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 **August 2001**

Attention:

All Health Check Providers

Health Check
Billing Guide
2001

TABLE OF CONTENTS

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

Effective with claims processed on or after September 1, 2001, several changes have been made to the Health Check Program. These changes are outlined in this Special Bulletin. Please replace the Health Check Billing Guide 2000 with this Special Bulletin. For your convenience, shading indicates new information.

HEALTH CHECK SCREENING COMPONENTS

The Health Check Program is a preventive 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 are required to 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 and hearing screenings**
  Visual assessment should be administered a minimum of two times in the first year of life, at 3 years of age, once between 4 and 5 years of age, and every three years thereafter.
  Hearing assessment should be administered a minimum of two times in the first year of life, annually until age 3, once between 4 and 5 years of age, and every three years thereafter.
- **Dental screening**
  Although an oral screening may be part of a physical examination, it is not a substitute for examination through direct referral to a dentist. A dental referral is required for every child beginning at 3 years of age. 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 - baby bottle caries - referral should 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 as indicated in the January 2001 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 1 and 9 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. Please contact your local WIC Program for required time frames.

Urinalysis
Urinalysis should be performed once at 5 years of age. To screen for infections, a dipstick leukocyte esterase test should be performed at least once between the ages of 11 and 21 (preferably at age 14) or more often as clinically indicated.

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 tuberculin screening is indicated. If none of the screening criteria listed on the following page are present, there is no recommendation for routine tuberculin screening.

The North Carolina Tuberculosis 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 tuberculin 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. Perform a **baseline screen** when these children/adolescents present for care:
   a. Foreign-born individuals arriving within the last five years from Asia, Africa, Caribbean, 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 homeless.

   c. Children/adolescents who are HIV-infected.

   d. Adolescents 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.

Lead Screening
Federal regulations state that all participating 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 can always perform a lead screening if 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.

Laboratory procedures, continued

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 three 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 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 - HCPCS Code W8010

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 a child is scheduled for a Health Check screening and an illness is detected, 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	18 months
2 months	2 years
4 months	3 years
6 months	4 years
12 months	5 years
15 months*	6 through 20 years of age (One screening every three years for children 6 years of age and older)

*** This screening may be performed at 9 months of age instead**

Interperiodic Screenings – HCPCS Code W8016

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

- 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.
- When children require either a kindergarten or sports physical **outside** the regular schedule.
- When children who'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.

In each of these circumstances, the screening provider must specify and document in the child's medical record the reason necessitating the interperiodic screening. These visits also require that all Health Check screening components be performed.

IMMUNIZATIONS

Immunization Administration Code W8012

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 immunizations are provided in addition to a Health Check screening or an office visit. The administration fee code (W8012) is reimbursed at $13.71 if one immunization is given or $27.42 if two or more are given. 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 below.

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 immunizations are provided in addition to a Health Check screening. Both are billed under the Medicaid provider number with the "C" suffix. 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 administration fee code is W8012 and is reimbursed at $13.71 if one immunization is given or $27.42 if two or more are given. For instructions on billing an immunization administration fee, refer to the chart below.

Local Health Department Providers
An immunization may not be billed if the immunization(s) is provided in addition to a Health Check screening. An immunization administration fee code (W8012) may be billed if an immunization is the only service provided that day or immunizations are provided in conjunction with an **office visit**. The administration fee code (W8012) 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 below.

Provider Type	Health Check Screening with Immunization(s)	Immunization(s) Only	Office Visit with Immunization(s)	Core Visit with Immunization(s)
Private Sector Providers	Bill W8012. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	Bill W8012. One immunization diagnosis code is required. Immunization procedure code(s) are required	Bill W8012. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.	N/A
FQHC/RHC Providers	Bill W8012. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	Bill W8012. One immunization diagnosis code is required. Immunization procedure code(s) are required.	N/A	Cannot bill W8012. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.
Local Health Department Providers	Cannot bill W8012. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	Bill W8012. One immunization diagnosis code is required. Immunization procedure code(s) are required.	Bill W8012. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.	N/A

Immunization procedure code(s) must be listed in block 24D of the HCFA-1500 claim form for all immunizations administered followed by the charges, if applicable.

