** 1-804-864-8060

HEALTH CHECK BILLING REQUIREMENTS

Instructions for billing a Health Check screening examination on the CMS-1500 claim form are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are as follows:

Requirement 1: Identify and Record Diagnosis Code(s)

Place diagnosis code(s) in the correct order in block 21. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Periodic Health Check Screening Examination – Use V20.2 as the Primary Diagnosis

The primary diagnosis V20.2 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V20.2) and **always** before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Interperiodic Health Check Screening Examination – Use V70.3 as the Primary Diagnosis

The primary diagnosis V70.3 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis V70.3 and **always** before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Requirement 2: Identify and Record Preventive Medicine Code and Component Codes

The preventive medicine CPT code with the EP modifier for Health Check screening examinations should be billed as outlined below. In addition to billing the preventive medicine code, developmental screening, vision and hearing CPT codes must be listed based on the ages outlined in the tables on page 35.

- A developmental screening CPT code with the EP modifier **must** be listed in addition to the preventive medicine CPT codes for a periodic Health Check examination when age appropriate. No additional reimbursement is allowed for this code. All providers may refer to the sample claims in this guide.

- Vision CPT codes with the EP modifier **must** be listed on the claim form in addition to the preventive medicine CPT codes for a periodic Health Check screening examination. No additional reimbursement is allowed for these codes. All providers may refer to the sample claims in this guide.

- Hearing CPT codes with the EP modifier **must** be listed on the claim form in addition to the preventive medicine CPT codes for a periodic Health Check screening examination. No additional reimbursement is allowed for these codes. All providers may refer to the sample claims in this guide.

Requirement 3: Health Check Modifier – EP

The Health Check CPT codes for periodic and interperiodic screening examinations must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. The vision, hearing, and developmental screening CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. **EP is a required modifier for all Health Check claims.**

HEALTH CHECK BILLING REQUIREMENTS, continued

Requirement 4: Record Referrals

N.C. Medicaid is HIPAA-compliant and is able to receive standard electronic HIPAA transactions.

Providers billing electronically using the services of a vendor or clearinghouse may reference the National HIPAA Implementation Guide and the North Carolina 837 Professional Claim Transaction Companion Guide for values regarding follow up-visits. The National HIPAA Implementation Guide for the 837 Claim Transaction can be accessed at http://www.wpc-edi.com.

The North Carolina Medicaid 837 Companion Guide can be accessed on the DMA website at http: http://www.ncdhhs.gov/dma/hipaa/837prof.pdf.

All electronically submitted claims should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening examination. List referral code indicator "F" when a referral is made for Family Planning services.

For providers billing on paper, a referral code indicator is used when a follow-up visit is necessary for a diagnosis detected during a Health Check examination. The indicator "R" should be listed in block 24H of the CMS-1500 claim form when this situation occurs. All providers may refer to the sample claims in this guide.

Requirement 5: Next Screening Date

Providers billing on paper may enter the next screening date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form.

Systematically Entered Next Screening Date; Paper Providers

Providers have the following choices for block 15 of the CMS-1500 claim form with a Health Check examination. All of these choices will result in an automatically entered NSD.

- **Leave block 15 blank.**
- **Place all zeros in block 15 (00/00/0000).**
- **Place all ones in block 15 (11/11/1111).**

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

Provider-Entered Next Screening Date; Paper Providers

Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is OUT of range with the periodicity schedule, the system will override the provider's NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

Note: Providers billing electronically are not required to enter a screening date (NSD) for health check screening claims.

HEALTH CHECK BILLING REQUIREMENTS, continued

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

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

- When billing one injectable immunization, private providers must use the administration CPT code 90471 or 90465 (one unit) with the EP modifier listed in block 24D.
- When additional injectable immunizations are provided, private providers must use the administration CPT code 90472 or 90466 with the EP modifier listed in block 24D.
- When billing one intranasal/oral immunization use CPT code 90467 or 90473 with the EP modifier in block 24D.
- When billing for one injectable vaccine and one intranasal/oral vaccine bill 90465 and 90468 or 90471 and 90474 with the EP modifier.
- When billing two or more injectable vaccines and one intranasal/oral vaccine bill 90465, 90466 and 90468 with EP modifier or 90471, 90472 and 90474 with EP modifier.

