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 V **August 2004**

Attention:

Medicare Part B Billers

Medicare Part B
Effective September 6, 2004

As previously published in the September 2002 Special Bulletin VI, the Division of Medical Assistance is required by the N.C. General Assembly to apply Medicaid pricing when processing claims for Medicare/Medicaid dually eligible recipients. In an effort to simplify the claims filing procedures documented in the September 2002 Special Bulletin VI, DMA will return to processing claims for professional services directly from Medicare.

Effective with **date of service September 6, 2004**, claims filed to **Medicare will be crossed over automatically** to Medicaid for payment if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for the recipient. It is the Providers responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare. Providers may verify that their Medicare provider number is cross-referenced to their Medicaid provider number by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888. If your Medicare provider number is not cross-referenced to your Medicaid provider number, you must complete and submit the Medicare Crossover Request form (available on page 20 or from DMA's website at http://www.dhhs.state.nc.us/dma/forms.html) and submit it by fax or mail to the fax number or address listed on the form. Claims will pay to the Medicaid provider number indicated on the claim filed to Medicare. If no Medicaid provider number is on the claim filed to Medicare, claims will pay to the Medicaid provider number indicated on the Medicare Crossover Request form.

Note: If you have more than more one Medicaid provider number, you should indicate on the Medicare claim the Medicaid provider number for which you want to receive payment.

Claims that do not crossover and have been paid by Medicare can be filed as an 837 professional transaction completing the Coordination of Benefits (COB) loop. Refer to the implementation guide at http://wpc-edi.com and the N.C. Medicaid HIPAA Companion Guide on DMA's website at http://www.dhhs.state.nc.us/dma/hipaa/compguides.html for instructions on completing the 837 professional transaction.

Claims that do not crossover and have been paid by Medicare can also be filed on a CMS-1500 claim form. The paper claim form must be submitted with the Medicare voucher attached.

The return to crossovers for professional services impacts Medicaid administrative policies, procedures, and billing guidelines for Medicare/Medicaid recipients.

Administrative Policy

Reimbursement requires compliance with all Medicaid guidelines. Medicaid's payment or non-payment is considered payment in full. The following administrative policies apply to 837 professional transactions and CMS 1500 claim forms for Medicare crossover claims.

Copayments

Services covered by **both** Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the appropriate Medicaid copayment. Refer to the May 2004 General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide for specific copayment requirements.

Carolina ACCESS Primary Care Providers

Services covered by **both** Medicare and Medicaid are not subject to Carolina ACCESS primary care provider referral authorization.

Prior Approval

Medicaid does not require prior approval for Part B services that are covered by Medicare. However, if Medicare does not cover a service and Medicaid requires prior approval, the provider must obtain prior approval.

24-Visit Limitation
Services covered by **both** Medicare and Medicaid are not subject to Medicaid's 24-visit limit per state fiscal year (July 1 through June 30).

Hysterectomy, Sterilization, and Abortion Consents/Statement
Procedures covered by **both** Medicare and Medicaid do not require sterilization consent forms, hysterectomy statements or abortion statements in order to receive reimbursement for the procedures. However, if Medicare does not cover the procedure, Medicaid requires the appropriate consent form/statements to be submitted. Forms must be mailed to the address listed on the form.

Durable Medical Equipment Span Dates
Durable Medical Equipment (DME) claims that currently span dates of service when filed to Medicare will be paid a percentage of the Medicare coinsurance and deductible when the "to" date of service is on or after September 6, 2004. Medicaid will not reimburse for future dates of service as Medicare does. Claims for future dates of service must be refiled to Medicaid after the "to" date of service on the claim has passed.

Optical Refractions
If a recipient has Medicare and there is no medical diagnosis, the provider needs to follow the Medicare guidelines when billing Medicare. However, Medicare does not cover refractions. So, if the patient also has Medicaid, the provider should bill Medicaid for refraction (CPT code 92015) with a refractive diagnosis. A copayment will be deducted for services not covered by Medicare unless the recipient qualifies for specific copayment exemptions.

Psychiatric Reductions
If Medicare reduces payment to the provider as a result of a psychiatric reduction, the psychiatric reduction cannot be billed to Medicaid. This psychiatric reduction is the recipient's responsibility.

Billing Guidelines

Effective with dates of service September 6, 2004, professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule. DMA established this Part B Reimbursement schedule to allow DMA to achieve aggregate Medicaid pricing for claims. The payment percentages are determined by the provider type and specialty. **Providers cannot bill the recipient for the remaining balance. Medicaid's payment or non-payment is considered payment in full.**