Universal Childhood Vaccine Distribution Program/Vaccines for Children Program

The 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 VFC/UCVDP vaccines for children ages birth through 18. Exceptions to this are noted in the table below.

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 Hepatitis B vaccine purchased 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 HCFA-1500 claim form are the same as when billing for other medical services except for these four critical requirements. The four coding **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. **When a Health Check screening is performed**, **V20.2 is always the "primary diagnosis"** followed by other codes for new or existing diagnoses. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing the immunization administration (W8012) fee only.

Requirement 2: Identify and Record HCPCS Code

Use the correct Health Check screening HCPCS code in block 24D:

Regular Periodic Screening Birth through 20 years of age	**W8010***	**V20.2 (Primary Diagnosis)**
Interperiodic Screening Birth through 20 years of age	**W8016***	**V20.2 (Primary Diagnosis)**

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

Requirement 3: Identify and Code Diagnosis Modifier(s)

The diagnosis modifier is a **two-character** code to be listed in block 24D with the screening HCPCS code to describe the outcome of a Health Check screening. A diagnosis modifier is required for **each medical diagnosis** listed in block 21.

If V20.2 is the only diagnosis code, modifier 1N must be present in block 24D.

Do not list the 1N modifier for any additional medical diagnosis (with the exception of an immunization diagnosis) that is listed after V20.2. Decide the outcome of the diagnosis and choose the appropriate diagnosis modifier from the list below. The modifiers listed below indicate the outcome of each medical diagnosis used in addition to V20.2.

The following table should be used to determine which modifier to use:

Follow-up with screening provider	**XF**
Referred to another provider	**XO**
No follow-up necessary	**ZF**

Note: Diagnosis modifiers may be duplicated.

Refer to pages 15 through 25 for sample claims.

Requirement 4: 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 HCFA-1500 claim form.

Systematically Entered Next Screening Date

Providers have the following choices for block 15 of the HCFA-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. The only reason for a NSD denial is if the date entered is not in the correct format and, therefore, is not a valid date. For example, 12/54/1999 or 44/10/2000 are not valid dates and the claim will deny with EOB 621.

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 on the HCFA-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, providers will be checking claim status on two separate claims.

Private Sector Health Check Providers Only

- A Health Check screening and an office visit cannot be billed on the same claim form (different dates of service).
- 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 code W8012 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 code or an office visit code, an immunization diagnosis is not required in block 21 of the claim form. When billing W8012 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 procedure codes** when billing W8012. Refer to the chart on page 6 and the sample claim forms beginning on page 15.

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 code W8012 can be billed if it is provided in addition to a Health Check screening 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 W8012 as the only service for that day, an immunization diagnosis code is required to be entered in block 21 of the claim form. W8012 cannot be billed in conjunction with a core visit. For reporting purposes, list immunization procedure codes in the appropriate block on the claim form (refer to the sample claim on page 23). **Always list immunization procedure codes** when billing W8012. Refer to the chart on page 6 and the sample claim forms beginning on page 21.

HEALTH CHECK COORDINATORS

Specially trained 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 kinds of activities HCCs perform include, but are not limited to the following:

- assuring families use 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
- 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

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 62 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
Anson	Anson County Health Dept.	704-694-5188
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
Caldwell	Caldwell County Health Dept.	828-757-1200
Camden	Albemarle Regional Health Services	252-338-4400
Catawba	Catawba County Health Dept.	828-326-5801
Chatham	Chatham County Health Dept.	919-525-8214

Health Check Coordinator Contact List, continued

County	Agency	Telephone Number
Cherokee	Cherokee County Health Dept.	828-837-7486
Chowan	Albemarle Regional Health Services	252-338-4400
Clay	Clay County Health Services	828-389-8052
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
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
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
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
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
Nash	Nash County Health Dept.	252-459-9819
New Hanover	New Hanover County Health Dept.	910-343-6500

Health Check Coordinator Contact List, continued

County	Agency	Telephone Number
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
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
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
Vance	Vance County Health Dept.	252-492-7915
Wake	Wake County Human Services	919-212-7000
Warren	Warren County Health Dept.	252-257-1185
Wayne	Wayne County Health Dept.	919-731-1000
Wilkes	Wilkes County Health Dept.	336-651-7450
Wilson	Wilson Community Health Center	252-243-9800