Note: If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 is $0.00.

HEALTH CHECK RELATED ICD-9 AND CPT CODES

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

	Preventive CPT Codes and Modifier	**Diagnoses Codes**
Periodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D Developmental Screening CPT Code 96110; at 6, 12, 18 or 24 months of age, at age 3, 4, and 5 years of age EP Modifier is required in block 24D Vision CPT code 99172 or 99173; beginning at age 3 EP Modifier is required in block 24D Hearing CPT code 92551, 92552, or 92587; beginning at age 4 EP Modifier is required in block 24D	V20.2 Primary Diagnosis
Interperiodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D	V70.3 Primary Diagnosis

PREVENTIVE MEDICINE CPT CODES

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

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

TIPS FOR BILLING

All Health Check Providers

- Two Health Check screening examinations on different dates of service cannot be billed on the same claim form.

- A formal, standardized developmental screening tool **must** be used during periodic screening examinations for children ages 6, 12, 18 or 24 months, and 3, 4, and 5 years of age or older.

- If the required vision and/or hearing screenings cannot be performed during a periodic screening examination due to a condition such as blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

- Report payments received from third party insurance in block 29 of the CMS-1500 claim form when preventive services (well child examinations) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit the claim to Medicaid.

Private Sector Health Check Providers Only

- A Health Check screening examination and an office visit with different dates of service cannot be billed on the same claim form.

- A Health Check screening examination and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.

- Immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier can be billed with a Health Check screening examination, office visit or if it is the only service provided that day. When billing in conjunction with a examination CPT code or an office visit code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier as the only service for that day, providers are required to use an immunization diagnosis in block 21 of the claim form. Always list immunization CPT procedure codes when billing these administration codes with the EP modifier. Refer to the sample claims in this guide.

- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for the Health Check examination and the amount billed for immunizations and any other service billed on the same date of service. Thus, it is necessary to check claim status for two separate claims.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers Only

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

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

- A Health Check screening examination and a core visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.

- Immunization administration CPT code 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier can be billed if it is provided in addition to a Health Check screening examination CPT code or if it is the only service provided that day. When billing in conjunction with an examination code, an immunization diagnosis is not required in block 21 of the claim form. When billing the above administration code for immunizations as the only service for that day, an immunization diagnosis code is required to be entered in block 21 of the claim form. The administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list immunization procedure codes in the appropriate block on the claim form. Always list immunization procedure codes when billing any immunization administration code with the EP modifier. Refer to the sample claims in this guide.

Local Health Departments

- Two Health Check screening examinations on different dates of service cannot be billed on the same claim form.

- A formal, standardized developmental screening tool **must** be used during periodic examinations for children ages 6 months, 12 months, 18 or 24 months, and 3, 4, and 5 years of age or older.

- If the required vision and/or hearing screenings cannot be performed during a periodic visit due to a condition such as blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

- When billing immunization administration CPT codes 90465, 90467, 90468, 90471, 90473 or 90474, the EP modifier must be entered. If the EP modifier is not entered, the reimbursement will be $0.00 per unit. There is no additional reimbursement for CPT immunization administration codes 90466 or 90472.

HEALTH CHECK COORDINATORS

Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services.

HCCs are currently located in 94 North Carolina counties and the Qualla Boundary. HCCs are stationed in local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA website at http://www.ncdhhs.gov/dma/ca/hcc.pdf.

The role and responsibilities of the HCC include but are not limited to the following:

- Using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- Educating families about the importance of establishing a medical home for their children
- Assisting families to use the health care services in a consistent and responsible manner
- Assisting with scheduling appointments or securing transportation
- Acting as a local information, referral, and resource person for families
- Providing advocacy services in addressing social, educational or health needs of the recipient
- Initiating follow-up as requested by providers when families need special assistance or fail to bring children in for Health Check or follow-up examinations
- Promoting Health Check and health prevention with other public and private organizations

Physicians, primary care providers (PCPs), and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and helps make preventive health care services more timely and effective.