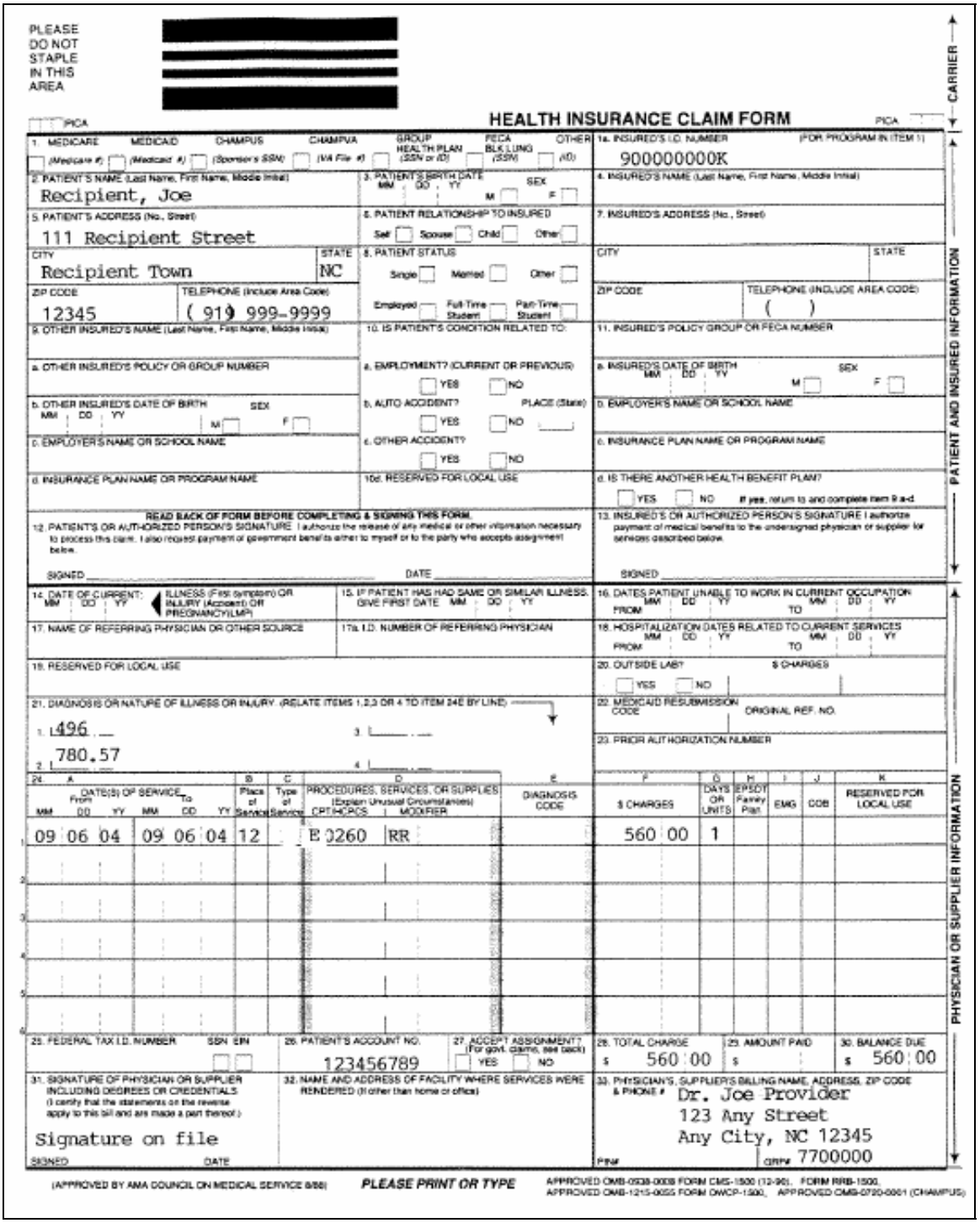
When a claim is denied by Medicare as non-covered, providers may file the claim to Medicaid. Providers must not override Medicare when Medicare denies the services for lack of medical necessity. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid through the 837 professional transaction (dental providers must file using the 837 dental transaction) using the instructions outlined in the PWK segment of the companion guide in the 2300 loop or on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. (A copy of the form is available on page 21 or from DMA's website at http://www.dhhs.state.nc.us/dma/forms.htm.) In order to ensure proper reimbursement, providers cannot file dates of service that have a from date of service prior to September 6, 2004 and a to date of service equal to or after September 6, 2004. Any claims – except DME – that span crossover processing versus Medicare TPL processing cannot be billed on the same claim form. Refer to the following instructions for how to bill for services provided to dually eligible recipients.

Note: Claim examples may not accurately reflect real medical situations nor correct Medicaid reimbursement rates for your provider type and specialty. For exact Medicaid reimbursement amounts refer to the Part B Reimbursement Schedule, which will be available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm beginning September 6, 2004.

CMS-1500 Claim Forms

Example 1: Medicare/Medicaid Only

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must file the claim directly to Medicare. **The Medicare claim will cross over automatically** to Medicaid if the provider is setup for crossover. If the claim does not crossover to Medicaid the provider must file the claim directly to Medicaid. The provider is required to submit an 837 professional transaction completing the COB loop or a paper CMS-1500 form attaching the Medicare voucher. **DO NOT INDICATE MEDICARE PAYMENT IN BLOCK 29**.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 496.__
2. 780.57
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 09 06 04	09 06 04	12		E 0260	RR		560 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456789

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

28. TOTAL CHARGE: $ 560 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 560 00

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

Signature on file

SIGNED DATE

32. 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 #

Dr. Joe Provider
123 Any Street
Any City, NC 12345
7700000

PIN# GRP#

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

Payment Calculation
Example 1 – Provider/Specialty Type with a 75% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
500.00	400.00	.00	100.00

Total Medicare Coinsurance/Deductible	Part B Reimbursement Schedule Payment %	Medicaid Payment
100.00	75.00%	75.00

Medicare Paid	**Medicaid Payment**	**Total Payment**
400.00	75.00	**475.00**

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

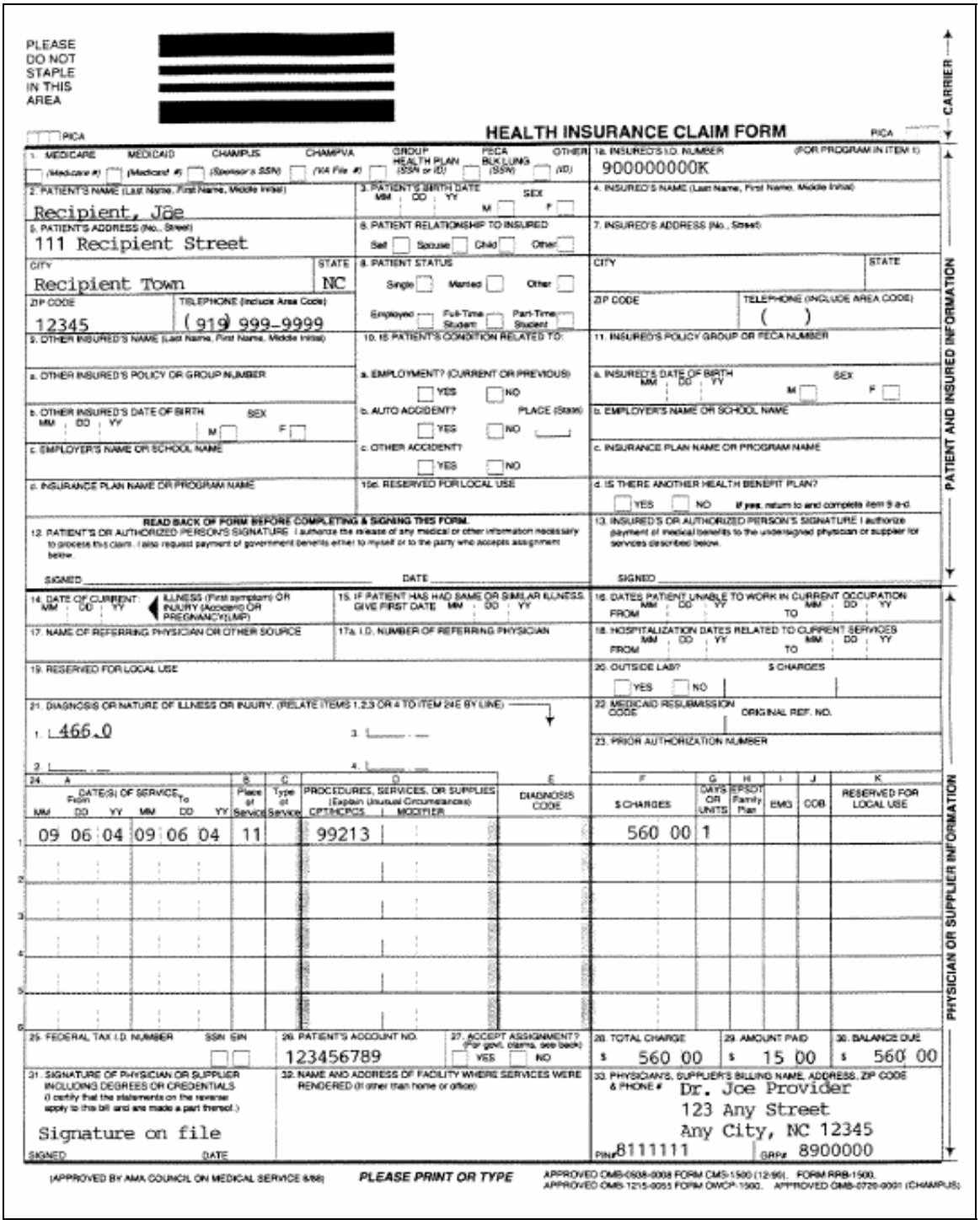
PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 7700000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE 2