HEALTH CHECK CLAIM FORM SAMPLES

There are eleven HCFA-1500 claim form samples and three examples of HSIS screens on the following pages. A copy of the back of the HCFA-1500 claim form precedes the first claim form 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 HCFA, 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.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Insert claim form here

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Private Providers
Regular Health Check Screening and Immunizations

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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): 900000000T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Menace, Dennis

3. PATIENT'S BIRTH DATE MM DD YY: 03 14 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: Chapel Hill STATE: NC

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

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (555) 555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 11 11 1111

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. ____.__
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 03 25 2001	03 25 2001	11	01	W8010	1N		78.91	1				
2 03 25 2001	03 25 2001	11	01	W8012			27.42	2				
3 03 25 2001	03 25 2001	11	01	90713			0.00	1				
4 03 25 2001	03 25 2001	11	01	90645			0.00	1				
5 03 25 2001	03 25 2001	11	01	90707			0.00	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 2235

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

28. TOTAL CHARGE: $ 106.33

29. AMOUNT PAID: $

30. BALANCE DUE: $ 106.33

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 3/25/01

SIGNED DATE

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

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

Betty Pediatrics
23 Mary Kay Lane
Raleigh, NC 55555

PIN# 7965432 GRP# 8902211

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Private Providers:
Regular Health Check Screening

PICA

HEALTH INSURANCE CLAIM FORM

1 MEDICARE (Medicare #) | 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)
900000000B

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)
Smith, Barbie

3. PATIENT'S BIRTH DATE MM DD YY: 01 11 1998 SEX M [ ] F [X]

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

5 PATIENT'S ADDRESS (No., Street)
191 Mattel Lane

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

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

CITY: Kenly | STATE: NC

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

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (555) 555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ... DATE ...

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

SIGNED

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

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

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 03 31 2001	03 31 2001	11	01	W8010	1N		78.91	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO. 22331

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

28. TOTAL CHARGE $ 78.91

29. AMOUNT PAID $

30. BALANCE DUE $ 78.91

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.)

SIGNED Signature on File DATE 4/2/01

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 Care
Health Start Road
Smithfield, NC 55555
PIN# 7923441 GRP# 8902623

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

Sample Claim for Private Providers
Regular Health Check Screening with Three (3) Sick Diagnoses
and Additional Procedure

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): 900000000J

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Temple, Shirley

3. PATIENT'S BIRTH DATE MM DD YY: 03 14 1999 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 4 Lollipop Lane

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

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

CITY: Durham STATE: NC

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

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (555)555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 03 18 2002

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. L382.9
3. L034.0
4. L460.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Clia #

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 03 24 2001	03 24 2001	11	01	W8010	XO XF XF		78.91	1				
2 03 24 2001	03 24 2001	11	01	87081			7.90	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 2235

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

28. TOTAL CHARGE: $ 86.81

29. AMOUNT PAID: $

30. BALANCE DUE: $ 86.81

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

Signature on file 3/24/01
SIGNED DATE

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

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

Saunders Pediatrics
24 Healthy Circle
Raleigh, NC 55555

PIN# 8932111 GRP# 8902221

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Private Provider
Billing for Immunization Administration Fee

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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): 900000000S

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 16 1996 SEX: M [X] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] 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: 55555 | TELEPHONE (Include Area Code): (555)555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING 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. V06.1
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 03 17 2001	03 17 2001	11	01	W8012			27.42	2				
2 03 17 2001	03 17 2001	11	01	90700			0.00	1				
3 03 17 2001	03 17 2001	11	01	90713			0.00	1				
4 03 17 2001	03 17 2001	11	01	90707			0.00	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.: 32144

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 3/17/2001
SIGNED DATE

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

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

Liz Pediatrics
23 Beach Lane
Raleigh, NC 55555

PIN# 7965432 GRP# 8902623

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Private Provider
Regular Office Visit with Immunizations

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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)

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

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 05 2000 SEX M ☐ F ☒

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: 55555 TELEPHONE (Include Area Code): (555) 555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

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

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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. L 382.9
2. L ____ . __
3. L ____ . __
4. L ____ . __

