North Carolina
Medicaid Special Bulletin

*An Information Service of the Division of Medical Assistance*

*Published by EDS, fiscal agent for the North Carolina Medicaid Program*

Number III July 2002

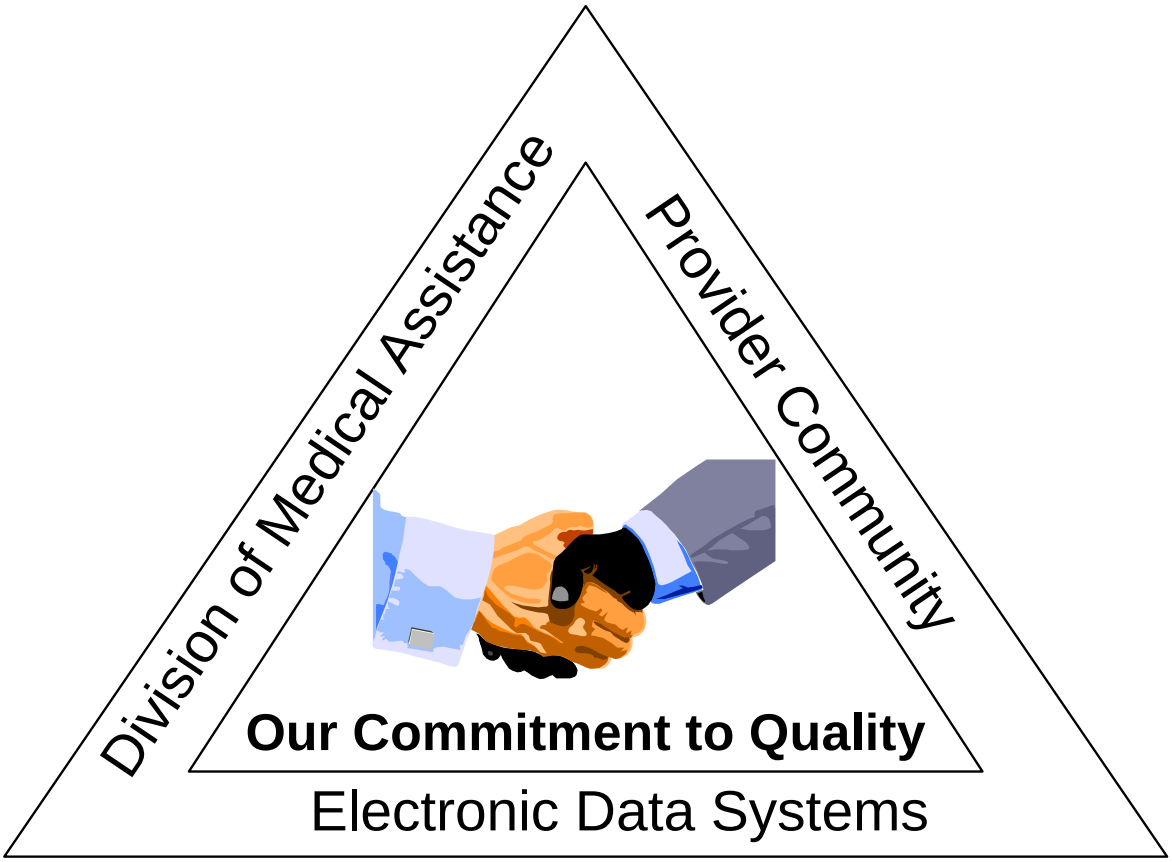
# Attention:
# All Health Check Providers

## Effective October 1, 2002


# Health Check
# Billing Guide
# 2002

# COMMITMENT TO QUALITY

**EDS and DMA share a common goal with the provider community to ensure quality health care is provided to all North Carolina Medicaid recipients in the most efficient and economical manner.**




**Quality is the process of delivering products and services that meet our customers' requirements and exceed their expectations to generate customer satisfaction and success.**

**www.dhhs.state.nc.us/dma**

# TABLE OF CONTENTS

**Effective with date of services October 1, 2002,** changes have been made to the Health Check Program to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). These changes are outlined in this special bulletin. This special bulletin replaces the Health Check Billing Guide 2001.

# HEALTH CHECK SCREENING COMPONENTS

The Health Check Program is a preventive care program for Medicaid-eligible children ages birth through 20. **A Health Check screening is the only well child preventive visit reimbursable by Medicaid**. **All Health Check components are required and are to be documented in the medical record. Each screening component is vital for measuring a child's physical, mental, and developmental growth.** Recipients are encouraged to receive their comprehensive health checkups and immunizations on a regular schedule. A complete Health Check screening consists of the following age-appropriate components, which must be performed and documented at each visit unless otherwise noted.

- **Comprehensive unclothed physical examination**

- **Comprehensive health history**

- **Nutritional assessment**

- **Anticipatory guidance and health education**

- **Measurements, blood pressure, and vital signs**
  Blood pressure is recommended to become a part of the exam between ages 3 and 4.

- **Developmental screening, including mental, emotional, and behavioral**
  Perform age-appropriate evaluation at each screening. In addition, three written developmental assessments should be performed: the first by 12 months, the second by 24 months, and the third by 60 months of age.

- **Immunizations**
  Federal regulations state that immunizations are to be provided at the time of screening if they are needed.

- **Vision screenings**
  A visual assessment must be administered with each periodic screening beginning at age 3.

- **Hearing screenings**
  A hearing assessment must be administered with each periodic screening beginning at age 4.

- **Dental screenings**
  A dental referral is required for every child beginning at 3 years of age. 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 (i.e., baby bottle caries), referrals must be made for needed dental services and documented in the patient's record. The periodicity schedule for dental examinations is not governed by the schedule for regular health screenings.

**Note:** Dental varnishing is not a requirement of the Health Check screening exam. Providers may bill for dental varnishing and receive reimbursement in addition to the Health Check screening. Providers are to utilize the codes and billing guidelines indicated in the August 2002 general Medicaid bulletin. Bulletins are available on the Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma.

- **Laboratory procedures**
  Includes hemoglobin or hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead screening.

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

  The Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) has specific time frames for hematocrit/hemoglobin testing for recertification for children birth up to 5 years of age and pregnant/postpartum women. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information.

  **Urinalysis**
  Urinalysis should be performed during the 5-year-old periodic screening as well as during periodic screenings for all sexually active males and females.

  **Sickle cell testing**
  North Carolina hospitals are required to screen all newborns for sickle cell prior to discharge. 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 results of the newborn sickle cell screening are not readily available, contact the hospital of birth. An infant not tested at birth should receive a sickle cell test prior to 3 months of age.

  **Tuberculin testing**
  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 screening is indicated. If none of the screening criteria below are present, there is no recommendation for routine TB screening.

  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. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local department of health.

## **Laboratory procedures,** continued

Tuberculin 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. Do a **baseline screen** when these children/adolescents present for care.

    a. Foreign-born individuals arriving within the last five years from Asia, Africa, Caribbean, 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 who inject illicit drugs or use crack cocaine.

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

**In addition to the TB Control Branch criteria:**
A TB screening performed as a part of a Health Check screening cannot be billed separately.

**Laboratory procedures,** continued

**Lead Screening**

**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 perform a lead screening when it is 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 screening test. 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 to 19 ug/dL** | **Confirmation (venous) testing should be conducted within 3 months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on 3 consecutive tests (venous or fingerstick). 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 to 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 3 consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old 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 Screening**

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 of specimens from children outside this age group need to contact the State Laboratory of Public Health at 919-733-3937.

**Note:** When the above laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

# HEALTH CHECK SCREENING SCHEDULES

## Periodic Screenings

The **preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP** are used to bill a periodic screening. (Refer to Health Check Billing Requirements on page 9.)

The schedule below outlines the recommended frequency of Health Check screenings dependent upon the age of the child. The intent of this schedule is to assure that a minimum number of screenings occur at critical points in a child's life.

**Note:** If an illness is detected during a Health Check screening, the provider may continue with the screening or bill a sick visit and reschedule the screening for a later date.

### Periodicity Schedule

| | | | |
|---|---|---|---|
| Within the first month | 6 months | 18 months | 4 years |
| 2 months | 9 or 15 months | 2 years | 5 years |
| 4 months | 12 months | 3 years | 6 through 20 years of age<br>(One screening every three years for children 6 years of age and older) |

## Interperiodic Screenings

The **preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP** are used to bill an interperiodic screening. (Refer to Health Check Billing Requirements on page 9.)

In addition to the periodicity schedule, interperiodic screenings are allowed in the following circumstances:

- When a child requires either a kindergarten or sports physical **outside** the regular schedule.
- When a child's physical, mental or developmental illnesses or conditions have already been diagnosed and have indications that the illness or condition may require closer monitoring.
- When the screening provider has determined there are medical indications that make it necessary to schedule additional screenings in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis, or treatment.
- Upon referral by a health, developmental or educational professional based on their determination of medical necessity. Examples of referral sources may include Head Start, Agricultural Extension Services, Early Intervention Programs or Special Education Programs.

**In each of these circumstances, the screening provider must specify and document in the child's medical record the reason necessitating the interperiodic screening.**

**Hearing and vision assessments are not required for an interperiodic screening. All other Health Check components must be performed during an interperiodic Health Check screening.**

# IMMUNIZATIONS

## Immunization Administration CPT Codes 90471 and 90472; with the EP Modifier

Medicaid reimburses providers for the administration of immunizations to Medicaid enrolled children, birth through 20 years of age, using the following guidelines.

**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 screening or an office visit.

- Administration of one immunization is billed with the administration CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Addition immunizations are billed with the administration CPT code 90472 with the EP modifier and are reimbursed at $13.71.

The maximum reimbursement for two or more immunizations will remain at $27.42 when using both CPT codes 90471 and 90472. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on billing an immunization administration fee, refer to the chart on page 7.

**Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) 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 screening. Health Check screenings and the immunization administration fees are billed under the Medicaid provider number with the "C" suffix.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with an **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPTcode 90472 with the **EP** modifier and are reimbursed at $13.71.

An immunization fee cannot be billed in conjunction with a core visit. Report the immunization given during the core visit without billing the administration fee. The total reimbursement for two or more immunizations will remain at $27.42 using both CPT codes. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D. For instructions on billing an immunization administration fee, refer to the chart on page 7.

**Local Health Department Providers**

An immunization administration fee may not be billed if immunization(s) is provided in addition to a Health Check screening. The immunization administration CPT codes 90471 and 90742 may be billed if immunizations are the only services provided that day or any immunizations are provided in conjunction with an **office visit**.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with an **EP** modifier and is reimbursed at $20.00.
- Additional immunizations are billed with the administration CPT code 90472 with the **EP** modifier and receive no additional reimbursement.

The immunization administration code is reimbursed at $20.00 regardless of the number of immunizations given. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on how to bill an immunization administration fee, refer to the chart on page 7.

**Immunizations,** continued

## Billing Guidelines for Immunizations

| Provider Type | Health Check Screening with Immunization(s) | Immunization(s) Only | Office Visit with Immunization(s) | Core Visit with Immunization(s) |
|---|---|---|---|---|
| **Private Sector Providers** | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>Immunization diagnosis code **not** required.<br>Immunization procedure code(s) are required. | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>One immunization diagnosis code is required.<br>Immunization procedure code(s) are required. | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>Immunization diagnosis code **not** required.<br>Immunization procedure code(s) are required. | N/A |
| **FQHC/RHC** | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>Immunization diagnosis code **not** required.<br>Immunization procedure code(s) are required. | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>One immunization diagnosis code is required.<br>Immunization procedure code(s) are required. | N/A | Cannot bill 90471 or 90472.<br>Immunization diagnosis code is **not** required.<br>Immunization procedure code(s) are required. |
| **Local Health Department Providers** | Cannot bill 90471 or 90472.<br>Immunization diagnosis code **not** required.<br>Immunization procedure code(s) are required. | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>One immunization diagnosis code is required.<br>Immunization procedure code(s) are required. | For one immunization, bill 90471 with the EP modifier.<br>For additional immunizations, bill 90472 with the EP modifier.<br>Immunization diagnosis code is **not** required.<br>Immunization procedure code(s) are required. | N/A |

**Immunization procedure code(s) must be listed in block 24D of the CMS-1500 claim form for all immunizations administered.**

## 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. An exception to this is noted below the table.

For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the VFC program vaccines, DMA will continue reimbursement for Medicaid covered vaccines.