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Mcare Primary												
JOE												
RECIPIENT *A* **pat**	**CO=92**	**RCC=**		**CLAIM NUMBER= 402004272250001NCXIX**				**EST AMT DUE=**				
900000000k	**acct=123456789**					**MED REC= 123456**				**ATTN PROV= 7700000**		
NCXIX	**09062004** **09062004**	**1 B**	**E0260**	**HOSPI BED W/ANY RR**	**56000**	**00**	**56000**	**46000**	**7500**	**0**	**7500**	**98**
DEDUCTBLE= .00	*PAT LIAB= .00*		*CO PAY= .00*	*TPL= 0*	*56000*	*00*	*56000*	*46000*	*7500*	*0*	*7500*	
ORIGINAL BILLED AMOUNT= 100.00			*ORIGINAL DETAIL COUNT = 1*			*TOTAL FINANCIAL PAYERS= 1*						

Example 2: Medicare/TPL/Medicaid

When the recipient has Medicare, Medicaid, and commercial insurance, which is primary to Medicaid, the provider must indicate the commercial insurance payment in block 29 and attach the Medicare voucher to the paper CMS-1500 form. **DO NOT INDICATE MEDICARE PAYMENT IN BLOCK 29**. For the 837 professional transaction, the provider must complete the COB loop for Medicare and the commercial insurance.



PLEASE DO NOT STAPLE IN THIS AREA

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HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY; SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 466.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 06 04 09 06 04	11		99213		560 00	1				
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 123456789

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

28. TOTAL CHARGE $ 560 00

29. AMOUNT PAID $ 15 00

30. BALANCE DUE $ 560 00

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

Signature on file

SIGNED DATE

32. 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 #

Dr. Joe Provider
123 Any Street
Any City, NC 12345

PIN# 8111111 GRP# 8900000

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

Payment Calculation
Example 2 – Provider/Specialty Type with a 65% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
500.00	400.00	.00	100.00

Total Medicare Coinsurance/Deductible	Part B Reimbursement Schedule Payment %	Medicaid Payable Charge	Commercial Insurance Payment	Medicaid Payment
100.00	65.00%	65.00	15.00	50.00

Medicare Paid	**Commercial Insurance Payment**	**Medicaid Payment**	**Total Payment**
400.00	15.00	50.00	**465.00**

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

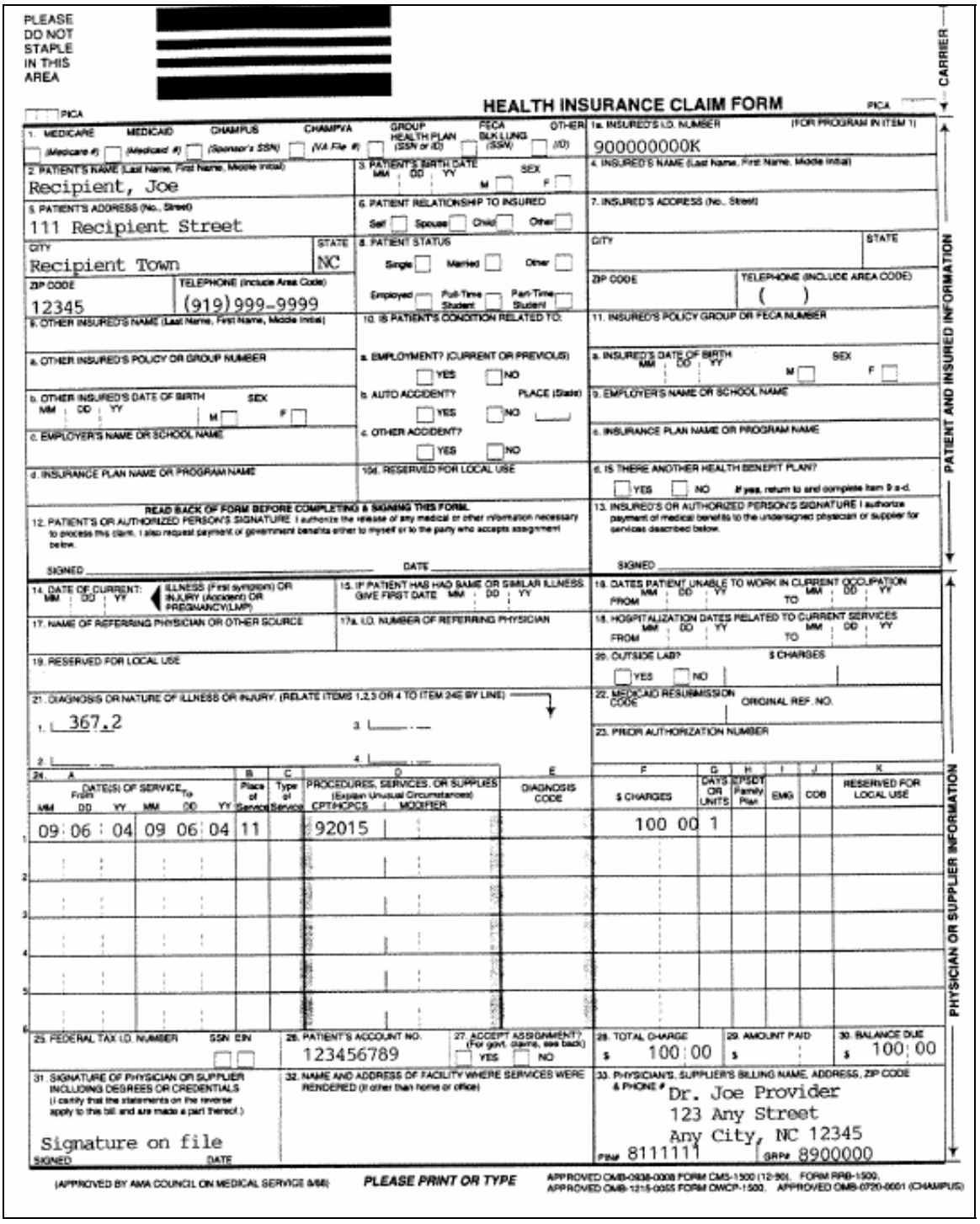
PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE 2