HEALTH CHECK CLAIM DENIALS – EXPLANATION OF BENEFITS (EOB)

EOB	Message	Tip
010	Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.	Verify the recipient's Medicaid identification (MID) number, date of birth (DOB), diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2501 Mail Service Center, Raleigh, NC 27699-2501.
060	Not in accordance with medical policy guidelines.	Verify that only one vision and/or hearing screening is billed per date of service. Make corrections and resubmit as a new day claim.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.	Verify diagnosis code is V20.2 or V70.3 for the Health Check examination according to the billing guidelines on page 32. Correct claim and resubmit.
349	Health Check Screen and related service not allowed same day, same provider, or member of same group.	Resubmit as an adjustment with documentation supporting unrelated services.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient's age. Only recipients age birth through 20 years of age are eligible for Health Check services.
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Immunizations(s) are available at no charge through the UCVDP/VFC Program.
1058	The only well child exam billable through the Medicaid program is a Health Check examination. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic examination with primary diagnosis V20.2 and interperiodic examinations with primary diagnosis V70.3. Check the preventive medicine code entered in block 24D of the claim form and append the EP modifier.
1422	Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check Special Bulletin.	Check the claim to ensure that the immunization procedure code(s) are billed on the same claim as the immunization administration code(s). Make corrections and resubmit as a new day claim.
1769	No additional payment made for vision, hearing and/or developmental screening services.	Payment is included in Health Check reimbursement.
1770	Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	Health Check services must be billed with the primary diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V25.9.
1771	All components were not rendered for this Health Check examination.	For periodic examinations, verify all required components, such as vision and/or hearing assessments were performed and reported on the claim form using the EP modifier. Make corrections and resubmit as a new day claim.

HEALTH CHECK BILLING REFERENCE SHEET

Date of Service _____

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

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

Health Check Examination Code			
Description	**Preventive Medicine Codes**	**Diagnosis Code**	✓
Regular Periodic Examination- Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V20.2	
Developmental Screening based on age	Development Screening CPT Code 96110 With EP Modifier		
Vision Screening based on age	Vision Screening CPT Code 99172 or 99173 With EP Modifier		
Hearing Screening based on age	Hearing Screening CPT Code 92551, 92552 or 92587 With EP Modifier		
Interperiodic Examination - Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V70.3	

Second Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	R; providers billing on paper E or F; providers billing electronically	
Third Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	R; providers billing on paper E or F; providers billing electronically	
Fourth Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	R; providers billing on paper E or F; providers billing electronically	

Description	**CPT Codes**	**Unit**	
Immunization Administration Fee	90471 **or** 90465 EP Modifier 90468 **or** 90474 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 **or** 90466 EP Modifier 90468 **or** 90474 EP Modifier	Additional immunizations	