**The following is a list of UCVDP/VFC vaccines:**

| Codes | Vaccines | Diagnosis Codes |
|---|---|---|
| 90645 | Hib-4 dose | V03.8 or V05.8 |
| 90647 | Hib-3 dose | V03.8 or V05.8 |
| 90657 | Influenza (6 to 35 months of age) **High-Risk Only** | V04.8 |
| 90658 | Influenza (3 years of age and above) **High-Risk Only** | V04.8 |
| 90669 | Pneumococcal - PCV7 **(2 through 59 months of age)** | V03.82 or V05.8 |
| 90700 | DTaP | V06.8 |
| 90702 | DT | V06.8 |
| 90707 | MMR | V06.4 |
| 90713 | IPV | V04.0 |
| 90716 | Varicella | V05.4 |
| 90718 | Td | V06.5 |
| 90732 | Pneumococcal - PPV23 **High-Risk Only** | V03.82 or V05.8 |
| 90744 | Hepatitis B Vaccine – Pediatric/Adolescent | V05.8 |

**Note:** DMA will reimburse for vaccines required to complete a series of injections when the series was started prior to the recipient's 19th birthday and for **high-risk** individuals 19 years of age and older.

**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 1-800-344-0569.**

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** (1-804-786-6246)

# HEALTH CHECK BILLING REQUIREMENTS

Instructions for billing a Health Check screening 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 – Use V20.2 as the Primary Diagnosis**
Medical diagnoses are listed after the primary diagnosis (V20.2). Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

**Interperiodic Health Check Screening – Use V70.3 as the Primary Diagnosis**
Medical diagnoses are listed after the primary diagnosis (V70.3). Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

## Requirement 2: Identify and Record the Preventive Medicine Code

The preventive medicine CPT codes with the EP modifier for Health Check screenings should be billed as outlined below. In addition to billing the preventive medicine codes, vision and hearing CPT codes must be listed based on the ages outlined in the Health Check Screening Components listed on page 1.

- A Health Check screening is the only well child visit reimbursable by Medicaid and must have V20.2 or V70.3 as the primary diagnosis code.

- Vision and hearing CPT codes must be listed in addition to the preventive CPT codes for a periodic Health Check screening. No additional reimbursement is allowed for these codes.

Use the correct Health Check screening preventive medicine codes with the EP modifier in block 24D of the CMS-1500 claim form:

| Screenings | Preventive CPT Codes and Modifier | Diagnoses Codes |
|---|---|---|
| Periodic Screening | CPT codes 99381-99385; 99391-99395<br>EP Modifier is required in block 24D<br><br>Vision CPT code 99173; age appropriate<br>Hearing CPT code 92551; age appropriate | V20.2 Primary Diagnosis |
| Interperiodic Screening | CPT codes 99381-99385; 99391-99395<br>EP Modifier is required in block 24D | V70.3 Primary Diagnosis |

**Health Check Billing Requirements,** continued

### Requirement 3: Health Check CPT Code Modifier - EP

The Health Check screening CPT codes for periodic and interperiodic screenings must have the modifier **EP** listed in block 24D of the CMS-1500 claim form. EP is the only modifier required for Health Check claims.

### Requirement 4: Record the Referral Code Indicator

A referral diagnosis indicator is used only when a follow up is necessary for a diagnosis found during a Health Check screening. The indicator "R" should be listed in block 24H of the CMS-1500 claim form when this situation occurs. Refer to pages 19, 20, 28, and 29 for sample claims.

### Requirement 5: Next Screening Date

Providers 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**

Providers have the following choices for block 15 of the CMS-1500 claim form with a Health Check screening. 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**

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.

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

Refer to the chart on page 7 for guidelines on when to bill the immunization administration CPT codes and EP modifier.

When billing one immunization, use the administration CPT code 90471 (one unit) with the EP modifier listed in block 24D.

When additional immunizations are provided use the administration CPT code 90472 with the EP modifier listed in block 24D.

Refer to pages 20 through 23, 25 through 27, 29, 31, and 32 for sample claims.

**NOTE:** If the EP modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90471 and 90742 is $3.41.

# TIPS FOR BILLING

## All Health Check Providers

- Two screenings on different dates of service cannot be billed on the same claim form.
- Third party insurance must be pursued and reported in block 29 of the CMS-1500 claim form when preventive services (well child screenings) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit a claim to Medicaid.
- When checking claim status on 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 screening and the amount billed for immunizations and any other service billed on the same date of service. Thus, it will be necessary to check claim status for two separate claims.
- When billing immunization administration CPT codes, the EP modifier must be entered in block 24D to receive the reimbursement rate of $13.71 for 90471 (health departments receive $20.00) and $13.71 for 90472 (no additional reimbursement for health departments). If the EP modifier is not entered in block 24D, the reimbursement will be $3.41 per unit. The reimbursement for these codes is $3.41 per unit for non-Health Check related services.

## Private Sector Health Check Providers Only

- A Health Check screening and an office visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening 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 code 90471 with EP and 90472 with EP can be billed with a Health Check screening, office visit or if it is the only service provided that day. When billing in conjunction with a screening 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 (90471 with EP and 90472 with EP) 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 90471with EP and 90472 with EP. Refer to the chart on page 7 and the sample claim forms beginning on pages 16 through 27.

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

- FQHCs and RHCs must bill Health Check services using their Medicaid provider number with the "C" suffix.
- A Health Check screening 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 90471 with EP and 90472 with EP can be billed if it is provided in addition to a Health Check screening CPT code or if it is the only service provided that day. When billing in conjunction with a screening code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with EP and 90472 with EP) 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 90471 with EP and 90742 with EP. Refer to the chart on page 7 and the sample claim forms on pages 28 through 32.

# 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. The roles of the HCCs 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
- 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 screenings
- promoting Health Check and health prevention with other public and private organizations

Physicians and other primary care providers and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication will significantly enhance recipient participation in Health Check and help make preventive care services more timely and effective.

**HCCs are currently located in 78 North Carolina counties and Qualla Boundary.**

HCCs are housed in local health departments, community and rural health centers, and other community agencies.

## Health Check Coordinator Contact List

| County | Agency | Telephone Number |
|---|---|---|
| **Alexander** | Alexander County Health Dept. | 828-623-9704 |
| **Alleghany** | Alleghany County Health Dept. | 336-372-5641 |
| **Ashe** | Ashe County Health Dept. | 336-246-9449 |
| **Avery** | Avery County Health Dept. | 828-733-6031 |
| **Bertie** | Bertie County Health Dept. | 252-794-5322 |
| **Brunswick** | Brunswick County Health Dept. | 910-253-2250 |
| **Buncombe** | Buncombe County Health Dept. | 828-250-5000 |
| **Burke** | Burke County Health Dept. | 828-439-4400 |
| **Cabarrus** | Cabarrus Health Alliance | 704-920-1000 |
| **Caldwell** | Caldwell County Health Dept. | 828-757-1200 |
| **Camden** | Albemarle Regional Health Services | 252-338-4400 |
| **Catawba** | Catawba County Health Dept. | 828-695-5800 |
| **Chatham** | Chatham County Health Dept. | 919-525-8214 |
| **Cherokee** | Cherokee County Health Dept. | 828-837-7486 |

**Health Check Coordinator Contact List,** continued

| County | Agency | Telephone Number |
|---|---|---|
| **Chowan** | Albemarle Regional Health Services | 252-338-4400 |
| **Clay** | Clay County Health Services | 828-389-8052 |
| **Cleveland** | Cleveland County Health Dept. | 704-484-5100 |
| **Columbus** | Columbus County Health Dept. | 910-640-6614 |
| **Craven** | Craven County Health Dept. | 252-636-4960 |
| **Cumberland** | Cape Fear Valley Health System | 910-609-4000 |
| **Currituck** | Albemarle Regional Health Services | 252-232-2271 |
| **Dare** | Dare County Health Dept. | 252-475-1198 |
| **Davie** | Davie County Health Dept. | 336-751-8700 |
| **Duplin** | Goshen Medical Center | 910-267-0421 |
| **Durham** | Durham County Health Dept. | 919-560-7700 |
| **Edgecombe** | Edgecombe County Health Dept. | 252-641-7511 |
| **Forsyth** | Forsyth County Dept of Health | 336-727-8231 |
| **Franklin** | Franklin County Health Dept. | 919-496-2533 |
| **Gaston** | Gaston Family Health Services | 704-853-5079 |
| **Gates** | Hertford/Gates District Health Dept. | 252-357-1380 |
| **Graham** | Graham County Health Dept. | 828-479-7900 |
| **Granville** | Granville County Health District | 919-693-2141 |
| **Greene** | Greene County Health Care, Inc. | 252-747-5841 |
| **Guilford** | Guilford County Health Dept. | 336-333-6001 |
| **Halifax** | Roanoke Amaranth Community Health Group | 252-536-2800 |
| **Harnett** | Harnett County Health Dept. | 910-893-7550 |
| **Haywood** | Haywood County Health Dept. | 828-452-6675 |
| **Hertford** | Hertford/Gates District Health Dept. | 252-358-7833 |
| **Hoke** | Hoke County Health Dept. | 910-875-3717 |
| **Hyde** | Hyde County Health Dept. | 252-926-4200 |
| **Jackson** | Jackson County Health Dept. | 828-586-8994 |
| **Jones** | Jones County Partnership for Children | 252-448-5272 |
| **Lenoir** | Kinston Community Health Center | 252-522-9800 |
| **Macon** | Macon County Public Health Center | 828-349-2081 |
| **Madison** | Madison County Health Dept. | 828-649-3531 |
| **McDowell** | Rutherford/Polk/McDowell District | 828-652-6811 |
| **Mitchell** | Toe River Health District | 828-765-2239 |
| **Moore** | Moore County Health Dept. | 919-947-3300 |
| **Nash** | Nash County Health Dept. | 252-459-9819 |

**Health Check Coordinator Contact List,** continued

| County | Agency | Telephone Number |
|---|---|---|
| **New Hanover** | New Hanover County Health Dept. | 910-343-6500 |
| **Northampton** | Roanoke Amaranth Community Health Group | 252-536-2800 |
| **Onslow** | Onslow County Health Dept. | 910-347-2154 |
| **Orange** | Orange County Health Dept. | 919-245-2400 |
| **Pamlico** | Pamlico County Health Dept. | 252-745-5111 |
| **Pasquotank** | Albemarle Regional Health Services | 252-338-4400 |
| **Pender** | Black River Health Services, Inc. | 910-259-1230 |
| **Perquimans** | Albemarle Regional Health Services | 252-338-4400 |
| **Person** | Person County Health Dept. | 336-597-2204 |
| **Polk** | Rutherford/Polk/McDowell District | 828-894-8271 |
| **Qualla Boundary** | Eastern Band of Cherokee Indians | 828-497-9163 |
| **Richmond** | Richmond County Health Dept. | 910-997-8300 |
| **Robeson** | Robeson County Health Dept. | 910-671-3200 |
| **Rockingham** | Rockingham County Health Dept. | 336-342-8140 |
| **Rutherford** | Rutherford/Polk/ McDowell District | 828-287-6100 |
| **Sampson** | Sampson County Health Dept. | 910-592-1131 |
| **Scotland** | Scotland County Health Dept. | 910-277-2470 |
| **Stanly** | Stanly County Health Dept. | 704-982-9171 |
| **Stokes** | Stokes County Health Dept. | 336-593-2400 |
| **Surry** | Surry County Health and Nutrition Center | 336-401-8400 |
| **Swain** | Swain District Health Dept. | 828-488-3198 |
| **Union** | Union County Health Dept. | 704-296-4800 |
| **Vance** | Vance County Health Dept. | 252-492-7915 |
| **Wake** | Wake County Human Services | 919-212-7000 |
| **Warren** | Warren County Health Dept. | 252-257-1185 |
| **Watauga** | Watauga County Health Dept. | 828-264-6635 |
| **Wayne** | Wayne County Health Dept. | 919-731-1000 |
| **Wilkes** | Wilkes County Health Dept. | 336-651-7450 |
| **Wilson** | Wilson Community Health Center | 252-243-9800 |
| **Yancey** | Toe River Health District | 828-765-2239 |

# HEALTH CHECK CLAIM FORM SAMPLES

There are 15 CMS-1500 claim form samples, including one split claim and six examples of HSIS screens on the following pages. A copy of the back of the CMS-1500 claim form precedes the first sample. **Note:** Medicaid payment (provider certification) information is shown and specifies that the provider of Medicaid services agrees to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charge.