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 03 20 2001	03 20 2001	11	01	99212			50.00	1				
2 03 20 2001	03 20 2001	11	01	W8012			27.42	2				
3 03 20 2001	03 20 2001	11	01	90713			0.00	1				
4 03 20 2001	03 20 2001	11	01	90707			0.00	1				
5 03 20 2001	03 20 2001	11	01	90645			0.00	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

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

28. TOTAL CHARGE: $ 77.42

29. AMOUNT PAID: $

30. BALANCE DUE: $ 77.42

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 3/20/01
SIGNED DATE

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

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

CS Community Health Care
Healthy Start Road
Smithfield, NC 55555

PIN# 7923441 GRP# 8902621

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

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Private Providers
Interperiodic Health Check Screening

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): 900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Robin, Christopher

3. PATIENT'S BIRTH DATE MM DD YY: 04 20 1990 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: Riddle | STATE: NC

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

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (555)555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

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

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

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING 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.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 27 2001	03 27 2001	11	01	W8016	1N		78.91	1				

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.: 3311

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

28. TOTAL CHARGE $ 78.91

29. AMOUNT PAID $

30. BALANCE DUE $ 78.91

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.)

SignatureonFile 3/27/01
SIGNED DATE

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

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

Clark Family Care
101 Bobkat Lane
Camden, NC 55555

PIN# 8923546 GRP# 8902111

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claims for FQHC/RHC Providers
Regular Health Check Screening and Immunizations

HEALTH INSURANCE CLAIM FORM

PICA ☐☐ — 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)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Menace, Dennis

3. PATIENT'S BIRTH DATE MM DD YY: 03 14 2000 | SEX: M ☒ 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: Chapel Hill | STATE: NC

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

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (555)555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

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

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

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

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 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.
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
03 25 2001	03 25 2001	11	01	W8010	1N		78.91	1				
03 25 2001	03 25 2001	11	01	W8012			27.42	2				
03 25 2001	03 25 2001	11	01	90713			0.00	1				
03 25 2001	03 25 2001	11	01	90645			0.00	1				
03 25 2001	03 25 2001	11	01	90707			0.00	1				

25. FEDERAL TAX I.D. NUMBER | SSN EIN ☐☐

26. PATIENT'S ACCOUNT NO.: 22335

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

28. TOTAL CHARGE: $ 106.33

29. AMOUNT PAID: $

30. BALANCE DUE: $ 106.33

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.)

SignatureonFile 3/5/01
SIGNED DATE

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

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

C.S. Community Health
Healthy Start Road
Smithfield, NC 55555

PIN# 7923441 GRP# 344000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for FQHC/RHC Providers:
Regular Health Check Screening with Three (3) Sick Diagnoses

APPROVED OMB 0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Temple, Shirley

3. PATIENT'S BIRTH DATE (MM DD YY): 03 14 1999 SEX: M ☐ F X

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

5. PATIENT'S ADDRESS (No., Street): 46 Lollipop Lane

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

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

CITY: Durham | STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (555) 555-5555

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

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

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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. 382.9
3. 034.0
4. 460

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 03 24 2001	03 24 2001	11	01	W8010	XD XF XF		78.91	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 4444

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

28. TOTAL CHARGE: $ 78.91

29. AMOUNT PAID: $

30. BALANCE DUE: $ 78.91

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.)

SIGNED Signature on File 4/2/01

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 #

Saunders Pediatrics
24 Healthy Circle
Murphy, NC 27222

PIN# 8932111 GRP# 343000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claims for FQHC/RHC Providers
Billing for Immunization Administration Fee

HEALTH INSURANCE CLAIM FORM

PICA ☐☐ — 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)

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: 01 16 1997 SEX M ☒ 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: 55555 — TELEPHONE (Include Area Code): (555) 555-5555

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

PATIENT AND INSURED INFORMATION

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. V06.1 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
03 17 2001	03 17 2001	11	01	W8012			27.42	2				
03 17 2001	03 17 2001	11	01	90700			0.00	1				
03 17 2001	03 17 2001	11	01	90713			0.00	1				
03 17 2001	03 17 2001	11	01	90707			0.00	1				

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 32144

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.)