IMMUNIZATION BILLING REFERENCE SHEET

Code	Description	Diagnosis	VFC
90281	Immune Globulin	V07.2	
90371	Hepatitis B Immune Globulin	V07.2	
90375	Rabies Immune Globulin	V07.2	
90376	Rabies Immune Globulin – Heat treated (RIG-HT)	V07.2	
90384	Rho (D) Immune Globulin Full Dose	V07.2	
90385	Rho (D) Immune Globulin Mini Dose	V07.2	
90389	Tetanus Immune Globulin	V07.2	
90396	Varicella-Zoster Immune Globulin	V07.2	
90585	BCG	V03.2	
90632	Hepatitis A Vaccine – Age 18 & up	V05.8	
90633	Hepatitis A Vaccine – 2 dose Age 2 & up	V05.3	VFC 12 mo – 18 yrs
90636*	Hepatitis A and B (Twinrix) (18 years only in local health departments or UCVDP/VFC prior-approved non-traditional sites)	V06.8	
90647	Hib 3-dose PRP-OMP (PedvaxHib)	V03.81	VFC 2 mo – 18 yrs
90648	Hib – 4 dose (ActHib)	V03.81	VFC 2 mo – 5 yrs
90649	Human papilloma virus, HPV, (Females 9 through 18 years of age) If the first dose of HPV is administered prior to age 19, UCVDP/VFC vaccine can be used to complete the series prior to age 20.	V04.89	
90655	Influenza, split virus, preservative free (6-35 months of age)	V04.81	VFC 6 mo – 35 mo
90656	Influenza, preservative free – Age 3 & older **Refer to ACIP Guidelines for children over 5 years of age.**	V04.81	VFC 3 yrs – 18 yrs
90657	Influenza, split virus (6 to 35 months of age)	V04.81	VFC 6 mo – 35 mo
90658	Influenza, split virus (Age 3 and up) **Refer to ACIP Guidelines for children over 5 years of age.**	V04.81	VFC 3 yrs – 18 yrs
90660	Influenza, live intranasal (FluMist) (5 through 18 years **Refer to ACIP Guidelines.**	V04.81	
90669	Pneumococcal PCV7 (2-59 months)	V03.82	VFC 2 mo – 5 yrs
90675	Rabies Vaccine – IM	V04.5	
90680	Rotavirus (6 to 32 weeks of age)	V04.89	VFC 6 wk to 32 wk
90700	DTaP	V06.1	VFC 2 mo – 7 yrs
90702	DT – Age under 7	V06.5	VFC 2 mo – 6 yrs
90703	Tetanus Toxoid	V03.7	
90704	Mumps	V04.6	
90705	Measles	V04.2	
90706	Rubella	V04.3	
90707*	MMR	V06.4	VFC 12 mo – 18 yrs
90710	MMRV (12 months through 6 years of age)	V06.8	VFC 12 mo-6 yrs
90713	IPV (Injectable Polio Vaccine)	V04.0	VFC 2 mo – 18 yrs
90714	Td	V06.5	
90715*	Tdap	V06.1	VFC 11 yrs -18 yrs
90716	Varicella	V05.4	VFC 12 mo – 18 yrs
90721	DTaP/Hib	V06.8	
90723	Combination DTaP, IPV, and Hepatitis B (>2 months through 6 years of age)	V06.8	
90732	Pneumococcal PPV23	V03.82 or V05.8	VFC 2 yrs – 18 yrs
90734	Meningococcal (11 through 18 years of age) **Must be eligible for VFC and be in ACIP recommended coverage**	V01.84	

	group.		
90744*	Hepatitis B Vaccine – Pediatric/adolescent If the first dose of Hepatitis B vaccine is administered prior to age 19, UCVDP vaccine can be used to complete the series prior to age 20.	V05.3	VFC 0 – 18 yrs
90746	Hepatitis B Vaccine – Age 19 and above	V05.8	
90747	Hepatitis B Vaccine - Dialysis Pt./immunosuppressed -4 dose	585	

The asterisk beside the CPT procedure code for the vaccines in the table above indicates that providers should refer to the Immunization Branch website at www.immunizenc.com for detailed information regarding vaccines that are provided for those recipients over 18 years of age through the UCVDP/VFC program or call the Immunization Branch at 1-877-873-6247.

Note: This list is subject to change. Updates regarding vaccines are published in the general Medicaid bulletins on DMA's web site at http://www.ncdhhs.gov/dma/.

Resource List

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

Policy Instructions: Early and Periodic Screening, Diagnostic and Treatment
http://www.ncdhhs.gov/dma/bulletin/EPSDT.pdf

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

Prior Approval Process and Request for Non-Covered Services
http://www.ncdhhs.gov/dma/bulletin/Section6.pdf
http://www.ncdhhs.gov/dma/Forms/NonCoveredServicesRequest.pdf.

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

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

Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2007.
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5551a7.htm.