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Mcare Primary												
RECIPIENT *JOE A* **pat**	**CO=92**	**RCC=**	**CLAIM NUMBER= 402004272250001NCXIX**						**EST AMT DUE=**			
900000000k	**acct=123456789**						**MED REC= 123456**			**ATTN PROV= 8111111**		
NCXIX	**09062004 09062004**	**1**	**99213**	**OV ESTAB. PT, MODERATE. PHY**	**56000**	**00**	**56000**	**46000**	**6500**	**1500**	**5000**	**8926**
DEDUCTBLE= .00	*PAT LIAB= .00*		*CO PAY= .00*	*TPL= 15.00*	*56000*	*00*	*56000*	*46000*	*6500*	*1500*	*5000*	
ORIGINAL BILLED AMOUNT= 100.00			*ORIGINAL DETAIL COUNT =*		*1*	*TOTAL FINANCIAL PAYERS=*		*1*				

Example 3: Medicare Non-Covered Services

When a claim is denied by Medicare as non-covered, the provider may file the claim to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, the provider must resubmit the claim to Medicaid through the 837 professional transaction (dental providers must file using the 837 dental transaction) using the instructions outlined in the PWK segment of the companion guide in the 2300 loop or on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. The claim will be reviewed to determine if payment is appropriate. The payment percentage is determined by the provider type and specialty.



PLEASE DO NOT STAPLE IN THIS AREA

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HEALTH INSURANCE CLAIM FORM

PICA

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): 900000000K

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

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

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

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

CITY: Recipient Town | STATE: NC

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

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (919)999-9999

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. 367.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	09 06 04	09 06 04	11		92015			100 00	1			
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456789

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

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. BALANCE DUE $ 100 00

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

Signature on file

SIGNED DATE

32. 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 #

Dr. Joe Provider
123 Any Street
Any City, NC 12345

PIN# 8111111 GRP# 8900000

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Payment Calculation
Example 3 – Provider/Specialty Type with a 65% of Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
0.00	0.00	.00	.00

Total Medicaid Billed Amount	Part B Reimbursement Schedule Payment %	Medicaid Payment
100.00	N/A*	62.90

***Note: Part B Reimbursement Schedule for Medicare non-covered services does not apply.**

Medicare Paid	**Medicaid Payment**	**Total Payment**
0.00	62.90	**62.90**

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

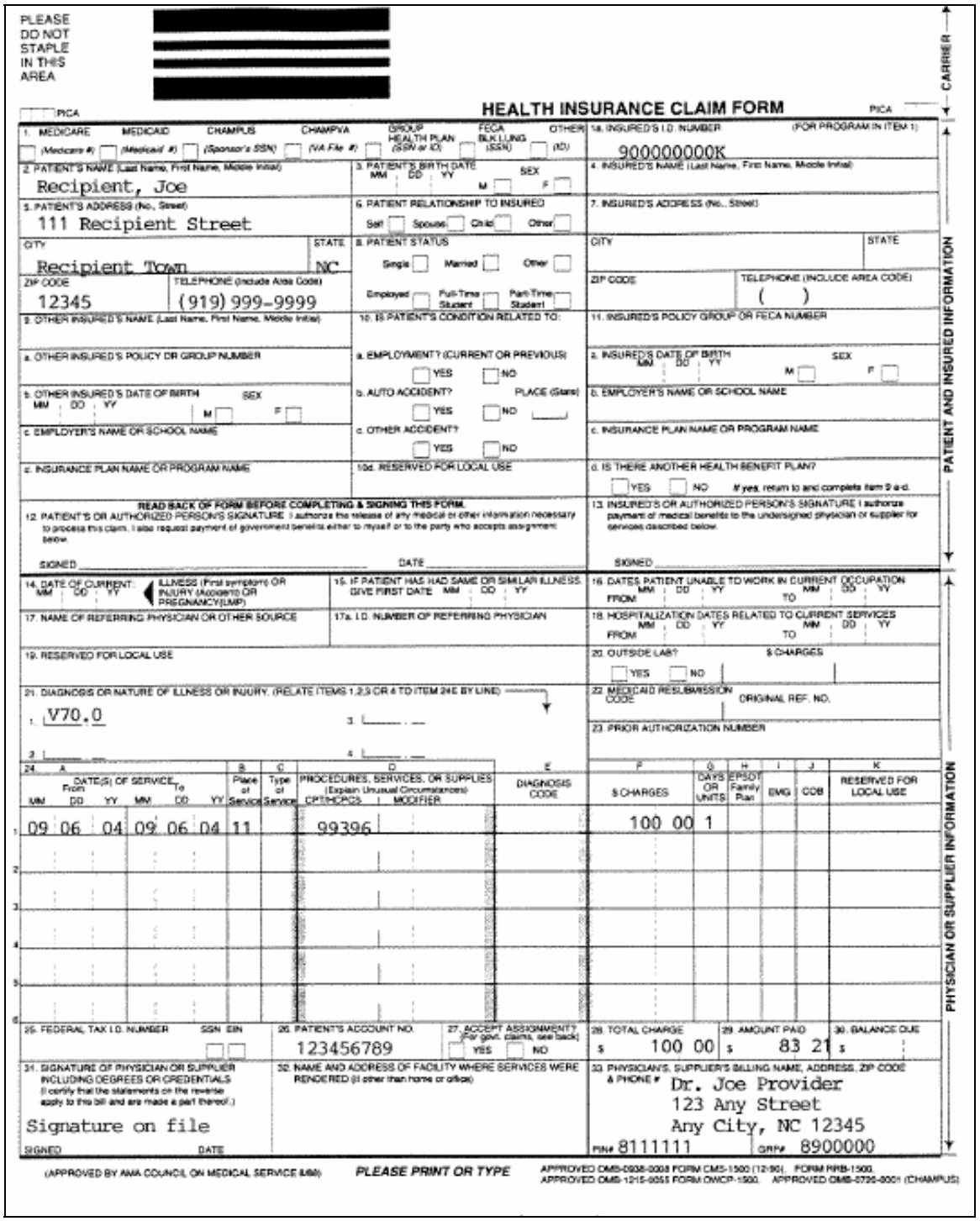
PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE 2