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

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

**REFERS TO GOVERNMENT PROGRAMS ONLY**

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

**BLACK LUNG AND FECA CLAIMS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

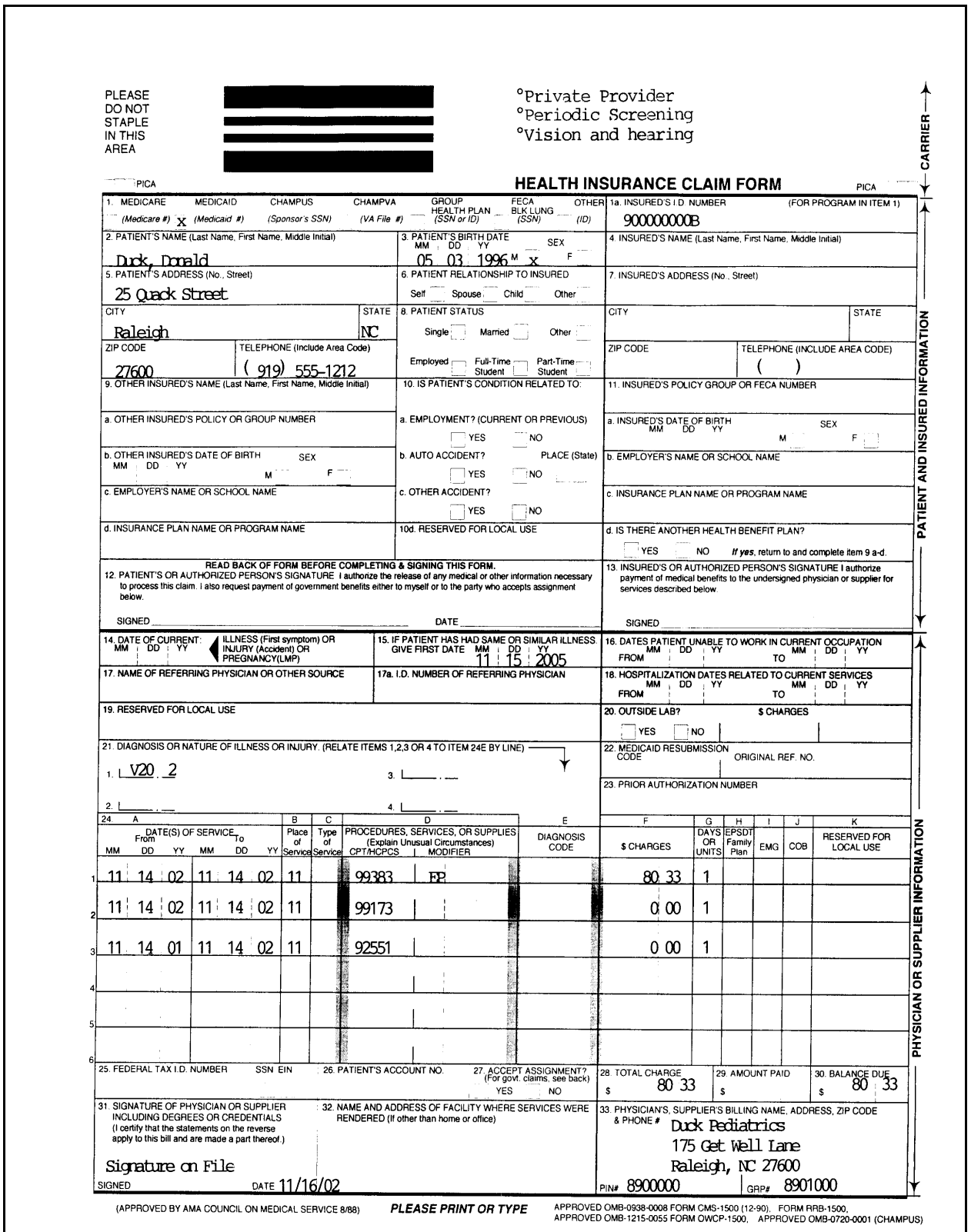
I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision and hearing

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Duck, Donald

3. PATIENT'S BIRTH DATE MM DD YY: 05 03 1996 — SEX: M x F

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

5. PATIENT'S ADDRESS (No., Street): 25 Quack Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Raleigh — STATE: NC

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

CITY — STATE

ZIP CODE: 27600 — TELEPHONE (Include Area Code): ( 919) 555-1212

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.

PATIENT AND INSURED INFORMATION

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: 11 15 2005

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

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

1. 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 Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 14 02 | 11 14 02 | 11 | | 99383 | EP | | 80 33 | 1 | | | | |
| 2 11 14 02 | 11 14 02 | 11 | | 99173 | | | 0 00 | 1 | | | | |
| 3 11 14 01 | 11 14 02 | 11 | | 92551 | | | 0 00 | 1 | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

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 11/16/02

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

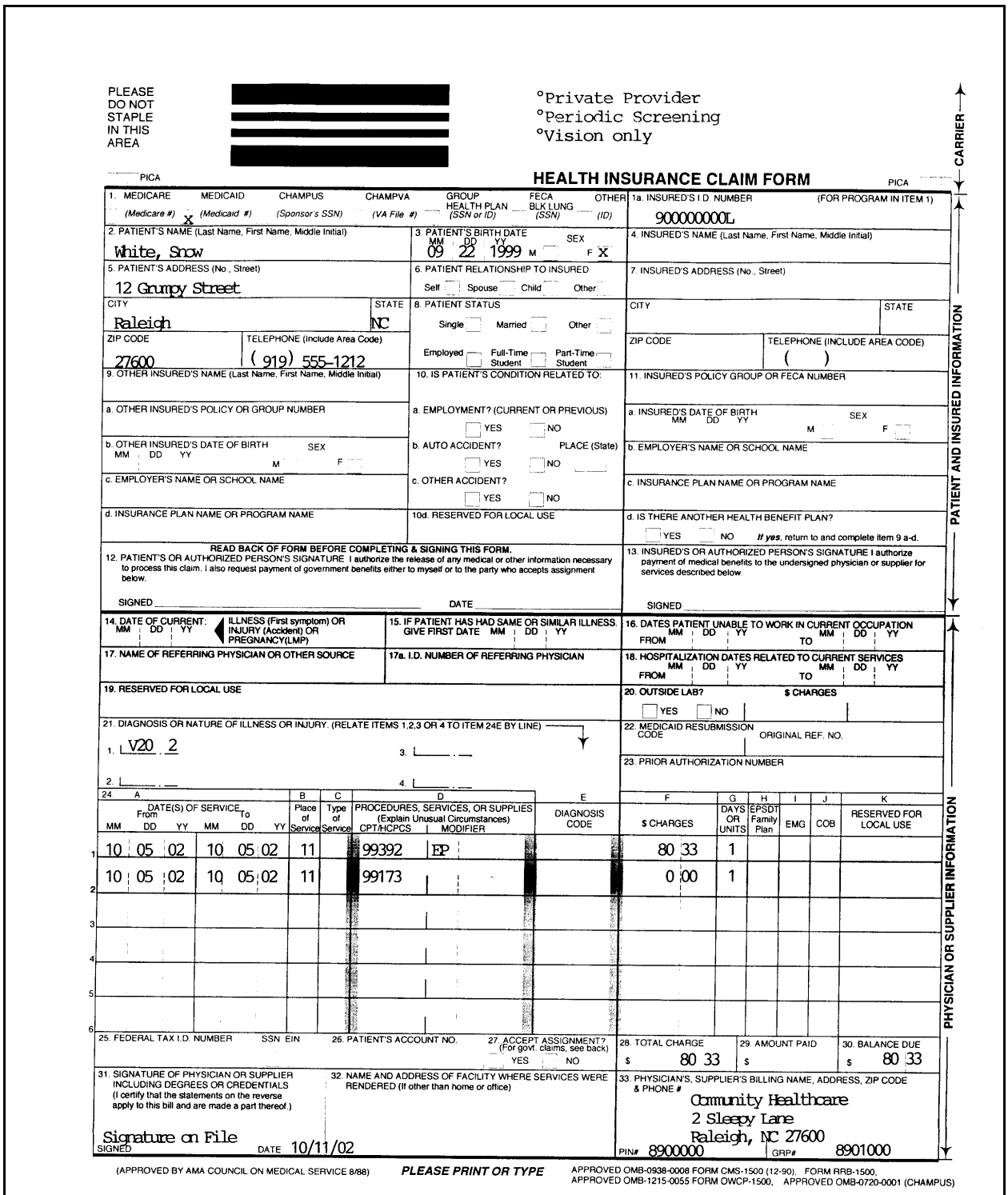
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Duck Pediatrics
175 Get Well Lane
Raleigh, NC 27600

PIN# 8900000 — GRP# 8901000

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

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision only

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000L

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): White, Snow

3. PATIENT'S BIRTH DATE MM DD YY: 09 22 1999 — SEX: M ; F X

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

5. PATIENT'S ADDRESS (No., Street): 12 Grumpy Street

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

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

CITY: Raleigh — STATE: NC

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

CITY — STATE

ZIP CODE: 27600 — TELEPHONE (Include Area Code): ( 919) 555-1212

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 _____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

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

1. 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 Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 10 05 02 | 10 05 02 | 11 | | 99392 | EP | | 80 33 | 1 | | | | |
| 2 10 05 02 | 10 05 02 | 11 | | 99173 | | | 0 00 | 1 | | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

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 10/11/02

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

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

Community Healthcare
2 Sleepy Lane
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision and hearing
°Referral Indicator

**HEALTH INSURANCE CLAIM FORM**

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000S

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patty, Peppermint

3. PATIENT'S BIRTH DATE (MM DD YY): 04 17 1984 — SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 10 Snoopy Road

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

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

CITY: Raleigh — STATE: NC

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

CITY — STATE

ZIP CODE: 27600 — TELEPHONE (Include Area Code): (919) 555-1212

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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

SIGNED _____ DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. V20.2
2. 460
3. 
4. 