Dental Varnishing
General Medicaid Bulletin, January 2007
http://www.ncdhhs.gov/dma/bulletin/0107revisedbulletin.pdf

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

Universal Childhood Vaccine Distribution Program (UCVDP)
www.immunizenc.com

North Carolina Immunization Branch
www.immunizenc.com

Physician's Fee Schedule
www.ncdhhs.gov/dma/fee/fee.htm

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

Resource List, continued

North Carolina 837 Professional Claim Transaction Guide
http://www.ncdhhs.gov/dma/hipaa/837prof.pdf

Health Check Coordinator Contact List
http://www.ncdhhs.gov /dma/ca/hcc.pdf

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

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

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

EDS Provider Services
1-800-688-6696

DMA Customer Services Center
1-888-245-0179

Private Provider
Periodic Examination
Developmental Screening

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) **123456789K**	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY **01 15 05** SEX M **X** F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY **Fun Town** STATE **NC**	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE **11111** TELEPHONE (Include Area Code) **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V20.2** 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	03	07	05	03	07	11		99393	EP		80 33	1		1D	8999999
															NPI	NPI Number
2	05	03	07	05	03	07	11		96110	EP		0 00	1		1D	8999999
															NPI	NPI Number
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ **80.33**	29. AMOUNT PAID $	30. BALANCE DUE $ **80.33**
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** b. **1D 5555555**		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Physician Counseling with Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) **123456789K**	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY **02 14 01** SEX M **X** F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY **Fun Town** STATE **NC**	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE **11111** TELEPHONE (Include Area Code) **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V06.8** 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 05 07	05 05 07	11		90465	EP		17 25	1		1D	555555K
											NPI	NPI Number
2	05 05 07	05 05 07	11		90468	EP		8 56	1		1D	555555K
											NPI	NPI Number
3	05 05 07	05 05 07	11		90710	EP		0 00	1		1D	555555K
											NPI	NPI Number
4	05 05 07	05 05 07	11		90707	EP		0 00	1		1D	555555K
											NPI	NPI Number
5	05 05 07	05 05 07	11		90700	EP		0 00	1		1D	555555K
											NPI	NPI Number
6												
											NPI	

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 $ **23.81**	29. AMOUNT PAID $	30. BALANCE DUE $ **23.81**
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** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** b. **1D 8999999**		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Periodic Examination

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joanna**	3. PATIENT'S BIRTH DATE MM DD YY: **03 22 07** SEX M ☐ F **X**	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V20.2** 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 **05 03 07**	**05 03 07**	**11**		**99381**	**EP**		**68.64**	**1**		**1D** NPI	**8999999** **NPI Number**
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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 $ **68.64**	29. AMOUNT PAID $	30. BALANCE DUE $ **68.64**
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** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **1D 888999D**		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Interperiodic Screening
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY: **03 28 97** SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V70.3** 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 05 07 05 05 07	11		99383	EP		80 33	1		1D NPI	555555K NPI Number
2 05 05 07 05 05 07	11		90471	EP		17 25	1		1D NPI	555555K NPI Number
3 05 05 07 05 05 07	11		90472	EP		9 71	1		1D NPI	555555K NPI Number
4 05 05 07 05 05 07	11		90715	EP		0 00	1		1D NPI	555555K NPI Number
5 05 05 07 05 05 07	11		90716	EP		0 00	1		1D NPI	555555K NPI Number
6 05 05 07 05 05 07	11		90707	EP		0 00	1		1D NPI	555555K NPI Number

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ 107.29	29. AMOUNT PAID $	30. BALANCE DUE $ 107.29
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** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. NPI NPI b. **1D 8999999**		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider – Split Claim
Periodic Examination
Developmental, Vision, and Hearing Screening
(Block 24H) Referral Indicator "R"
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 03 02 03 — SEX: M [x] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	
CITY: Fun Town — STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] — Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY — STATE	
ZIP CODE: 11111 — TELEPHONE (Include Area Code): (555) 555-5555	
ZIP CODE — TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. V20.2 — 2. — 3. — 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. — 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 — 05 01 07 — 05 01 07	11		99382	EP		80 33	1	R	1D / NPI	555555K / NPI Number
2 — 05 01 07 — 05 01 07	11		96110	EP		0 00	1		1D / NPI	555555K / NPI Number
3 — 05 01 07 — 05 01 07	11		99172	EP		0 00	1		1D / NPI	555555K / NPI Number
4 — 05 01 07 — 05 01 07	11		92551	EP		0 00	1		1D / NPI	555555K / NPI Number
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ 80.33	29. AMOUNT PAID $	30. BALANCE DUE $ 80.33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature on File	123 That St That City, NC 27606-1234	Dr J P Provider 123 Any St Any City, NC 27523-5678
SIGNED DATE	a. NPI b.	a. NPI NPI b. 1D 8999999