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Medical												
JOE												
RECIPIENT	*A*	**CO=92**	**RCC=**	**CLAIM NUMBER= 252004272250001NCXIX**					**EST AMT DUE=**			
900000000k	**pat acct=123456789**								**MED REC= 123456**		**ATTN PROV= 8111111**	
NCXIX	**09062004 09062004**		**1**	**92015 DETERMINATION OF REFRACTIVE**	**10000**	**00**	**10000**	**00**	**6290**	**0**	**6290**	**98**
DEDUCTBLE= .00	*PAT LIAB= .00*			*CO PAY= .00*	*TPL= 0*	*10000*	*00*	*10000*	*00*	*6290*	*0*	*6290*	
ORIGINAL BILLED AMOUNT= 100.00				*ORIGINAL DETAIL COUNT = 1*					*TOTAL FINANCIAL PAYERS= 1*			

Example 4: Medicare Non-Covered and Commercial Insurance Payment

When a recipient has Medicare, Medicaid, and commercial insurance which is primary to Medicaid, and the claim is denied by Medicare as non-covered, providers may file the claim to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers can resubmit the claim to Medicaid through the 837 professional transaction (dental providers must file using the 837 dental transaction) using the instructions outlined in the PWK segment of the companion guide in the 2300 loop and completing the COB loop. Providers can also file on paper with the commercial insurance payment amount entered in block 29, and the Medicare voucher and a Medicaid Resolution Inquiry form attached. The claim will be reviewed to determine if the payment is appropriate.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V70.0 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 09 06 04	09 06 04	11		99396			100 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456789

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

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $ 83 21

30. BALANCE DUE: $

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

Signature on file

SIGNED DATE

32. 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 #

Dr. Joe Provider
123 Any Street
Any City, NC 12345

PIN# 8111111 GRP# 8900000

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

Payment Calculation
Example 4 – Provider/Specialty Type with a 65% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
0.00	0.00	.00	.00

Total Medicaid Billed Amount	Part B Reimbursement Schedule Payment %	Medicaid Payable Charge	Commercial Insurance Payment	Medicaid Payment
100.00	N/A*	96.86	83.21	13.65

***Note: Part B Reimbursement Schedule for Medicare non-covered services does not apply.**

Medicare Paid	**Commercial Insurance Payment**	**Medicaid Payment**	**Total Payment**
0.00	83.21	13.65	**96.86**

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

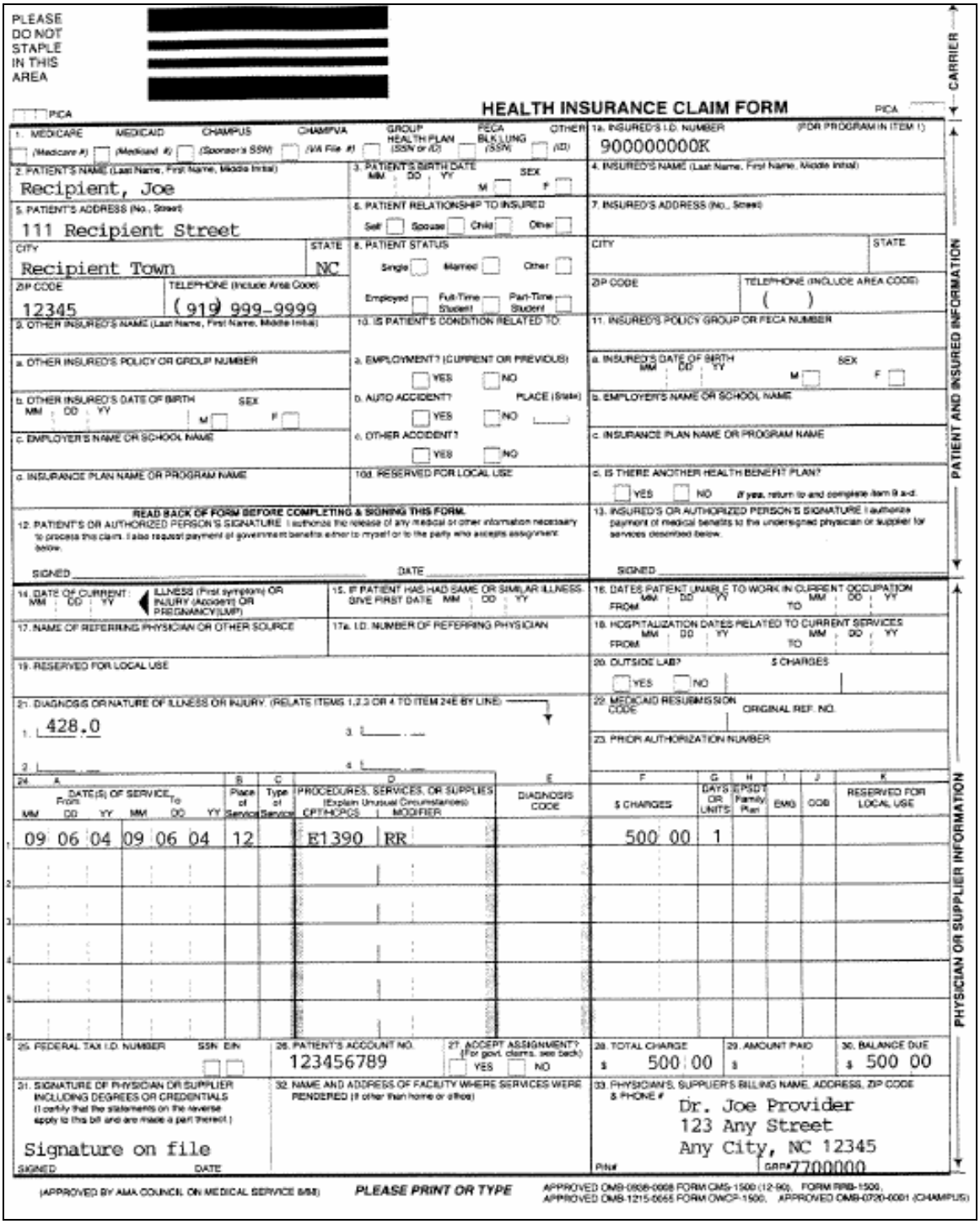
PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE 2

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Medical												
RECIPIENT	*JOE A*											
	pat											
900000000k	**acct=123456789**											
	09062004			**ESTAB. PT PHYSICAL EXAM:**								
NCXIX	**09062004**		**1**	**99396** **40**	**10000**	**00**	**10000**	**00**	**9686**	**8321**	**1365**	**8926**
DEDUCTBLE=	*.00*	*PAT LIAB=*	*.00*	*CO PAY=* *.00* *TPL=* *83.21*	*10000*	*00*	*10000*	*00*	*9686*	*8321*	*1365*	
ORIGINAL BILLED AMOUNT=			*100.00*	*ORIGINAL DETAIL COUNT =*	*1*							