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From (MM DD YY) | To (MM DD YY) | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 12 09 02 | 12 09 02 | 11 | | 99385 | EP | | 80 33 | 1 | R | | | |
| 2 12 09 02 | 12 09 02 | 11 | | 87081 | | | 12 10 | 1 | | | | |
| 3 12 09 02 | 12 09 02 | 11 | | 99173 | | | 0 00 | 1 | | | | |
| 4 12 09 02 | 12 09 02 | 11 | | 92551 | | | 0 00 | 1 | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN — 26. PATIENT'S ACCOUNT NO. — 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 92 43 — 29. AMOUNT PAID $ — 30. BALANCE DUE $ 92 43

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 12/15/02

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

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

Peanuts Healthcare
102 Charlie Brown Lane
Raleigh, NC 27600

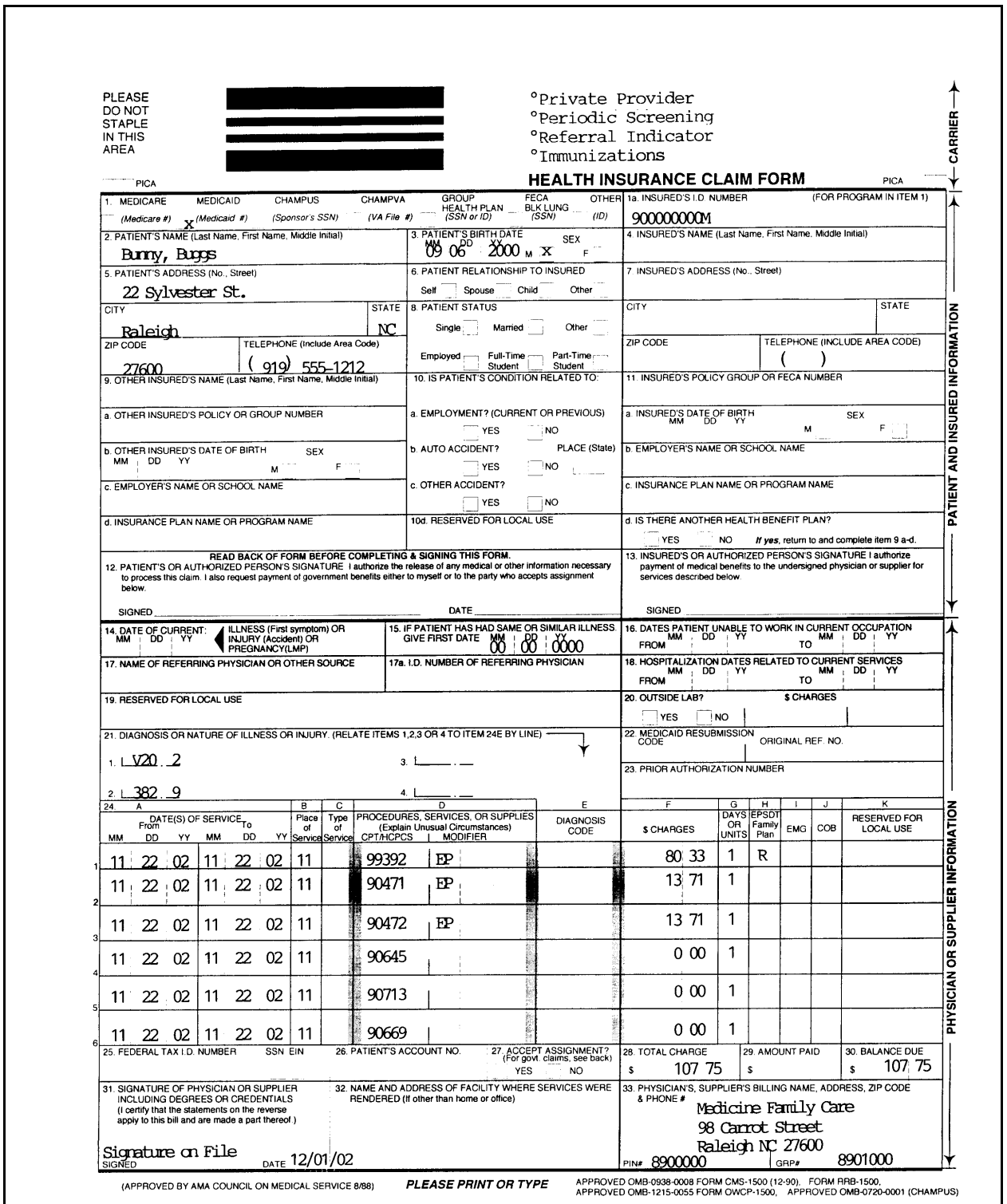
PIN# 8900000 — GRP# 8901000

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Referral Indicator
°Immunizations

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bunny, Buggs

3. PATIENT'S BIRTH DATE MM DD YY: 09 06 2000 SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 22 Sylvester St.

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Raleigh STATE: NC

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

CITY: STATE:

ZIP CODE: 27600 TELEPHONE (Include Area Code): ( 919) 555-1212

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 00 00 0000

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V20.2
2. 382.9
3. 
4. 

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 22 02 | 11 22 02 | 11 | | 99392 | EP | | 80 33 | 1 | R | | | |
| 2 11 22 02 | 11 22 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 3 11 22 02 | 11 22 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 4 11 22 02 | 11 22 02 | 11 | | 90645 | | | 0 00 | 1 | | | | |
| 5 11 22 02 | 11 22 02 | 11 | | 90713 | | | 0 00 | 1 | | | | |
| 6 11 22 02 | 11 22 02 | 11 | | 90669 | | | 0 00 | 1 | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 107 75

29. AMOUNT PAID $

30. BALANCE DUE $ 107 75

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 12/01/02

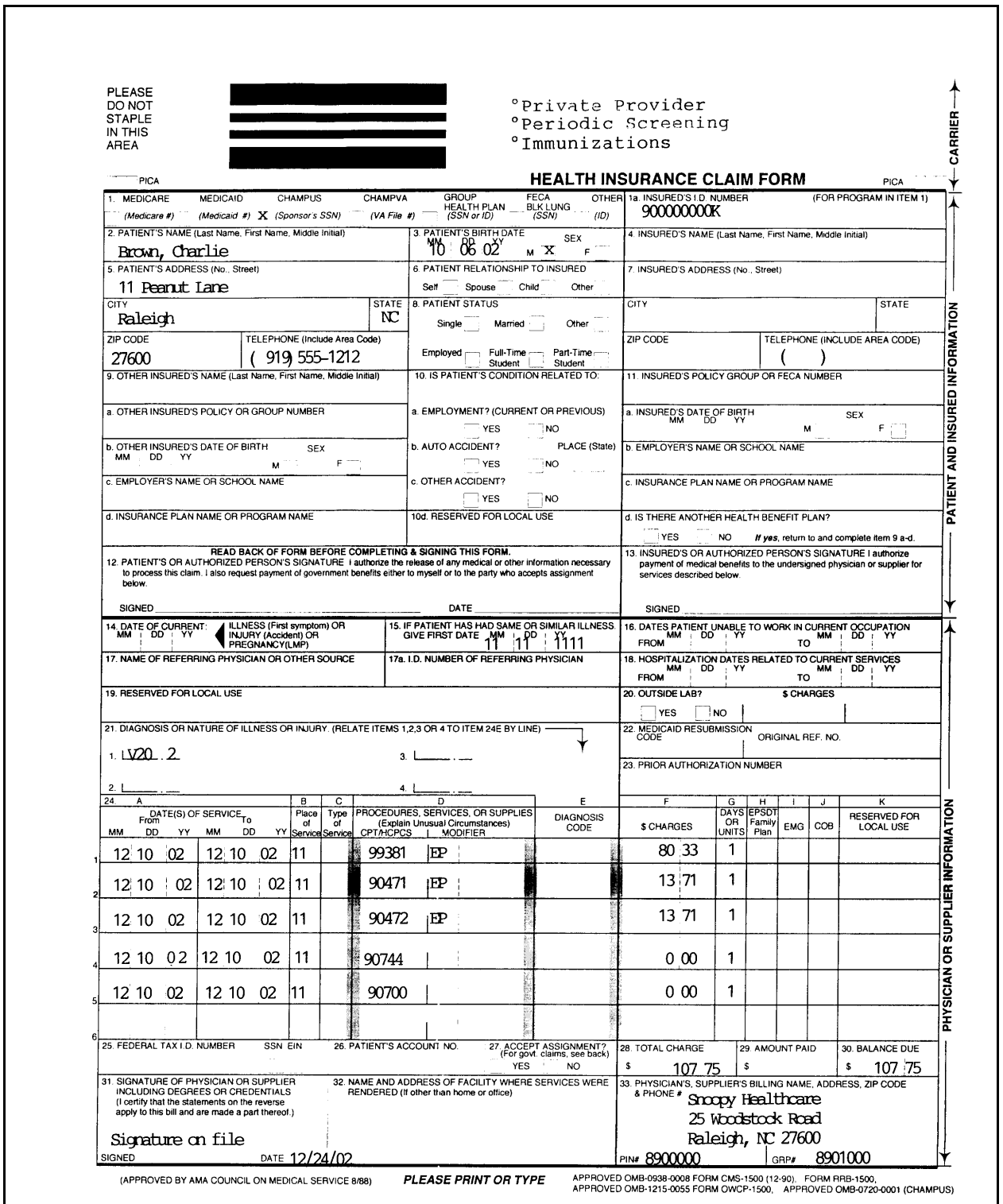
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Medicine Family Care
98 Carrot Street
Raleigh NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Immunizations

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000K

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brown, Charlie

3. PATIENT'S BIRTH DATE MM DD YY: 10 06 02 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street): 11 Peanut Lane

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Raleigh STATE: NC

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

CITY: STATE:

ZIP CODE: 27600 TELEPHONE (Include Area Code): ( 919) 555-1212

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

PATIENT AND INSURED INFORMATION

**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: 11 11 1111

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. LV20.2 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 12 10 02 | 12 10 02 | 11 | | 99381 | EP | | 80 33 | 1 | | | | |
| 2 12 10 02 | 12 10 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 3 12 10 02 | 12 10 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 4 12 10 02 | 12 10 02 | 11 | | 90744 | | | 0 00 | 1 | | | | |
| 5 12 10 02 | 12 10 02 | 11 | | 90700 | | | 0 00 | 1 | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 107 75

29. AMOUNT PAID $

30. BALANCE DUE $ 107 75

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 12/24/02

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

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

Snoopy Healthcare
25 Woodstock Road
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

°Private Providers
°Periodic Screening
°Vision and hearing
°Immunizations (see next claim)

°Paper billers only/split claim

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

| | |
|---|---|
| 1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) — X | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 910000000K |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bubble, Joey | 3. PATIENT'S BIRTH DATE MM DD YY: 08 01 97 SEX: M X F |
| 5. PATIENT'S ADDRESS (No., Street): 10 Bubblegum Road | 6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other |
| CITY: Raleigh STATE: NC | 8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student |
| ZIP CODE: 27600 TELEPHONE (Include Area Code): ( 919) 555-1212 | |
| 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? PLACE (State) YES NO |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE |

| | |
|---|---|
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 7. INSURED'S ADDRESS (No., Street) | |
| 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. | |

PATIENT AND INSURED INFORMATION

**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 PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY | |
| 19. RESERVED FOR LOCAL USE | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 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 Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 01 02 | 11 01 02 | 11 | | 99393 | EP | | 80 33 | 1 | | | | |
| 2 11 01 02 | 11 01 02 | 11 | | 99173 | | | 0 00 | 1 | | | | |
| 3 11 01 02 | 11 01 02 | 11 | | 92551 | | | 0 00 | 1 | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

| | | | |
|---|---|---|---|
| 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 12/10/02

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

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

Cherry Healthcare
2000 Hubba Bubba Lane
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Continued from previous claim

°Private Provider
°Immunizations only

°Paper billers only/split claim from previous page

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 910000000K

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bubble, Joey

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 97 — SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 10 Bubblegum Road

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Raleigh — STATE: NC

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

CITY: — STATE:

ZIP CODE: 27600 — TELEPHONE (Include Area Code): ( 919) 555-1212

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.