SIGNED Signature on File DATE 3/17/01

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 Healthcare
23 Marley Street
Mount Airy, NC 55555

PIN# 7965432 GRP# 344000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for FQHC/RHC Providers
Core Visit with Immunizations

HEALTH INSURANCE CLAIM FORM

PICA ☐ ☐ — 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)

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

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

3. PATIENT'S BIRTH DATE MM DD YY: 12 05 1999 SEX M ☒ F ☐

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

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

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

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

CITY: Durham — STATE: NC

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

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (555) 555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

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

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

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING 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 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
03 20 2001	03 20 2001	11	01	Y2058			65.00	1				
03 20 2001	03 20 2001	11	01	90700			0.00	1				
03 20 2001	03 20 2001	11	01	90707			0.00	1				
03 20 2001	03 20 2001	11	01	90645			0.00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 12345

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

28. TOTAL CHARGE: $ 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.)

SIGNED Signature on File DATE 3/20/01

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
Smart Road
Smithfield, NC 55555

PIN# 7923441 GRP# 343000A

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for FQHC/RHC Providers:
Interperiodic Health Check Screening

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

3. PATIENT'S BIRTH DATE (MM DD YY): 04 20 1990 | 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: Puddle | STATE: NC

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

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (555) 555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO

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

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

b. AUTO ACCIDENT? YES | NO | PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: | DATE:

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

SIGNED:

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

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

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

17. NAME OF REFERRING 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.
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	03 27 2001 | 03 27 2001	11	01	W8016	1N		78.91	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: SSN | EIN

26. PATIENT'S ACCOUNT NO.: 3311

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

28. TOTAL CHARGE: $ 78.91

29. AMOUNT PAID: $

30. BALANCE DUE: $ 78.91

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.)

SIGNED: Signature on File DATE: 4/26/01

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
Durham, NC 55555

PIN# 8922111 | GRP# 343000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN (OPTION 65) FOR LOCAL HEALTH DEPARTMENTS THAT USE THE N.C. HEALTH SERVICES INFORMATION SYSTEM (HSIS)

Example #1 - Health Check Periodic Screen with Immunizations

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID 555555555    DATE 081501   ACTION A
MESSAGE:

NAME: Smith, Hercules  A                                  POST-OP FROM DT: ______
SERVICE GROUP:                                                    THRU DT: ______
DIAG CODES A: V20 2  B: V06 8  C: V06 4  D: V05 8  E:        F:        G:
           H:        I:        J:        K:        L:        M:        N:
 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  W8010  1N __ __  A _ _ _  ROS__  01   71  _____  03  _____  _   99999
 R  IM  90700  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90707  __ __ __  C _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  IM  90644  __ __ __  D _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example # 2 - Immunization Administation Fee and Immunizations

```
NEXT RECORD:  COUNTY 999    SCREEN 65    ID 555555555    DATE 081701   ACTION A
MESSAGE:

NAME: Robin, Christopher A                                POST-OP FROM DT: ______
SERVICE GROUP:                                                    THRU DT: ______
DIAG CODES A: V06 1  B: V06 8  C: V04 0  D:        E:        F:        G:
           H:        I:        J:        K:        L:        M:        N:
 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  W8012  __ __ __  A _ _ _  NURSE  01   71  _____  03  _____  _   99999
 R  IM  90700  __ __ __  B _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  IM  90713  __ __ __  C _ _ _  NURSE  01   71  _____  __  _____  _   99999
```

Example # 3 - Office Visit with Immunizations

```
NEXT RECORD:  COUNTY 999    SCREEN 65    ID 555555555    DATE 080101   ACTION A
MESSAGE

NAME: Who, Horton H.                                      POST-OP FROM DT: ______
SERVICE GROUP:                                                    THRU DT: ______
DIAG CODES A:493 02  B: V06 1  C: V06 5  D: V05 8  E:        F:        G:
           H:        I:        J:        K:        L:        M:        N:
 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  99203  __ __ __  A _ _ _  PHY__  01   71  _____  __  _____  _   99999
 B  IM  W8012  __ __ __  B _ _ _  NURSE  01   71  _____  03  _____  _   99999
 R  IM  90718  __ __ __  C _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  IM  90744  __ __ __  D _ _ _  NURSE  01   71  _____  __  _____  _   99999
```