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

2nd Page of Split Claim
Private Provider
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY: **03 02 03** SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V03.82** 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 01 07	05 01 07	11		90465	EP		17 25	1		1D NPI	555555K NPI Number
2	05 01 07	05 01 07	11		90468	EP		9 71	1		1D NPI	555555K NPI Number
3	05 01 07	05 01 07	11		90732	EP		0 00	1		1D NPI	555555K NPI Number
4	05 01 07	05 01 07	11		90700	EP		0 00	1		1D NPI	555555K NPI Number
5	05 01 07	05 01 07	11		90707	EP		0 00	1		1D NPI	555555K NPI Number
6											NPI	

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 $ **26.96**	29. AMOUNT PAID $	30. BALANCE DUE $ **26.96**
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **1D 8999999**	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Periodic Examination
Vision & Hearing Screenings
(Block 24H) Referral Indicator "E"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joanna**	3. PATIENT'S BIRTH DATE MM DD YY: **01 01 98** SEX M ☐ F **x**
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code): ( )
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ____ 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V20.2** 2. ____ 3. ____ 4. ____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 03 07 05 03 07	11		99383	EP		80 33	1	E	1D NPI	111111D NPI Number
2	05 03 07 05 03 07	11		99172	EP		0 00	1		1D NPI	111111D NPI Number
3	05 03 07 05 03 07	11		92551	EP		0 00	1		1D NPI	111111D NPI Number
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 80.33
29. AMOUNT PAID $	30. BALANCE DUE $ 80.33		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. NPI NPI b. 1D 8888881

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Periodic Examination
Vision & Hearing Screenings

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY **03 11 94** SEX M [x] F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY **Fun Town** STATE **NC**	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE **11111** TELEPHONE (Include Area Code) **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ____ 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V20.2** 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	03	07	05	03	07	11		99394	EP		80.33	1		1D NPI	8111111 NPI Number
2	05	03	07	05	03	07	11		99172	EP		0.00	1		1D NPI	8111111 NPI Number
3	05	03	07	05	03	07	11		92551	EP		0.00	1		1D NPI	8111111 NPI Number
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 80.33
29. AMOUNT PAID $	30. BALANCE DUE $ 80.33		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St** **That City, NC 27606-1234** a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) **The JP Provider Clinic** **123 Any St** **Any City, NC 27523-5678** a. **NPI** NPI b. **1D 343000C**	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Interperiodic Examination
(Block 24H) Referral Indicator "F"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joanna**	3. PATIENT'S BIRTH DATE MM DD YY: **06 15 88** SEX M ☐ F **x**	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. **V70.3** 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 **05 15 07**	**05 15 07**	**11**		**99395**	**EP**		**80.33**	**1**	**F**	**1D** NPI	**8999999** **NPI Number**
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ **80.33**	29. AMOUNT PAID $	30. BALANCE DUE $ **80.33**
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **The JP Provider Clinic 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **1D 344000C**		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Immunizations Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY: **12 25 05** SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V03.81** 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 05 07 05 05 07	11		90471	EP		17 25	1		1D NPI	5555555 NPI Number
2 05 05 07 05 05 07	11		90472	EP		9 71	1		1D NPI	5555555 NPI Number
3 05 05 07 05 05 07	11		90713	EP		0 00	1		1D NPI	5555555 NPI Number
4 05 05 07 05 05 07	11		90716	EP		0 00	1		1D NPI	555555K NPI Number
5 05 05 07 05 05 07	11		90647	EP		0 00	1		1D NPI	5555555 NPI Number
6 05 05 07 05 05 07	11		90700	EP		0 00	1		1D NPI	5555555 NPI Number