PATIENT AND INSURED INFORMATION

**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 — MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

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

1. V04.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 01 02 | 11 01 02 | 11 | | 90471 | EP | | 1371 | 1 | | | | |
| 2 11 01 02 | 11 01 02 | 11 | | 90472 | EP | | 1371 | 1 | | | | |
| 3 11 01 02 | 11 01 02 | 11 | | 90713 | | | 000 | 1 | | | | |
| 4 11 01 02 | 11 01 02 | 11 | | 90700 | | | 000 | 1 | | | | |
| 5 11 01 02 | 11 01 02 | 11 | | 90707 | | | 000 | 1 | | | | |
| 6 | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

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 $ 27 42

29. AMOUNT PAID $

30. BALANCE DUE $ 27 42

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 12/10/02

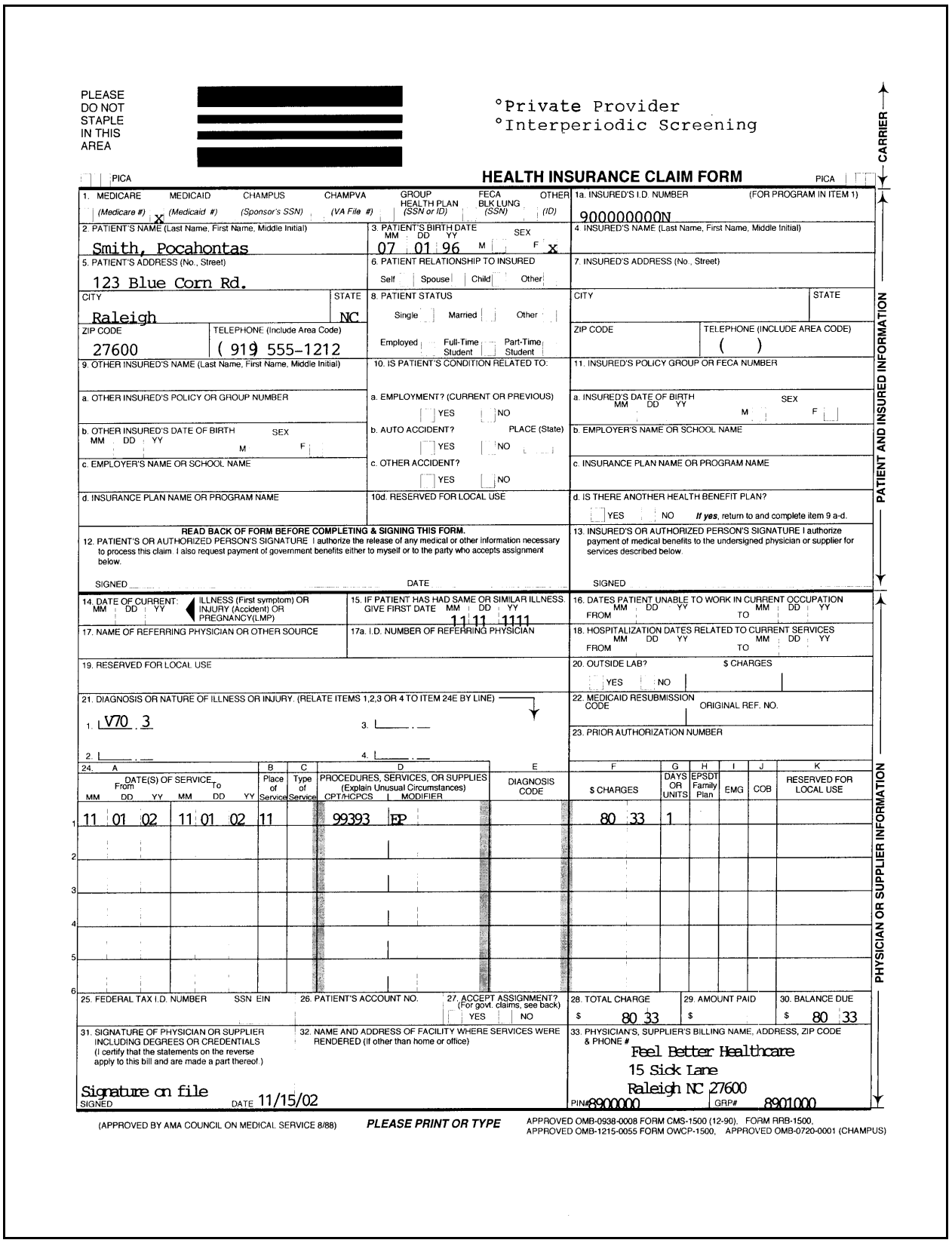
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Cherry Health Care
2000 Hubba Bubba Lane
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Interperiodic Screening

CARRIER

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000N

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Pocahontas

3. PATIENT'S BIRTH DATE (MM DD YY): 07 01 96 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Blue Corn Rd.

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

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

CITY: Raleigh STATE: NC

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

CITY: STATE:

ZIP CODE: 27600 TELEPHONE (Include Area Code): ( 919) 555-1212

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): 11 11 1111

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. V70.3
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A DATE(S) OF SERVICE From (MM DD YY) To (MM DD YY) | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 01 02 11 01 02 | 11 | | 99393 | EP | | 80 33 | 1 | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 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 11/15/02

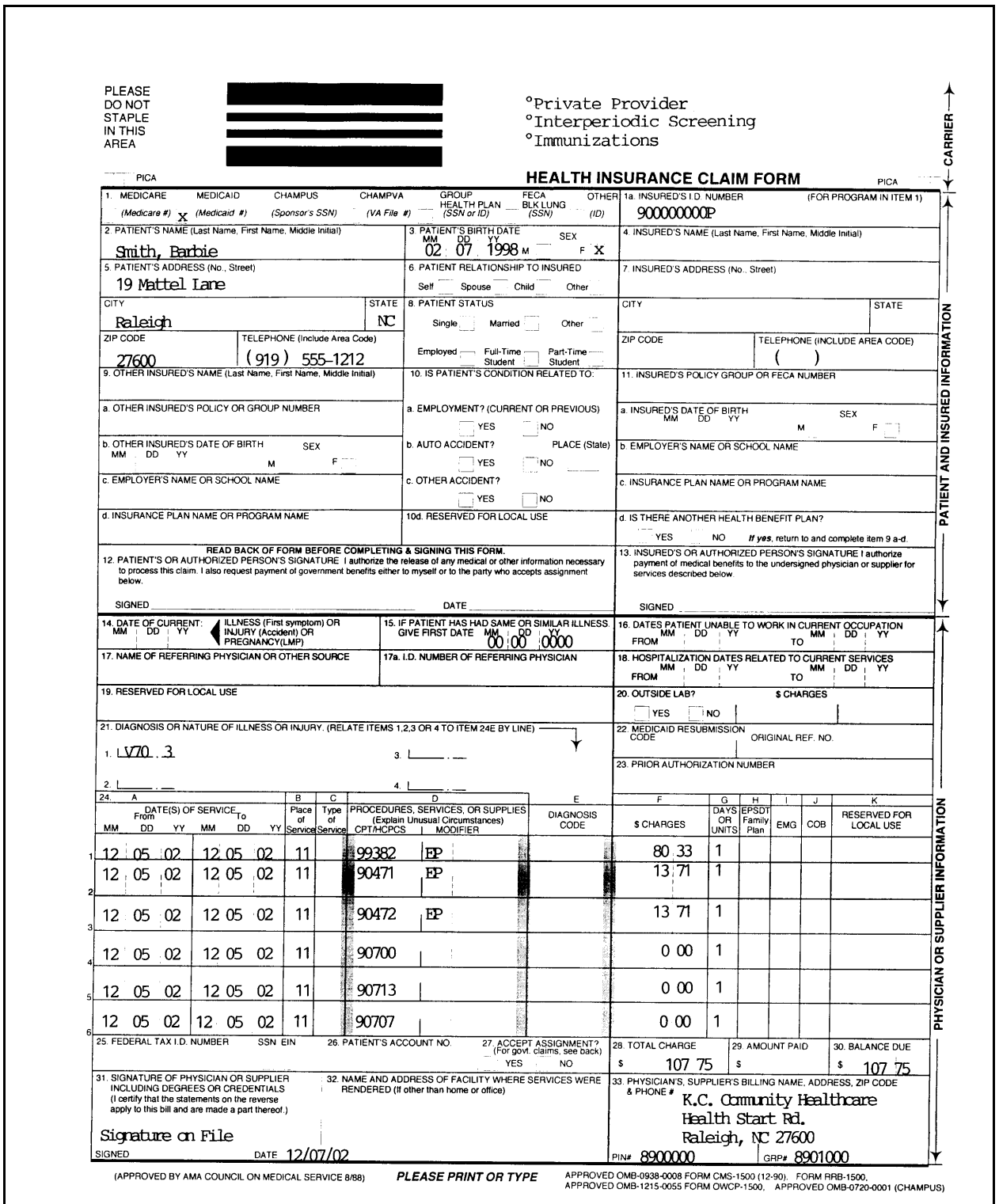
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Feel Better Healthcare
15 Sick Lane
Raleigh NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Interperiodic Screening
°Immunizations

CARRIER

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000P

| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY / SEX | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
|---|---|---|
| Smith, Barbie | 02 07 1998 M F X | |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS (No., Street) |
| 19 Mattel Lane | Self Spouse Child Other | |
| CITY / STATE | 8. PATIENT STATUS | CITY / STATE |
| Raleigh NC | Single Married Other | |
| ZIP CODE / TELEPHONE (Include Area Code) | Employed Full-Time Student Part-Time Student | ZIP CODE / TELEPHONE (INCLUDE AREA CODE) |
| 27600 (919) 555-1212 | | ( ) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F | b. AUTO ACCIDENT? PLACE (State) YES NO | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d. |

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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

SIGNED _____ DATE _____

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

SIGNED _____

| 14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
|---|---|---|
| | 00 00 0000 | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? YES NO / $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | 22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. |
| 1. V70.3 3. | | 23. PRIOR AUTHORIZATION NUMBER |
| 2. 4. | | |

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 12 05 02 | 12 05 02 | 11 | | 99382 | EP | | 80 33 | 1 | | | | |
| 2 12 05 02 | 12 05 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 3 12 05 02 | 12 05 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 4 12 05 02 | 12 05 02 | 11 | | 90700 | | | 0 00 | 1 | | | | |
| 5 12 05 02 | 12 05 02 | 11 | | 90713 | | | 0 00 | 1 | | | | |
| 6 12 05 02 | 12 05 02 | 11 | | 90707 | | | 0 00 | 1 | | | | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. BALANCE DUE |
|---|---|---|---|---|---|
| | | | $ 107 75 | $ | $ 107 75 |

| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # |
|---|---|---|
| Signature on File | | K.C. Community Healthcare<br>Health Start Rd.<br>Raleigh, NC 27600 |
| SIGNED DATE 12/07/02 | | PIN# 8900000 GRP# 8901000 |

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

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Immunizations only

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000J

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Barkley, Charles

3. PATIENT'S BIRTH DATE MM DD YY: 09 06 2002 | SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 22 Basketball Court

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

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

CITY: Raleigh | STATE: NC

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

CITY | STATE

ZIP CODE: 27600 | TELEPHONE (Include Area Code): (919 ) 555-1212

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO | $ CHARGES

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

1. V04.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24 A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11 22 02 | 11 22 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 2 | 11 22 02 | 11 22 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 3 | 11 22 02 | 11 22 02 | 11 | | 90700 | | | 0 00 | 1 | | | | |
| 4 | 11 22 02 | 11 22 02 | 11 | | 90713 | | | 0 00 | 1 | | | | |
| 5 | 11 22 02 | 11 22 02 | 11 | | 90744 | | | 0 00 | 1 | | | | |
| 6 | 11 22 02 | 11 22 02 | 11 | | 90647 | | | 0 00 | 1 | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 27 42