TIPS FOR DECREASING DENIALS

EOB	Message	Tip
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 whether related services billed on same or different claim as the Health Check screening were 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.
621	Date of next Health Check Screening missing, invalid or not required MM/DD/CCYY format in block 15 of HCFA-1500 claim form.	Make sure the date is in correct MM/DD/CCYY format and is a valid date. An invalid date would be a month or day where the number is above 12 or 31, respectively. If block 15 of the HCFA-1500 is left blank, or contains all zeros or ones, a system generated next screening date will be automatically entered.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient's age. Only recipients ages birth through 20 years of age are eligible for Health Check program services.
734	V20.2 must be primary diagnosis for Health Check Screening visit.	Diagnosis code V20.2 must be the primary diagnosis code for all Health Check screening. Enter V20.2 in block 21; item 1 of the HCFA-1500 claim form.
735	Diagnosis modifier missing or invalid for diagnosis code(s). Health Check visit requires each listed diagnosis to have a corresponding modifier in block 24D. V20.2 must be primary DX.	Each diagnosis code must have a corresponding diagnosis modifier with the screening HCPCS code. Refer to the list of diagnosis modifiers on page 8 for the appropriate modifiers.
760	Only one diagnosis modifier allowed in block 24D per diagnosis code. 1N is not allowed in conjunction with another diagnosis modifier such as ZF, etc.	Each **diagnosis** code must have only one **diagnosis** modifier. • For paper billers, if there are more modifiers than will fit in the modifier column of block 24D, continue on the next line. **DO NOT** repeat the date of service, place of service, type of service, or procedure code information on this line. • If all findings are normal, modifier 1N must be appended to the screening code. • Modifier 1N cannot be used in combination with another diagnosis modifier such as ZF on the same screening code. All non-immunization diagnoses must have diagnosis modifiers.

TIPS FOR DECREASING DENIALS, continued

EOB	Message	Tip
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 VFC Program.
1037	Thank you for reporting vaccines. The vaccine is not available through VFC Program. Refile if you purchased vaccine.	Immunization(s) billed is not available through the free vaccine program. If immunization was billed in error, resubmit corrected claim as an adjustment.
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.	V20.2 may only be billed with W8010 for regular screenings and W8016 for interperiodic screenings. Check the HCPCS 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.

HEALTH CHECK BILLING WORKSHEET

The Health Check Billing Worksheet (see page 29) has been updated to reflect the above changes in billing a Health Check screening.

If you have any 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 Screening Code			
Description	**HCPCS Code**	**Diagnosis Code**	
Regular Periodic Screening - Birth through 20 years	W8010	V20.2	
Interperiodic Screening - Birth through 20 years	W8016	V20.2	

Primary Diagnosis			
V20.2	**All Findings Normal**	**Modifier** 1N	

Second Diagnosis _____ (if applicable)		
Description	**Mod**	
Follow-up with screening provider	XF	
Referred to another provider	XO	
No follow-up necessary	ZF	

Third Diagnosis _____ (if applicable)		
Description	**Mod**	
Follow-up with screening provider	XF	
Referred to another provider	XO	
No follow-up necessary	ZF	

Fourth Diagnosis _____ (if applicable)		
Description	**Mod**	
Follow-up with screening provider	XF	
Referred to another provider	XO	
No follow-up necessary	ZF	

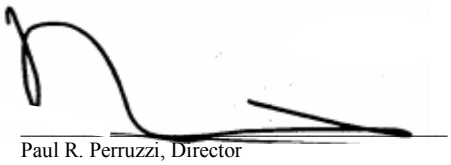
Description	**HCPCS Code**	**Unit(s)***	
Immunization Administration Fee	W8012*	One immunization given	
		Two or more immunization given	

***Health Departments can only bill one unit with HCPC Code W8012**

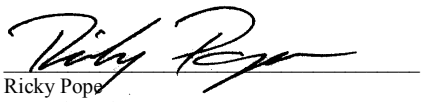
IMMUNIZATION BILLING WORKSHEET*

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		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
90659	Influenza, whole virus	V04.8							
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
90701	DTP	V06.1		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							
90712	Poliovirus (oral)	V04.0		1	2	3	4	5	6
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							
90720	Combined DTP/Hib	V06.8		1	2	3	4	5	6
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**.



Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

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

P.O. Box 300001
Raleigh, North Carolina 27622