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 $ 26 96	29. AMOUNT PAID $	30. BALANCE DUE $ 26 96
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **The JP Provider Clinic 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **1D 344000C**		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Core Visit
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY: **09 09 05** SEX: M [x] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]		CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]		a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **382.9** 2. _____ 3. _____ 4. _____			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	20	07	05	20	07	11		T1015			65 00	1		1D	8999999
															NPI	NPI Number
2	05	20	07	05	20	07	11		90700	EP		0 00	1		1D	8999999
															NPI	NPI Number
3	05	20	07	05	20	07	11		90707	EP		0 00	1		1D	8999999
															NPI	NPI Number
4	05	20	07	05	20	07	11		90716	EP		0 00	1		1D	8999999
															NPI	NPI Number
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ **65.00**
29. AMOUNT PAID $	30. BALANCE DUE $ **65.00**		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **The JP Provider Clinic 123 Any St Any City, NC 27523-5678** a. NPI NPI b. **1D 343000A**

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider – Split Claim
Periodic Examination

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joanna**	3. PATIENT'S BIRTH DATE MM DD YY: **04 30 07** SEX M ☐ F **X**	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V20.2** 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 **06 29 07**	**06 29 07**	**11**		**99391**	**EP**		**68.64**	**1**		**1D** NPI	**100000X** **NPI Number**
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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 $ **68.64**	29. AMOUNT PAID $	30. BALANCE DUE $ **68.64**
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** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **1D 89999YY**		

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

2nd Page of Split Claim
Private Provider
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joanna	3. PATIENT'S BIRTH DATE MM DD YY: 04 30 07 SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V03.81 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06	29	07	06	29	07	11		90465	EP		17 25	1		1D NPI	100000X NPI Number
2	06	29	07	06	29	07	11		90466	EP		9 71	1		1D NPI	100000X NPI Number
3	06	29	07	06	29	07	11		90744	EP		0 00	1		1D NPI	100000X NPI Number
4	06	29	07	06	29	07	11		90732	EP		0 00	1		1D NPI	100000X NPI Number
5	06	29	07	06	29	07	11		90680	EP		0 00	1		1D NPI	100000X NPI Number
6	05	05	07	05	05	07	11		90467	EP		0 00	1		1D NPI	100000X NPI Number

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 $ 26 96
29. AMOUNT PAID $	30. BALANCE DUE $ 26 96		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI NPI b. 1D 89999YY	

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Immunizations Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY: **09 06 02** SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. **V06.1** 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03 21 07	03 21 07	11		90471	EP		17 25	1		1D NPI	555555K NPI Number
2	03 21 07	03 21 07	11		90472	EP		9 71	1		1D NPI	555555K NPI Number
3	03 21 07	03 21 07	11		90700	EP		0 00	1		1D NPI	555555K NPI Number
4	03 21 07	03 21 07	11		90713	EP		0 00	1		1D NPI	555555K NPI Number
5	03 21 07	03 21 07	11		90707	EP		0 00	1		1D NPI	555555K NPI Number
6											NPI	

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 $ 26.96	29. AMOUNT PAID $	30. BALANCE DUE $ 26.96
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **1D 8999999**		

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

N.C. Health Services Information System Screen Examples

Following are screen entry examples of the services screen (Option 65) for local health departments that use the N.C. Health Services Information System (HSIS)

Example #1 - Health Check Periodic Screening Examination for six-month-old child
Developmental Screening
Immunization Injections

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID            DATE 010707   ACTION A
MESSAGE:

NAME: Brown, Charlie                                  DATE OF DIAB EVAL:______
SERVICE GROUP:                                        FPW ANN EXAM DATE:______
DIAG CODES A: V20.2_ B: ___.__ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
          H: ___.__
PHY ORDER DATE FOR AT: ______  OT: ______   PT: ______   SPL: ______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99381  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  96110  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90700  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90713  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example #2 – Health Check Periodic Screening Examination for 18-year-old
Vision Screening
Hearing Screening
Diagnosis warrants a referral for a followup visit, designated with "ST/S2"

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 010207   ACTION A
MESSAGE:

NAME: Peppermint, Patty                               DATE OF DIAB EVAL:______
SERVICE GROUP:                                        FPW ANN EXAM DATE:______