CLAIM NUMBER= 252004272250001NCXIX **EST AMT DUE=**
MED REC= 123456 **ATTN PROV= 8111111**
TOTAL FINANCIAL PAYERS= *1*

Example 5: Medicare Paid and Commercial Insurance Non-Covered

When the recipient has Medicare, Medicaid, and commercial insurance, and the commercial insurance denies the service, the provider must submit a paper claim with the Medicare voucher and the commercial insurance denial attached to the claim. **DO NOT INDICATE MEDICARE PAYMENT IN BLOCK 29**.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 428.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 06 04 09 06 04	12		E1390 RR		500 00	1				
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 123456789

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

28. TOTAL CHARGE $ 500 00

29. AMOUNT PAID $

30. BALANCE DUE $ 500 00

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

Signature on file

SIGNED DATE

32. 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 #

Dr. Joe Provider
123 Any Street
Any City, NC 12345

PIN# GRP# 7700000

PHYSICIAN OR SUPPLIER INFORMATION

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

Payment Calculation
Example 5 – Provider/Specialty Type with a 75% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
500.00	400.00	.00	100.00

Total Medicare Coins/Deductible	Part B Reimbursement Schedule Payment %	Medicaid Payable charge	TPL Payment
100.00	75.00%	75.00	0.00

Medicare Paid	**Commercial Payment**	**Medicaid Payment**	**Total Payment**
400.00	0.00	**75.00**	**475.00**

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

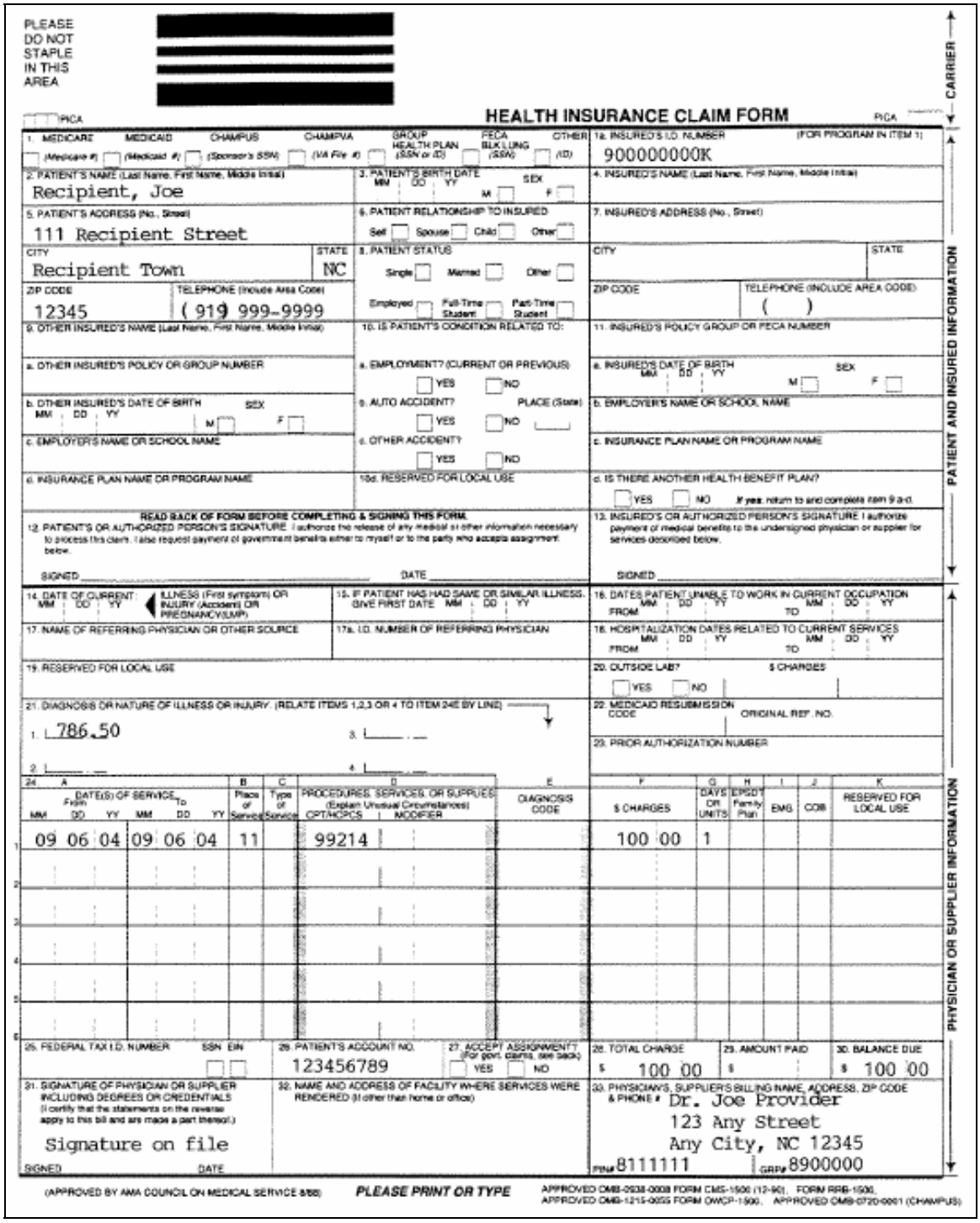
PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 7700000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE 2

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Mcare Primary												
JOE												
RECIPIENT *A*	**CO=92**	**RCC=**		**CLAIM NUMBER= 102004272250001NCXIX**				**EST AMT DUE=**				
pat												
900000000k	**acct=123456789**						**MED REC= 123456**			**ATTN PROV= 7700000**		
	09062004			**OXYGEN CONCENTRATOR,**								
NCXIX	**09062004**	**1 B**	**E1390**	**CAPABL**	**50000**	**00**	**50000**	**40000**	**7500**	**0**	**7500**	**98**
			RR									
DEDUCTBLE= .00	*PAT LIAB= .00*		*CO PAY= .00*	*TPL= 0*	*50000*	*00*	*50000*	*40000*	*7500*	*0*	*7500*	
ORIGINAL BILLED AMOUNT= 100.00			*ORIGINAL DETAIL COUNT =*		*1*	*TOTAL FINANCIAL PAYERS=*			*1*			

Example 6: Medicare Applies 100 Percent of Payment Toward the Deductible

When the recipient has both Medicare and Medicaid, and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the claim will pay a percentage reduction of the deductible. **The Medicare claim will cross over automatically** if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for the recipient. If the claim does not crossover to Medicaid, the provider can submit an 837 professional transaction completing the COB loop or the provider can file a paper CMS-1500 form with the Medicare voucher attached.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA — HEALTH INSURANCE CLAIM FORM — PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000K

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe
3. PATIENT'S BIRTH DATE / SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street
6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other
7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town — STATE: NC
8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student
CITY — STATE