29. AMOUNT PAID: $

30. BALANCE DUE: $ 27 42

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 11/24/02

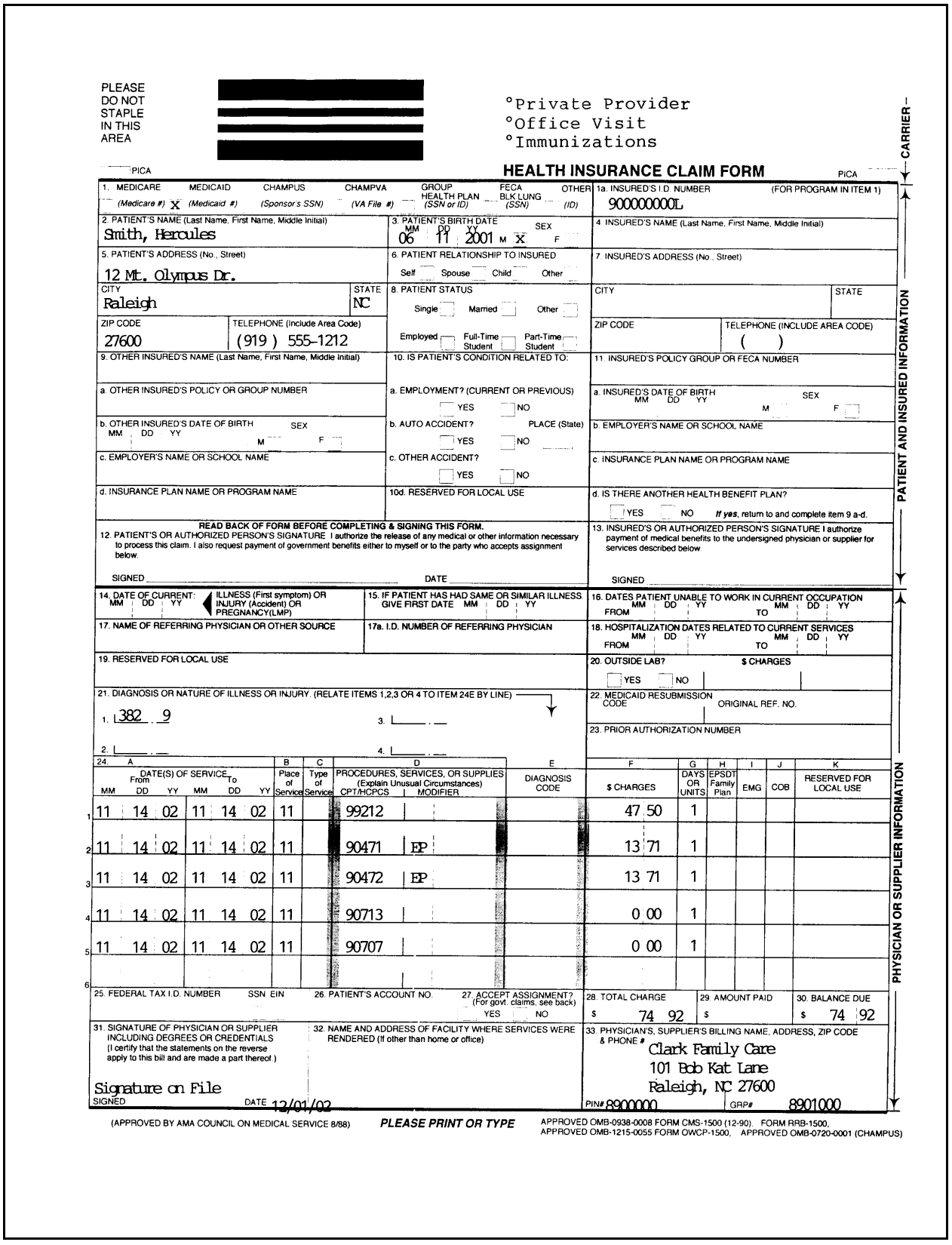
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Strickland Pediatrics
21 Fortune Drive
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Office Visit
°Immunizations

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000L

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Hercules

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 2001 | SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 12 Mt. Olympus Dr.

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

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

CITY: Raleigh | STATE: NC

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

CITY | STATE

ZIP CODE: 27600 | TELEPHONE (Include Area Code): (919) 555-1212

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.

PATIENT AND INSURED INFORMATION

**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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. 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 Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11 14 02 \| 11 14 02 | 11 | | 99212 | | | 47 50 | 1 | | | | |
| 2 | 11 14 02 \| 11 14 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 3 | 11 14 02 \| 11 14 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 4 | 11 14 02 \| 11 14 02 | 11 | | 90713 | | | 0 00 | 1 | | | | |
| 5 | 11 14 02 \| 11 14 02 | 11 | | 90707 | | | 0 00 | 1 | | | | |
| 6 | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

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 $ 74 92

29. AMOUNT PAID $

30. BALANCE DUE $ 74 92

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 12/01/02

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

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

Clark Family Care
101 Bob Kat Lane
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

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

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Periodic Screening
°Vision and hearing
°Referral Indicator

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. MEDICARE (Medicare #) | MEDICAID X (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) | | |
| | | | | | | | 900000000L | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | 3. PATIENT'S BIRTH DATE MM DD YY | SEX M | F X | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | |
| Temple, Shirley | | | 07 01 1997 | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | 6. PATIENT RELATIONSHIP TO INSURED | | | | 7. INSURED'S ADDRESS (No., Street) | | |
| 46 Lollipop Lane | | | Self | Spouse | Child | Other | | | |
| CITY | | STATE | 8. PATIENT STATUS | | | | CITY | | STATE |
| Raleigh | | NC | Single | Married | Other | | | | |
| ZIP CODE | TELEPHONE (Include Area Code) | | Employed | Full-Time Student | Part-Time Student | | ZIP CODE | TELEPHONE (INCLUDE AREA CODE) | |
| 27600 | (919) 555-1212 | | | | | | | ( ) | |
| 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) | | | | a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F | b. AUTO ACCIDENT? | | PLACE (State) | | b. EMPLOYER'S NAME OR SCHOOL NAME | | |
| | | | YES | NO | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | c. OTHER ACCIDENT? | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | |
| | | | YES | NO | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | 10d. RESERVED FOR LOCAL USE | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | | |
| | | | | | | | YES NO *If yes*, 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 _____

PATIENT AND INSURED INFORMATION

| | | |
|---|---|---|
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. |
| 1. L V20.2 3. L 034.0 | | 23. PRIOR AUTHORIZATION NUMBER |
| 2. L 382.9 4. L 460. | | |

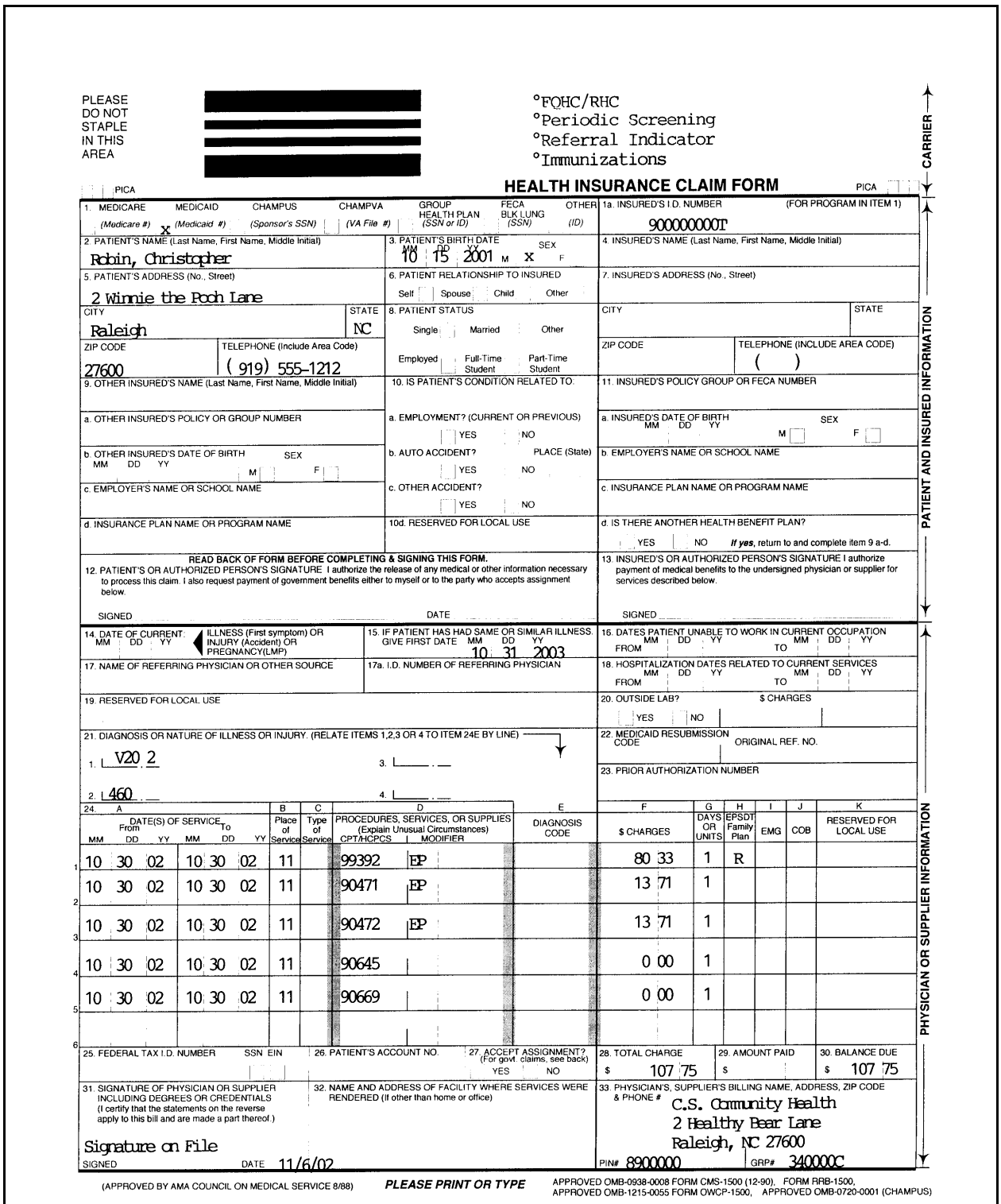
| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 10 11 02 | 10 11 02 | 11 | | 99383 | EP | | 80 33 | 1 | R | | | |
| 2 10 11 02 | 10 11 02 | 11 | | 99173 | | | 0 00 | 1 | | | | |
| 3 10 11 02 | 10 11 02 | 11 | | 92551 | | | 0 00 | 1 | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ 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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # |
|---|---|---|
| Signature on File SIGNED DATE 11/12/02 | | Saunders Pediatrics 24 Healthy Circle Raleigh, NC 27600 PIN# 8900000 GRP# 340000C |

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Periodic Screening
°Referral Indicator
°Immunizations

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

PATIENT AND INSURED INFORMATION

| | | |
|---|---|---|
| 1. MEDICARE (Medicare #) MEDICAID (Medicaid #) X CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) | | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 900000000T |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Robin, Christopher | 3. PATIENT'S BIRTH DATE MM DD YY 10 15 2001 SEX M X F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) 2 Winnie the Pooh Lane | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street) |
| CITY Raleigh STATE NC | 8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student | CITY STATE |
| ZIP CODE 27600 TELEPHONE (Include Area Code) ( 919) 555-1212 | | ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( ) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | b. AUTO ACCIDENT? PLACE (State) YES NO | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d. |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED |

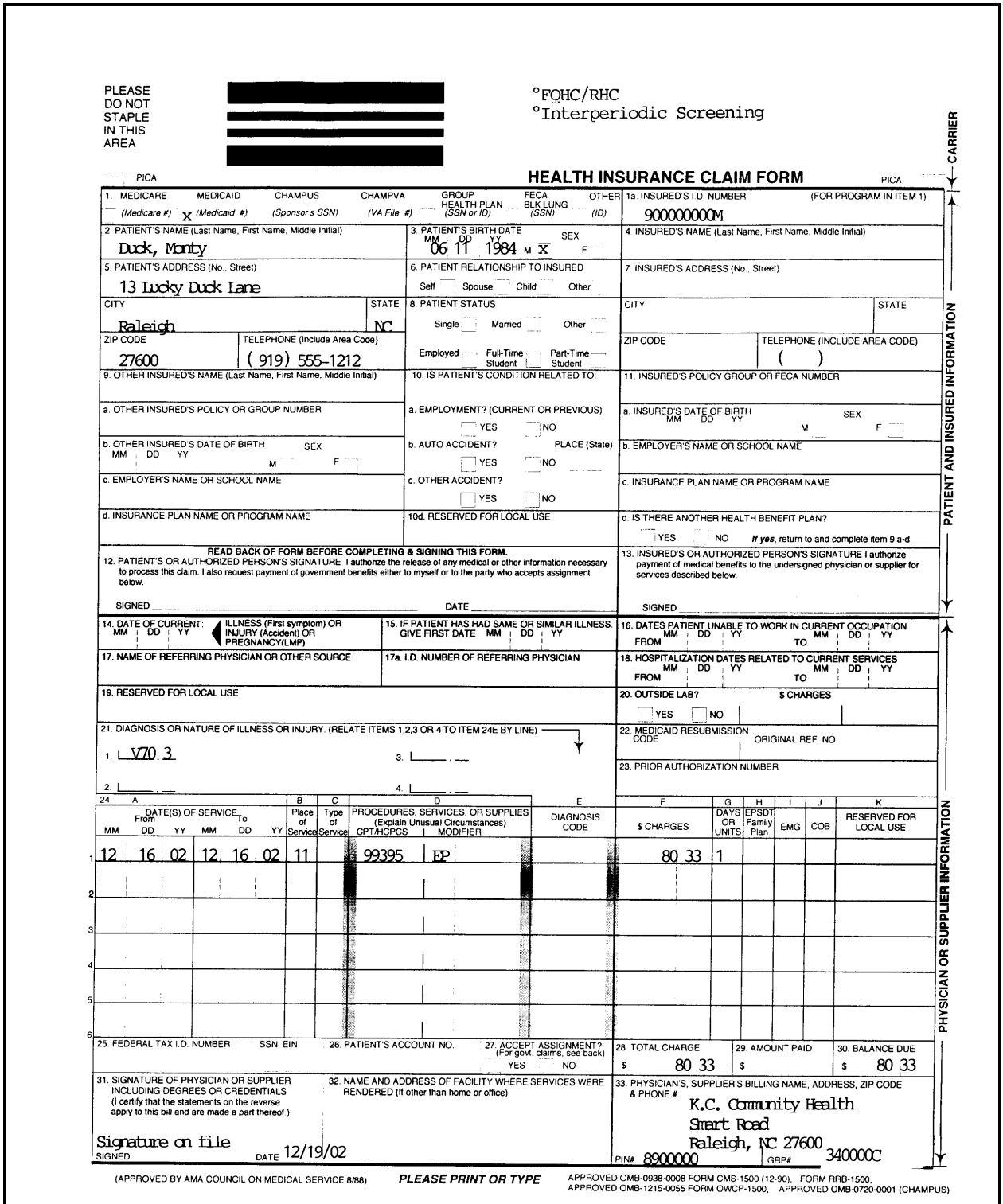
PHYSICIAN OR SUPPLIER INFORMATION

| | | |
|---|---|---|
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 10 31 2003 | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V20.2 2. 460. 3. . 4. . | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER |

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 10 30 02 | 10 30 02 | 11 | | 99392 | EP | | 80 33 | 1 | R | | | |
| 2 10 30 02 | 10 30 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 3 10 30 02 | 10 30 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 4 10 30 02 | 10 30 02 | 11 | | 90645 | | | 0 00 | 1 | | | | |
| 5 10 30 02 | 10 30 02 | 11 | | 90669 | | | 0 00 | 1 | | | | |
| 6 | | | | | | | | | | | | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ 107 75 | 29. AMOUNT PAID $ | 30. BALANCE DUE $ 107 75 |
|---|---|---|---|---|---|
| 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 11/6/02 | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # C.S. Community Health 2 Healthy Bear Lane Raleigh, NC 27600 PIN# 8900000 GRP# 340000C | | |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Interperiodic Screening

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Duck, Monty

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 1984 | SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 13 Lucky Duck Lane

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

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

CITY: Raleigh | STATE: NC

8. PATIENT STATUS: Single | Married | Other

CITY | STATE

ZIP CODE: 27600 | TELEPHONE (Include Area Code): ( 919) 555-1212

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 _____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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 Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 12 16 02 | 12 16 02 | 11 | | 99395 | EP | | 80 33 | 1 | | | | |
| 2 | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 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 12/19/02

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

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

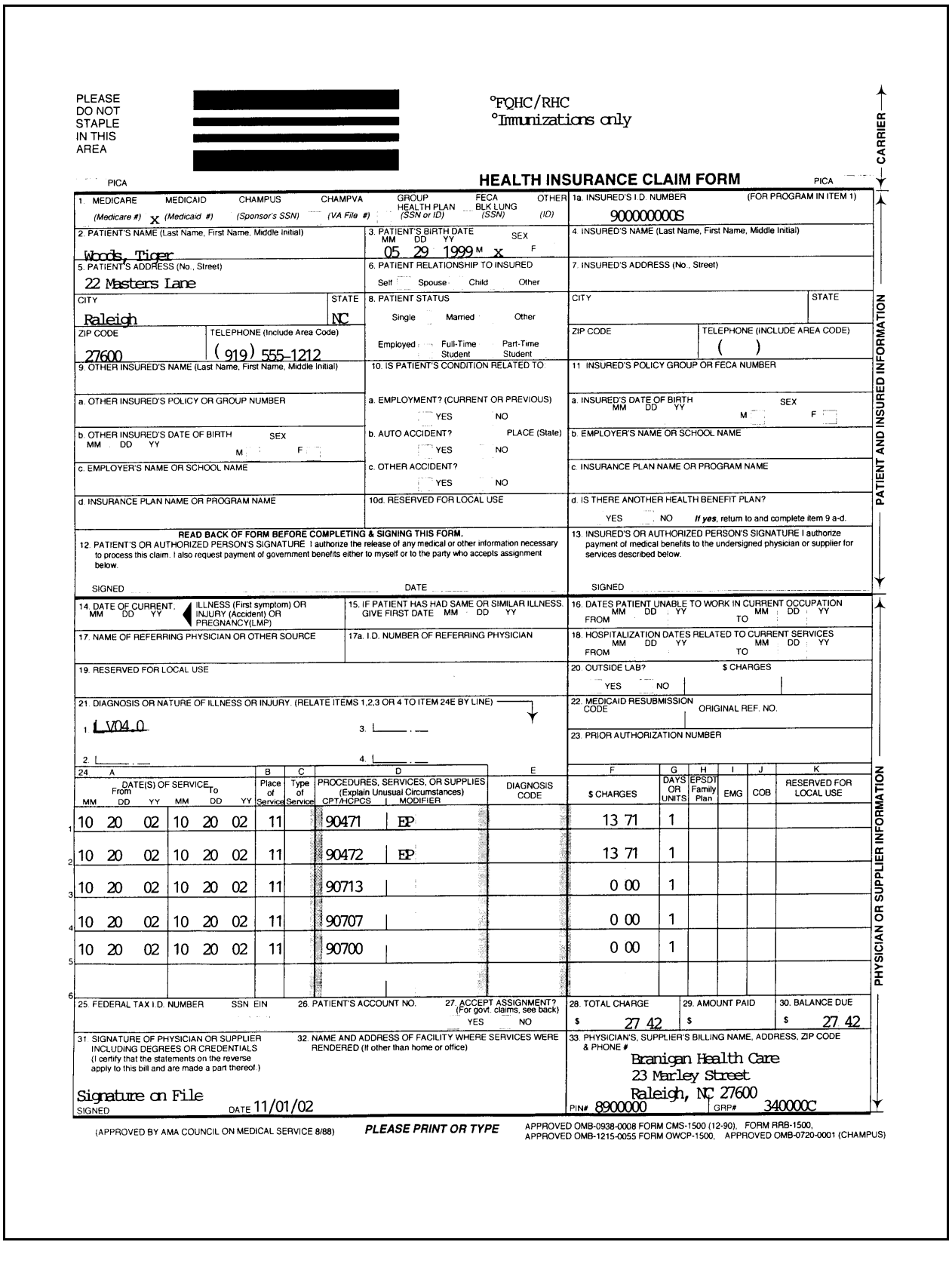
K.C. Community Health
Smart Road
Raleigh, NC 27600

PIN# 8900000 GRP# 340000C

PHYSICIAN OR SUPPLIER INFORMATION

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

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Immunizations only

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000S

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Woods, Tiger

3. PATIENT'S BIRTH DATE MM DD YY: 05 29 1999 | SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 22 Masters Lane

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

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

CITY: Raleigh | STATE: NC

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

CITY | STATE

ZIP CODE: 27600 | TELEPHONE (Include Area Code): (919) 555-1212

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.

PATIENT AND INSURED INFORMATION

**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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V04.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 10 20 02 | 10 20 02 | 11 | | 90471 | EP | | 13 71 | 1 | | | | |
| 2 10 20 02 | 10 20 02 | 11 | | 90472 | EP | | 13 71 | 1 | | | | |
| 3 10 20 02 | 10 20 02 | 11 | | 90713 | | | 0 00 | 1 | | | | |
| 4 10 20 02 | 10 20 02 | 11 | | 90707 | | | 0 00 | 1 | | | | |
| 5 10 20 02 | 10 20 02 | 11 | | 90700 | | | 0 00 | 1 | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 27 42

29. AMOUNT PAID $

30. BALANCE DUE $ 27 42

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 11/01/02

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

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

Branigan Health Care
23 Marley Street
Raleigh, NC 27600

PIN# 8900000 GRP# 340000C

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

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Core visit
°Immunizations

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

| | | |
|---|---|---|
| 1. MEDICARE (Medicare #) MEDICAID (Medicaid #) X CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) | | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 900000000F |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Menace, Dennis | 3. PATIENT'S BIRTH DATE MM DD YY 12 05 2000 SEX M X F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) 16 Pester Lane | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street) |
| CITY Raleigh STATE NC | 8. PATIENT STATUS Single Married Other | CITY STATE |
| ZIP CODE 27600 TELEPHONE (Include Area Code) ( 919) 555-1212 | Employed Full-Time Student Part-Time Student | ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( ) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | b. AUTO ACCIDENT? PLACE (State) YES NO | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d. |

PATIENT AND INSURED INFORMATION

**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 PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 382 9 2. 3. 4. | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER |

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 10 20 02 10 20 02 | 11 | | T1015 | | | 65 00 | 1 | | | | |
| 2 10 20 02 10 20 02 | 11 | | 90700 | | | 0 00 | 1 | | | | |
| 3 10 20 02 10 20 02 | 11 | | 90707 | | | 0 00 | 1 | | | | |
| 4 10 20 02 10 20 02 | 11 | | 90645 | | | 0 00 | 1 | | | | |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |

| | | |
|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO |
| 28. TOTAL CHARGE $ 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 10/25/02

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

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

C.S. Community Health
12 Smart Road
Raleigh, NC 27600

PIN# 8900000 GRP# 340000A

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

## SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN (OPTION 65) FOR LOCAL HEALTH DEPARTMENT'S THAT USE THE NC HEALTH SERVICES INFORMATION SYSTEM (HSIS)

**Example #1 - Health Check Periodic Screening for a 1 month old child and two immunizations.**

```
NEXT RECORD:  COUNTY 999    SCREEN 65     ID 222222222     DATE 121002    ACTION A
MESSAGE:

NAME: Brown, Charlie                                          POST-OP FROM DT: _____
SERVICE GROUP:                                                      THRU DT: _____
DIAG CODES A: V20.2  B:          C:          D:          E:          F:          G:
              H:          I:          J:          K:          HLTH CHK/EPSDT REFERRAL:_

 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  90471    EP __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  90472    EP __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  90744    __ __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  90700    __ __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
```

**Example #2 – Health Check Periodic Screening for an 18 year old with an additional procedure, plus Vision and Hearing Screenings. Diagnosis warrants a referral for a followup visit, designated with a "R" entered in the HLTH CHK/EPSDT REFERRAL data field.**

```
NEXT RECORD:  COUNTY 999    SCREEN 65     ID 333333333     DATE 120902    ACTION A
MESSAGE:

NAME: Patty, Peppermint                                       POST-OP FROM DT: _____
SERVICE GROUP:                                                      THRU DT: _____
DIAG CODES A: V20.2  B: 460.__ C:          D:          E:          F:          G:
              H:          I:          J:          K:          HLTH CHK/EPSDT REFERRAL: R

 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 __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 B  CH  87081    __ __ __  B _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  99173    __ __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  92551    __ __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
```

**Example #3 - Health Check Interperiodic Screening for a child age 4 with two immunizations.**

```
NEXT RECORD:  COUNTY 999    SCREEN 65     ID 444444444     DATE 120902    ACTION A
MESSAGE:

NAME: Smith, Barbie                                           POST-OP FROM DT: _____
SERVICE GROUP:                                                      THRU DT: _____
DIAG CODES A: V70.3_ B:          C:          D:          E:          F:          G:
              H:          I:          J:          K:          HLTH CHK/EPSDT REFERRAL:_

 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  90471    EP __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  90472    EP __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  90645    __ __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
 R  CH  90658    __ __ __  A _ _ _    ROS__ 01    71       _____  __   _____ _    99999
```

**Local Health Departments using HSIS – Continued**

**Example #4 – Health Check Periodic Screening and immunizations for child age 1 with referral/followup indicator.**

```
NEXT RECORD:  COUNTY 999     SCREEN 65     ID 444444444     DATE 120902  ACTION A
MESSAGE:

NAME:  Robin, Christopher                                  POST-OP FROM DT: _______
SERVICE GROUP:                                                    THRU DT: _______
DIAG CODES A: V20.2_ B: 460.__ C:         D:         E:         F:         G:
           H:         I:         J:         K:         HLTH CHK/EPSDT REFERRAL: R

 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   90471   EP __ __  A _ _ _   ROS__  01    71    _____  __   _____  _   99999
 R  CH   90472   EP __ __  A _ _ _   ROS__  01    71    _____  __   _____  _   99999
 R  CH   90645   __ __ __  A _ _ _   ROS__  01    71    _____  __   _____  _   99999
 R  CH   90669   __ __ __  A _ _ _   ROS__  01    71    _____  __   _____  _   99999
```

**Example #5 – Immunization Administration fee ONLY for child age 3.**

```
NEXT RECORD:  COUNTY 999     SCREEN 65     ID 555555555     DATE 112202  ACTION A
MESSAGE

NAME: Barkley, Charles                                     POST-OP FROM DT: _______
SERVICE GROUP:                                                    THRU DT: _______
DIAG CODES A: V06.8_  B:         C:         D          E:         F:         G:
           H:         I:         J:         K:          HLTH CHK/EPSDT REFERRAL:_

 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 _ _ _   NURSE 01    71    _____  __   _____  _   99999
 R  IM   90472   EP __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
 R  IM   90700   __ __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
 R  IM   90713   __ __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
 R  IM   90744   __ __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
 R  IM   90647   __ __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
```

**Example #6 – Office Visit with one immunization for a child age 2.**

```
NEXT RECORD:  COUNTY 999     SCREEN 65     ID 666666666     DATE 111402  ACTION A
MESSAGE

NAME: Smith, Hercules                                      POST-OP FROM DT: _______
SERVICE GROUP:                                                    THRU DT: _______
DIAG CODES A: 382.9_  B: ___.__ C: ___.__ D: ___.__ E:         F:         G:
           H:         I:         J:         K:         HLTH CHK/EPSDT REFERRAL:_

 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 _ _ _   PHY   01    71    _____  __   _____  _   99999
 B  CH   90471   EP __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
 R  CH   90716   __ __ __  A _ _ _   NURSE 01    71    _____  __   _____  _   99999
```

# TIPS FOR DECREASING DENIALS

| 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 ID (MID) number, 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 Remittance and Status Report to the DMA Claims Analysis Unit, 2519 Mail Service Center, Raleigh, NC 27699-2519. |
| 024 | Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill detail as a new claim. | Verify procedure code, modifier and/or procedure code/modifier combination is valid according to the billing guidelines on pages 9 and 10. Correct claim and resubmit. |
| 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 screening according to the billing guidelines on page 9. Correct claim and resubmit. |
| 349 | Health Check screening and related service not allowed same day, same provider or member of same group. Resubmit as an adjustment with documentation supporting related services. | Verify if related services billed on same or different claim as the Health Check screening are Health Check components. Health Check screening and related services will not be paid for same date of service initially. Resubmit as an adjustment with medical documentation supporting the need for related 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 program services. |
| 1035 | This EOB is for internal tracking of Health Check visits. To determine if claim paid or denied, look in the screening section of your RA. | This EOB is for reporting purposes only. To determine if the claim paid or denied, look under the screening section of the RA |
| 1036 | Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed. | Immunizations(s) are free through the UCVDP/VFC Program. |
| 1058 | The only well child exam billable through the Medicaid program is a Health Check screening. For information about billing Health Check, please call 1-800-688-6696. | Bill periodic screening with V20.2 and interperiodic screenings with V70.3. Check the preventive medicine code entered in block 24D of the claim form. |
| 1174 | Thanks for reporting vaccine to our database. This vaccine is available at no charge through the VFC program and therefore is not reimbursable through Medicaid. | No payment allowed. |

**Tips For Decreasing Denials,** continued

| EOB | Message | Tip |
|---|---|---|
| 1422 | Immunization administration not allowed without the appropriate immunization. Refer to the July 2002 Special Health Check 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. |
| 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 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 V250.9. |
| 1771 | All components were not rendered for this Health Check screening. | For periodic screenings, verify all required components, such as vision and or hearing assessments were performed and reported on the claim form. Make corrections and resubmit as a new day claim. |

# HEALTH CHECK BILLING WORKSHEET

The Health Check Billing Worksheet (see page 38) may be used in your practice to facilitate Health Check billing.

For additional billing questions please contact EDS at 1-800-688-6696 or 919-851-8888.

# HEALTH CHECK BILLING WORKSHEET

Date of Service _____

| Patient's Name | Next Screening Date (optional) |
|---|---|
| Medicaid ID number | Date of Birth |

| **Health Check Diagnosis Code** | | |
|---|---|---|
| Periodic Health Check Screening | Periodic Health Check Screening V20.2 | |
| Interperiodic Health Check Screening | Interperiodic Health Check Screening V70.3 | |

| **Health Check Screening Code** | | | |
|---|---|---|---|
| **Description** | **Preventive Medicine Codes** | **Diagnosis Code** | ✓ |
| Regular Periodic Screening - Birth through 20 years | 99381-9985; 99391-99395 With EP Modifier | V20.2 | |
| Vision Assessment based on age | Vision Assessment CPT Code 99173 | | |
| Hearing Assessment based on age | Hearing Assessment CPT Code 92551 | | |
| Interperiodic Screening - Birth through 20 years | 99381-9985; 99391-99395 With EP Modifier | V70.3 | |

| **Second Diagnosis _____ (if applicable)** | | |
|---|---|---|
| **Description** | **Indicator** | ✓ |
| Follow-up with screening provider or another provider | R | |

| **Third Diagnosis _____ (if applicable)** | | |
|---|---|---|
| **Description** | **Indicator** | ✓ |
| Follow-up with screening provider or another provider | R | |

| **Fourth Diagnosis _____ (if applicable)** | | |
|---|---|---|
| **Description** | **Indicator** | ✓ |
| Follow-up with screening provider or another provider | R | |

| **Description** | **CPT Codes** | **Unit** | |
|---|---|---|---|
| Immunization Administration Fee | 90471 EP Modifier | One immunization | |
| Additional Immunization Administration Fee | 90472 EP Modifier | Additional immunizations | |

# IMMUNIZATION BILLING WORKSHEET*

| Code | Description | Diagnosis | VFC | Dose Given | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 90371 | Hepatitis B Immune Globulin | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90375 | Rabies Immune Globulin | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90376 | Rabies Immune Globulin – Heat treated (RIG-HT) | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90384 | Rho (D) Immune Globulin Full Dose | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90385 | Rho (D) Immune Globulin Mini Dose | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90389 | Tetanus Immune Globulin | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90396 | Varicella-Zoster Immune Globulin | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90585 | BCG | V03.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90632 | Hepatitis A Vaccine – Age 18 & up | V05.8 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90633 | Hepatitis A Vaccine – Age 2 & up | V05.8 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90645 | Hib – 4 dose (Brand name – Hib Titer) | V03.8 or V05.8 | VFC 2 mo – 5 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90646 | Hib – booster | V03.8 or V05.8 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90647 | Hib – 3 dose (Brand name – PedVax) | V03.8 or V05.8 | VFC 2 mo – 5 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90648 | Hib – 4 dose (Brand name – ActHib) | V03.8 or V05.8 | VFC 2 mo – 5 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90657 | Influenza (6-35 months of age) | V04.8 | VFC 6 mo – 35 mo | 1 | 2 | 3 | 4 | 5 | 6 |
| 90658 | Influenza (3 years and above) | V04.8 | VFC 3 yrs – 18 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90669 | Pneumococcal PCV7 (2-59 months) | V03.82 or V05.8 | VFC 2 mo – 59 mo | 1 | 2 | 3 | 4 | 5 | 6 |
| 90675 | Rabies – IM | V04.5 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90676 | Rabies Vaccine – Intradermal use | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90700 | DTaP | V06.8 | VFC 2 mo – 7 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90702 | DT | V06.8 | VFC 2 mo – 6 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90703 | Tetanus Toxoid | V03.7 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90704 | Mumps | V04.6 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90705 | Measles | V04.2 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90706 | Rubella | V04.3 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90707 | MMR | V06.4 | VFC 12 mo – 18 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90708 | MR | V06.8 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90709 | Rubella and Mumps | V06.8 | | | | | | | |
| 90713 | IPV (Injectable Polio Vaccine) | V04.0 | VFC 2 mo – 18 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90716 | Varicella | V05.4 | VFC 12 mo – 18 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90718 | Td | V06.5 | VFC 7 yrs – 18 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90719 | Diptheria Toxoid | V03.5 | | | | | | | |
| 90721 | DTaP/HIB | V06.8 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90725 | Cholera | V03.0 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90732 | Pneumococcal PPV23 (High Risk Only) | V03.82 or V05.8 | VFC 2 yrs – 18 yrs | | | | | | |
| 90733 | Meningococcal | V03.89 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90744 | Hepatitis B Vaccine – Pediatric/adol | V05.8 | VFC 0 through 18 yrs | 1 | 2 | 3 | 4 | 5 | 6 |
| 90746 | Hepatitis B Vaccine – Age 19 and above | V05.8 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90747 | Hepatitis B Vaccine - Dialysis Pt./immunosuppressed | 585 | | 1 | 2 | 3 | 4 | 5 | 6 |
| 90281 | Immune Globulin | V07.2 | | 1 | 2 | 3 | 4 | 5 | 6 |

*** This list is subject to change**.

Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services

Ricky Pope
Executive Director
EDS

e

**Presorted Standard**
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 300001
Raleigh, North Carolina 27622