DIAG CODES A: V20.2  B: 690.4_ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
          H: ___.__
PHY ORDER DATE FOR AT: ______  OT: ______   PT: ______   SPL: ______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99385  EP ST S2  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  99173  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  92552  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  87081  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #3 – Health Check Periodic Screening Examination for 4-year-old child
Developmental Screening
Vision Screening
Hearing Screening

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 010507   ACTION A
MESSAGE:

NAME: Smith, Barbie                                   DATE OF DIAB EVAL:_______
SERVICE GROUP:                                        FPW ANN EXAM DATE:_______
DIAG CODES A: V20.2_ B: ___.__ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
PHY ORDER DATE FOR AT: _______  OT: _______   PT: _______   SPL: _______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99392  EP __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
 R  CH  96110  __ __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
 R  CH  99172  __ __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
 R  CH  92587  __ __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
```

Example #4 – Health Check Periodic Screening Examination for 1-year-old child
Developmental Screening

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 021307  ACTION A
MESSAGE:

NAME: Robin, Christopher                              DATE OF DIAB EVAL:_______
SERVICE GROUP:                                        FPW ANN EXAM DATE:_______
DIAG CODES A: V20.2_ B: ___.__ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
PHY ORDER DATE FOR AT: _______  OT: _______   PT: _______   SPL: _______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99382  EP __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
 R  CH  96110  __ __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #5 – Immunization Administration Fee ONLY with Immunizations Injectables for 4-year old child

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 020507   ACTION A
MESSAGE:

NAME: Barkley, Charles                                 DATE OF DIAB EVAL:______
SERVICE GROUP:                                         FPW ANN EXAM DATE:______
DIAG CODES A: V06.8_ B: ___.__ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
PHY ORDER DATE FOR AT: _______  OT: _______   PT: _______   SPL: _______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  IM  90471  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90744  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90713  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example #6 – Office Visit with One Immunization Injectable for 2-year old child

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 020107   ACTION A
MESSAGE:

NAME: Smith, Hercules                                  DATE OF DIAB EVAL:______
SERVICE GROUP:                                         FPW ANN EXAM DATE:______
DIAG CODES A: 382.9_ B: ___.__ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
PHY ORDER DATE FOR AT: _______  OT: _______   PT: _______   SPL: _______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99212  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90471  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90716  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #7 – Immunizations Only
Immunization Administration Fee with Immunizations Injectables w/Physician Counseling
Immunization Administration Fee for Oral Vaccine w/Physician Counseling

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 020607   ACTION A
MESSAGE:

NAME: Beanstalk, Jack                                  DATE OF DIAB EVAL:______
SERVICE GROUP:                                         FPW ANN EXAM DATE:______
DIAG CODES A: V04.89 B: V06.8_ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
          H: ___.__
PHY ORDER DATE FOR AT: ______  OT: ______   PT: ______   SPL: ______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  IM  90465  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90744  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 B  IM  90647  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90468 EP __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90680  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example #8 – Immunizations Only
Administration Fee for Vaccine Injection without physician counseling
Administration Fee for Oral Vaccine without physician counseling

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 020907   ACTION A
MESSAGE:

NAME: Jones, Peanut                                    DATE OF DIAB EVAL:______
SERVICE GROUP:                                         FPW ANN EXAM DATE:______
DIAG CODES A: V04.89 B: V06.8_ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
          H: ___.__
PHY ORDER DATE FOR AT: ______  OT: ______   PT: ______   SPL: ______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  IM  90471  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90744  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 B  IM  90647  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90474  EP __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90680  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #9 – Office Visit at which Oral Vaccine was provided without physician counseling

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID              DATE 020107   ACTION A
MESSAGE:

NAME: Smith, Peter Pan                                  DATE OF DIAB EVAL:_______
SERVICE GROUP:                                         FPW ANN EXAM DATE:_______
DIAG CODES A: 382.9_ B: ___.__ C: ___.__ D: ___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
PHY ORDER DATE FOR AT: _______  OT: _______   PT: _______   SPL: _______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99212  __ __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
 R  CH  90473  EP __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
 R  CH  90680  __ __ __  A _ _ _  ROS__  01   71  ______  __  ______  _   99999
```