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (919) 999-9999
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 / SEX

b. OTHER INSURED'S DATE OF BIRTH / SEX
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)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 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. 786.50 3. 2. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 06 04	09 06 04	11		99214			100 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO. 123456789
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 100 00
29. AMOUNT PAID $
30. BALANCE DUE $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on file
SIGNED DATE
32. 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 #
Dr. Joe Provider
123 Any Street
Any City, NC 12345
PIN# 8111111 GRP# 8900000

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

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

Payment Calculation
Example 6 – Provider/Specialty Type with a 75% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
100.00	00.00	100.00	0.00

Total Medicare Coinsurance/Deductible	Part B Reimbursement Schedule Payment %	Medicaid Payment
100.00	75.00%	75.00

Medicare Paid	**Medicaid Payment**	**Total Payment**
0.00	75.00	**75.00**

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE 2

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
Paid Claims												
Mcare Primary												
RECIPIENT *JOE A*	**CO=92**	**RCC=**		**CLAIM NUMBER= 402004272250001NCXIX**					**EST AMT DUE=**			
900000000k pat	**acct=123456789**								**MED REC= 123456**		**ATTN PROV= 8111111**	
NCXIX	**09062004 09062004**		**1**	**99214 OV ESTAB. PT, SEVERE. PHYS**	**10000**	**00**	**10000**	**00**	**7500**	**0**	**7500**	**98**
DEDUCTBLE= .00	*PAT LIAB= .00*			*CO PAY= .00*	*TPL= 0*	*10000*	*00*	*10000*	*00*	*7500*	*0*	*7500*
ORIGINAL BILLED AMOUNT= 100.00				*ORIGINAL DETAIL COUNT =*		*1*		*TOTAL FINANCIAL PAYERS=*		*1*		

Medicaid Reimbursement Method Reference Guide

Date of Service	Payment Method	Reference
Prior to 10-01-2001	Paid 100% of coinsurance and deductible	NCXIX State Plan
From 10-01-2001 through 09-30-2002	Medicaid allowable for professional services is calculated based on 95 percent of the Medicare allowed amount and compared to the coinsurance and deductible. Medicaid pays the lesser of the two.	March 2002 Special Bulletin Number I http://www.dhhs.state.nc.us/dma/bulletin.htm
From 10-01-2002 through 09-05-2004	Medicaid deducts the Medicare payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider.	September 2002 Medicaid Special Bulletin VI http://www.dhhs.state.nc.us/dma/bulletin.htm
After 09-06-2004	Medicare part B services will be paid according to the Medicaid Part B Reimbursement schedule.	August 2004 Medicaid Special Bulletin V http://www.dhhs.state.nc.us/dma/bulletin.htm

Medicare Part B Reference Sheet for Crossover Changes for Professional Services

For dates of service 09-06-2004-to present:

Example	Filing Instructions
Medicare/Medicaid	Claims will crossover directly from Medicare. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached. If filed as an 837 professional transaction the COB loop must be completed. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment.
Medicare/TPL/Medicaid	Claims must be filed directly to Medicaid. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached and block 29 must indicate the commercial insurance payment. A voucher from the commercial insurance is not needed when the commercial insurance payment is entered in block 29. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment. If filed as an 837 professional transaction, the COB loop must be completed for both Medicare and commercial insurance.
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare. Or, providers can file the claim to Medicaid on a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare and completing the COB loop for the commercial insurance. Or, providers can submit a CMS-1500 form (dental providers may file using the ADA form) to Medicaid with commercial insurance payment entered in block 29 (field 32 for the ADA form), and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form).
Medicare Paid and Commercial Insurance Non-Covered	All providers must submit the claim to Medicaid on a CMS-1500 form with the Medicare voucher, commercial insurance denial, and a Medicaid Resolution Inquiry form attached. Medicaid will review the commercial insurance denial to determine if Medicaid will pay the claim. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment.
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims will crossover directly from Medicare. If filed as an 837 professional transaction, the COB loop must be completed. If filed on paper all providers must bill on a CMS-1500 form with the Medicare voucher attached.

For dates of service from 10-01-2002 through 09-05-2004:

Example	Filing Instructions
Medicare/Medicaid	Claims must be filed directly to Medicaid. Medicaid deducts the Medicare payment amount from the Medicaid allowable amount and the difference is paid to the provider. If claim is filed as an 837 professional transaction (dental providers may file using the 837 dental transaction), the COB loop must be completed. If claim is filed on paper, the provider must enter the Medicare payment amount including any Medicare penalties and/or outpatient psychiatric reduction in block 29 (field 32 for the ADA form).
Medicare/Commercial Insurance/Medicaid	Claims must be filed directly to Medicaid. If claim is filed as an 837 professional transaction (dental providers may file using the 837 dental transaction), the COB loop must be completed for both Medicare and commercial insurance. If claim is filed on a CMS-1500 form (dental providers may file using the ADA form), the provider must total both the Medicare payment and the commercial insurance payment and enter the total payment amount including any Medicare penalties and/or outpatient psychiatric reduction in block 29 (field 32 for the ADA form). Medicaid deducts the total amount from the Medicaid allowable amount and the difference is paid to the provider. Paper claims must be submitted with both the Medicare voucher and the commercial insurance voucher attached.
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file using the 837 professional transaction overriding Medicare. Dental providers may file using the 837 dental transaction (no Medicare override is required). Or, providers can file the claim to Medicaid on a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction overriding Medicare and completing the COB loop for the commercial insurance. Dental providers must file using the 837 dental transaction (no Medicare override is required) and completing the COB loop for the commercial insurance. Or, providers can submit a CMS-1500 form (dental providers may file using the ADA form) to Medicaid with commercial insurance payment entered in block 29 (field 32 for the ADA form), and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form).
Medicare Paid and Commercial Insurance Non-Covered	Claims must be filed directly to Medicaid. When the recipient has Medicare, commercial insurance, and Medicaid and the commercial insurance denies the service, the provider must submit a CMS-1500 form (dental providers may file using the ADA form) with the Medicare payment amount including penalties and outpatient psychiatric reduction in block 29 (field 32 for the ADA form) and attach the commercial insurance denial to the claim.
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims must be filed directly to Medicaid. When the recipient has both Medicare and Medicaid coverage and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the provider must submit a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher attached to the claim. The claim will pay a percentage of the deductible up to the Medicaid allowed amount.

For dates of service from 10-01-2001 through 09-30-2002:

Example	Filing Instructions
Medicare/Medicaid	Claims will crossover directly from Medicare. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached. If filed as an 837 professional transaction the COB loop must be completed. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment.
Medicare/Commercial Insurance/Medicaid	Claims must be filed directly to Medicaid. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached and block 29 must indicate the commercial insurance payment. A voucher from the commercial insurance is not needed when the commercial insurance payment is entered in block 29. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment. If filed as an 837 professional transaction, the COB loop must be completed for both Medicare and commercial insurance.
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare. Or, providers can file the claim to Medicaid on a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare and completing the COB loop for the commercial insurance. Or, providers can also submit a CMS-1500 form (dental providers may file using the ADA form) to Medicaid with commercial insurance payment entered in block 29 (field 32 for the ADA form), and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form).
Medicare Paid and Commercial Insurance Non-Covered	All providers must submit the claim to Medicaid on a CMS-1500 form with the Medicare voucher, commercial insurance denial, and a Medicaid Resolution Inquiry form attached. Medicaid will review the commercial insurance denial to determine if Medicaid will pay the claim. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment.
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims will crossover directly from Medicare. If filed as an 837 professional transaction, the COB loop must be completed. If filed on paper, all providers must bill on a CMS-1500 form with the Medicare voucher attached.

For dates of service prior to 10-01-2001:

Example	Filing Instructions
Medicare/Medicaid	Claims will crossover directly from Medicare. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached. If filed as an 837 professional transaction the COB loop must be completed. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment.
Medicare/Commercial Insurance/Medicaid	Claims must be filed directly to Medicaid. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached and block 29 must indicate the commercial insurance payment. A voucher from the commercial insurance is not needed when the commercial insurance payment is entered in block 29. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment. If filed as an 837 professional transaction, the COB loop must be completed for both Medicare and commercial insurance.
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file using the 837 professional transaction overriding Medicare. Dental providers may file using the 837 dental transaction (no Medicare override is required). Or, providers can file the claim to Medicaid on a CMS-1500 form with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. Dental providers may file the ADA form without a Medicare voucher or a Medicaid Resolution Inquiry form attached.
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file using the 837 professional overriding Medicare and completing the COB loop for the commercial insurance. Dental providers may file using the 837 dental transaction (no Medicare override is required). Or, providers can also submit a CMS-1500 form to Medicaid with commercial insurance payment entered in block 29 and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form). Dental providers may file using the ADA form with the commercial insurance payment entered in field 32 with no Medicare voucher or Medicaid Resolution Inquiry form attached.
Medicare Paid and Commercial Insurance Non-Covered	All providers must submit the claim to Medicaid on a CMS-1500 form with the Medicare voucher, commercial insurance denial, and a Medicaid Resolution Inquiry form attached. Medicaid will review the commercial insurance denial to determine if Medicaid will pay the claim. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29.** These are automatically deducted at the time the claim is processed for payment.
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims will crossover directly from Medicare. If filed as an 837 professional transaction, the COB loop must be completed. If filed on paper all providers must bill on a CMS-1500 form with the Medicare voucher attached.

Medicare Crossover Reference Request

Provider Name:_____

Contact Person (required): _____ Telephone (required): _____

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

Medicare Part A Intermediaries

- ☐ Riverbend GBA Medicare Part A (Tennessee)
  http://www.riverbendgba.com
- ☐ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina)
  http://www.palmettogba.com
- ☐ Trailblazer Medicare Part A (Colorado, New Mexico and Texas)
  http://www.the-medicare.com
- ☐ United Government Services Medicare Part A (Wisconsin) http://www.ugsmedicare.com
- ☐ Palmetto Medicare Part A (South Carolina)
  http://www.palmettogba.com*
- ☐ AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky)
  http://www.adminastar.com*
- ☐ Carefirst of Maryland Medicare Part A (Maryland)
  http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm*
- ☐ Veritus Medicare Part A (Pennsylvania)
  http://www.veritusmedicare.com*
- ☐ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida)
  http://www.floridamedicare.com *

Medicare Part B Carrier

- ☐ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho)
  http://www.cignamedicare.com
- ☐ AdminaStar Medicare Part B (Indiana and Kentucky)
  http://www.adminastar.com*
- ☐ Palmetto Medicare Part B (South Carolina)
  http://www.palmettogba.com*

Medicare Regional DMERC

- ☐ Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); http://www.palmettogba.com

*Trading Partners currently in testing phase.

Action to be taken:

☐ ***Addition*** *- This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: _____ Medicaid Provider number:_____

☐ ***Change*** *- This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

Mail completed form to:
P.O. Box 300009
Raleigh, NC 27622
FAX: 1-919-851-4014
1-800-688-6696

PVS002, Revised 07/04

Medicaid Resolution Inquiry

Mail To:

EDS Provider Services

P O Box 300009

Raleigh, NC 27622

Please Check: ☐ Medicare Override ☐Time Limit Override ☐Third Party Override

NOTE: PLEASE USE THIS FORM FOR **OVERRIDES AND INQUIRIES ONLY**.

CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.

ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: _____

Provider Name and Address: _____

_____

Patient's Name: _____Recipient ID: _____

Date of Service: From: / / to / /Claim Number: _____

Billed Amount: _____ Paid Amount: _____ RA Date: _____

Please Specify Reason for Inquiry Request:

Signature of Sender: Date: Phone #:

TO BE USED BY EDS ONLY

Remarks:

Medicare Part B Seminar Schedule

Seminars for Medicare Part B Crossovers are scheduled for August and September 2004. This seminar will focus on changes for providers as a result of returning to crossovers effective date of service September 6, 2004. Medicaid billing personnel, supervisors, and office managers are encouraged to attend.

Each site will have two sessions – a morning and an afternoon session. The morning seminars will begin at 9:00 a.m. and end at 11:00 a.m. The afternoon sessions will begin at 1:00 p.m. and end at 3:00 p.m. Providers are encouraged to arrive at least 15 minutes before the session begins to complete registration. Lunch will not be provided at the seminars. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the registration form on page 23 or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend.

Monday, August 30, 2004
Greenville Hilton
207 Greenville Blvd SW
Greenville, NC

Wednesday, September 1, 2004
Jane S. McKimmon Center
1101 Gorman Street
Raleigh, NC

Thursday, September 2, 2004
Holiday Inn Select
5790 University Parkway
Winston Salem, NC

Directions to the Part B Seminars

Greenville Hilton – Greenville
Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right on Allen Road. After traveling approximately 2 miles, Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for approximately 2½ miles. The Greenville Hilton is located on the right.

Jane S. McKimmon Center – Raleigh
Traveling East on I-40
Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40
Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Holiday Inn Select – Winston-Salem
Take I-40 to NC Hwy 52 north. Travel approximately 8 miles to exit 115B, University Parkway South. The hotel is located on the right.

Medicare Part B Seminar Registration Form

(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number _____ Fax Number _____

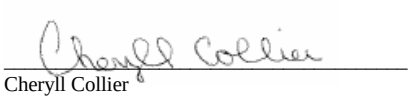
1 or **2** (circle one) person(s) will attend the seminar at _____ on _____

(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622

FAX: 919-851-4014

Gary H. Fugnay, Director
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS