North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

Number VI

September 2002

Attention:

All Providers

Medicare Part B Billing Guidelines

REVISED DRAFT NOVEMBER 14, 2002

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Introduction

Effective with dates of service October 1, 2002, billing and payment guidelines have changed for Medicaid claims when Medicare Part B is the recipient's primary payer. For any recipient with Medicare Part B coverage in addition to Medicaid coverage, providers must file claims directly to Medicare and receive Medicare payment or denial before submitting the claim to Medicaid. Claims filed to Medicare will no longer be crossed over automatically to Medicaid for payment. Once the provider receives the Medicare voucher, the provider is required to submit a claim for those Medicaid covered services directly to Medicaid indicating the Medicare payment as a third party payment on the claim form. These claims are referred to as Medicare TPL claims. Claims can be submitted to Medicaid either electronically or on paper.

The Balanced Budget Act of 1997 permits states to limit payment for dually eligible recipients (Medicare/Medicaid eligible) to no more than Medicaid's maximum allowable rate. The Division of Medical Assistance (DMA) is implementing this change to ensure that all claims, including claims for Medicaid recipients who have Medicare as the primary payer, are processed based on Medicaid editing, auditing, and pricing, and that services rendered to dually eligible recipients are reimbursed at the same rate as services rendered to straight Medicaid fee-for-service recipients.

This change impacts Medicaid medical policies, procedures and billing guidelines for institutional, professional, and dental claims (UB-92, CMS-1500, and ADA) filed to Medicaid.

Medical Policy

The following medical policies have been affected by this change.

Copayments

Services covered by 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 approved Medicaid copayment. Refer to the *Basic Medicaid* handout for additional information on copayments.

Carolina ACCESS (CA) Primary Care Providers (PCPs)

When the recipient is enrolled in Carolina ACCESS – as indicated on the Medicaid identification (MID) card – and the recipient is also eligible for Medicare, the provider is responsible for obtaining a Carolina ACCESS referral. Enter the referral number in block 19 of the CMS-1500 claim form or form locator 83B on the UB-92 claim form as appropriate.

Prior Approval

Medicaid does not require prior approval for any service that is covered by Medicare. However, if Medicare denies a service and Medicaid requires prior approval, the provider must obtain prior approval.

24-Visit Limitation

Dually eligible recipients are now subject to Medicaid's 24-visit limit per state fiscal year (July 1 through June 30).

Hysterectomy, Sterilization, and Abortion Consents/Statements

Medicaid requires providers to submit hysterectomy and sterilization consent forms, as well as abortion statements in order to receive reimbursement for these services for dually eligible recipients. Forms must be mailed to the address listed on the form.

Eligibility

With the implementation of this change, it is imperative that providers refer to the recipient's MID card to determine if the recipient is enrolled with Medicare as a primary insurance.

Blue Medicaid Identification (MID) Card

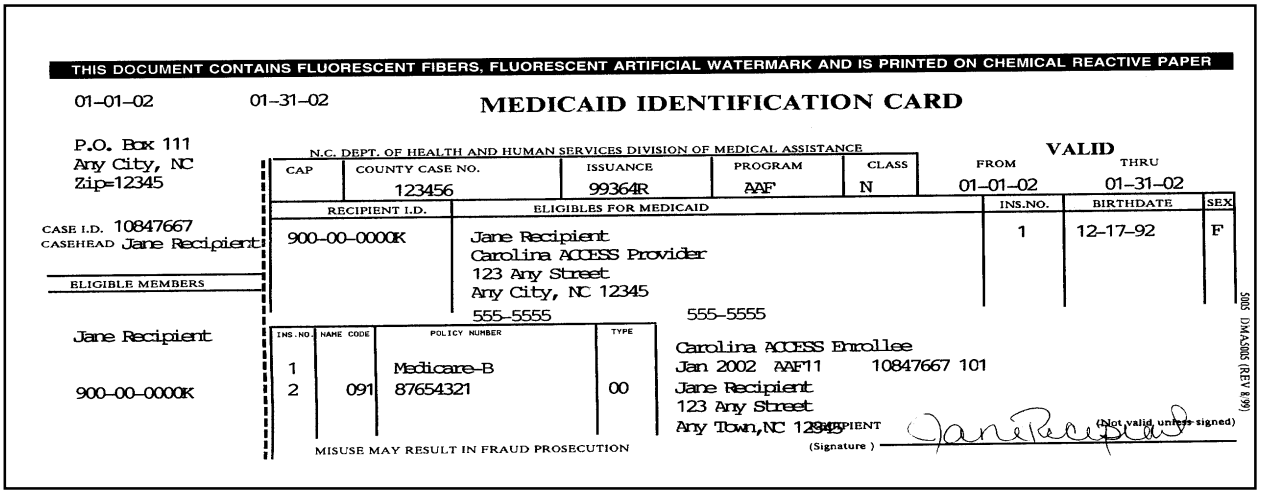
The words *Medicare A, Medicare B, or Medicare A&B* will appear in the insurance data block on the blue MID card. Refer to the example below.

The blue MID card indicates the recipient is eligible for all covered Medicaid services. The card identifies the casehead of the family and all other eligible persons in the family. Each eligible family member has a specific recipient MID number. Family members are only eligible for Medicaid if their name and MID number appear on the card. If the recipient's card is marked "Prepaid Healthplan" or "HMO Enrollee," contact the provider listed on the card before providing services, except in an emergency.

For Carolina ACCESS (CA) recipients, the blue MID card indicates the name of the CA primary care provider (PCP), the provider's address, and the daytime and after-hours telephone numbers. "Carolina ACCESS Enrollee" appears above the recipient's address. The service provider must contact the CA PCP whose name appears on the MID card to receive a Carolina ACCESS referral prior to providing services. Each CA enrollee in a family receives a separate MID card.

For recipients enrolled in a Medicaid HMO, the blue MID card indicates the name of the HMO, the HMO's address, member services telephone number, and 24-hour medical advice line telephone number.

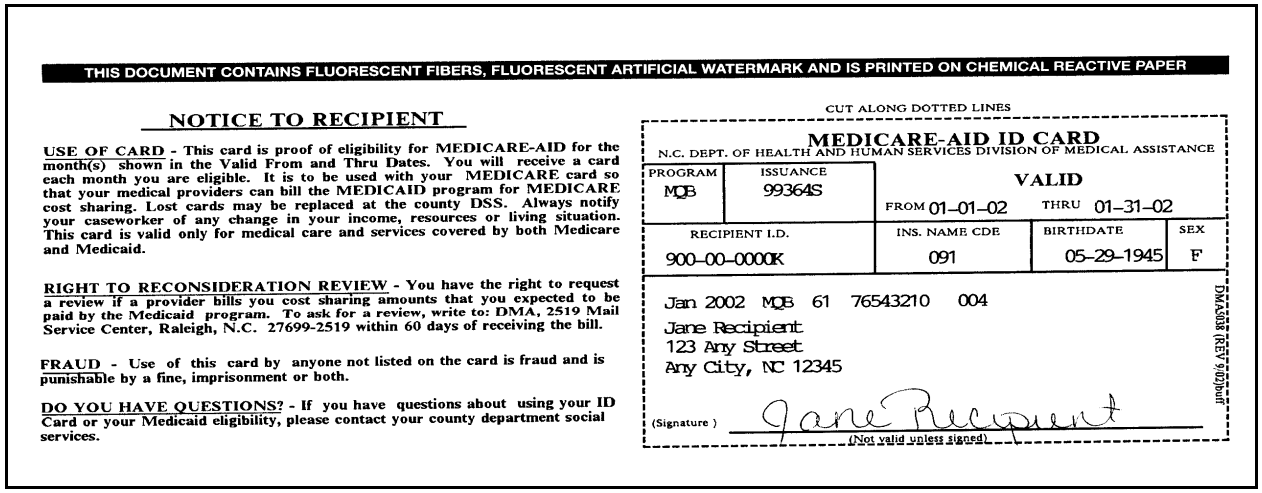
Example of Blue MID Card



Buff MEDICARE-AID ID Card

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q class) card, indicates the recipient is eligible for the MEDICARE-AID program. If both Medicare and Medicaid allow the service, Medicaid will pay the difference between the Medicare cost-sharing amounts and the Medicaid maximum allowable for the service. If Medicare denies the service, Medicaid will also deny. Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in Medicaid Managed Care programs.

Example of Buff MEDICARE-AID ID Card



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

NOTICE TO RECIPIENT

USE OF CARD - This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

RIGHT TO RECONSIDERATION REVIEW - You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

FRAUD - Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

DO YOU HAVE QUESTIONS? - If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department social services.

CUT ALONG DOTTED LINES

MEDICARE-AID ID CARD
N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

PROGRAM	ISSUANCE	VALID FROM	THRU
MQB	99364S	01-01-02	01-31-02

RECIPIENT I.D.	INS. NAME CDE	BIRTHDATE	SEX
900-00-0000K	091	05-29-1945	F

Jan 2002 MQB 61 76543210 004
Jane Recipient
123 Any Street
Any City, NC 12345

(Signature) Jane Recipient
(Not valid unless signed)

DMA308 (REV 9/02)buff

NOTICE TO PROVIDERS

ENROLLMENT - To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-857-4017 for information and forms.

BENEFITS - Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services to this recipient.

USE OF CARD - Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

BILLING - Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties, contractual adjustments or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

buffA (Rev.9/02)

Billing the Recipient

A Medicaid recipient may be billed for services, including the Medicare cost sharing amounts, under the following conditions:

- The recipient does not present a Medicaid identification (MID) card showing eligibility for that date of service.
- The provider does not accept the recipient as a Medicaid patient and informs the recipient prior to rendering the service. The recipient agrees to be billed as private pay.
- The provider may bill a patient accepted as a Medicaid patient for allowable Medicaid deductibles or copayments.
- The service is non-covered by Medicaid and the provider informs the recipient prior to rendering the service. The recipient agrees to be billed as private pay.
- The recipient exceeds the 24-visit limit for provider visits for the state fiscal year (July 1 through June 30).
- The recipient has MEDICARE-AID (MQB-Q) coverage and the service is non-covered by Medicare. MQB-Q recipients receive a buff MEDICARE-AID card.
- The patient is no longer eligible for Medicaid as defined in 10 NCAC 50B.

Billing Guidelines

The list of Medicare noncovered services published in the draft version of this Special Bulletin is not included in the final version. When a claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. 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 on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached (see page 33 for a copy of the form). Refer to the following instructions for how to bill for services provided to dually eligible recipients.

CMS-1500 Claim Forms

Refer to pages 8 through 13 for examples of claims filed on the CMS-1500 claim form.

Example 1: Medicare/Medicaid Only

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must enter the Medicare payment amount including penalties and outpatient psychiatric reduction in block 29. Medicaid deducts the Medicare payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider. These claims can be filed electronically.

Payment Calculation

Procedure Code	Medicaid Allowable
99214	$70.81
G0001	$ 4.06
Total Medicaid Allowed =	$74.87

Total Medicare Payment (block 29) = $78.81

Total Medicaid allowed		Total Medicare payment		Total Medicaid pays to the provider
$74.87	-	$78.81	=	less than zero

Therefore, the provider is paid zero by Medicaid.

Example 2: Medicare/TPL/Medicaid

When the recipient has both Medicare and Medicaid coverage, and another insurance primary to Medicaid, the provider must total both the Medicare payment and the commercial insurance payment and enter the total payment amount including penalties and outpatient psychiatric reduction in block 29. Medicaid deducts the total amount from the Medicaid maximum allowable amount and the difference is paid to the provider. The provider must submit a paper claim with both the Medicare voucher and the commercial insurance voucher attached.

Payment Calculation

Procedure Code	Medicaid Allowable
E0260	$138.73
Total Medicaid Allowed =	$138.73

Total Medicare/TPL Payment (block 29) = $106.53

Total Medicaid allowed	-	Total Medicare/TPL payment	=	Total Medicaid pays to the provider
$138.73	-	$106.53	=	$32.20

Therefore, the provider is paid $32.20 by Medicaid.

Example 3: Medicare Non-Covered Services

When a claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. 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 on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

Payment Calculation

Procedure Code	Medicaid Allowable
92015	$61.23
Total Medicaid Allowed =	$61.23

Total Medicare Payment (block 29) = $ 0.00

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$61.23	-	$0.00	=	$61.23

Therefore, the provider is paid $61.23 by Medicaid.

Example 4: Medicare Non-Covered and TPL Payment

When a recipient has Medicare, commercial insurance, and Medicaid coverage, and the claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. 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 on paper with the commercial insurance payment amount 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.

Payment Calculation

Procedure Code	Medicaid Allowable
99396	$92.72
Total Medicaid Allowed =	$92.72

Total TPL Payment (block 29) = $83.21

Total Medicaid allowed	-	Total TPL payment	=	Total Medicaid pays to the provider
$92.72	-	$83.21	=	$9.51

Therefore, the provider is paid $9.51 by Medicaid.

Example 5: Medicare Paid and TPL Non-Covered

When the recipient has Medicare, commercial insurance, and Medicaid coverage and the commercial insurance denies the service, the provider must submit a paper claim with the Medicare payment amount including penalties and outpatient psychiatric reduction in block 29 with the commercial insurance denial attached to the claim.

Payment Calculation

Procedure Code	Medicaid Allowable
E1390	$209.50
Total Medicaid Allowed =	$209.50

Total Medicare Payment (block 29) = $167.60

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$209.50	-	$167.60	=	$41.90

Therefore, the provider is paid $41.90 by Medicaid.

Example 6: Medicare Applies 100 Percent of Payment Towards the Deductible
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 paper claim with the Medicare voucher attached to the claim. The claim will then pay up to the Medicaid allowable.

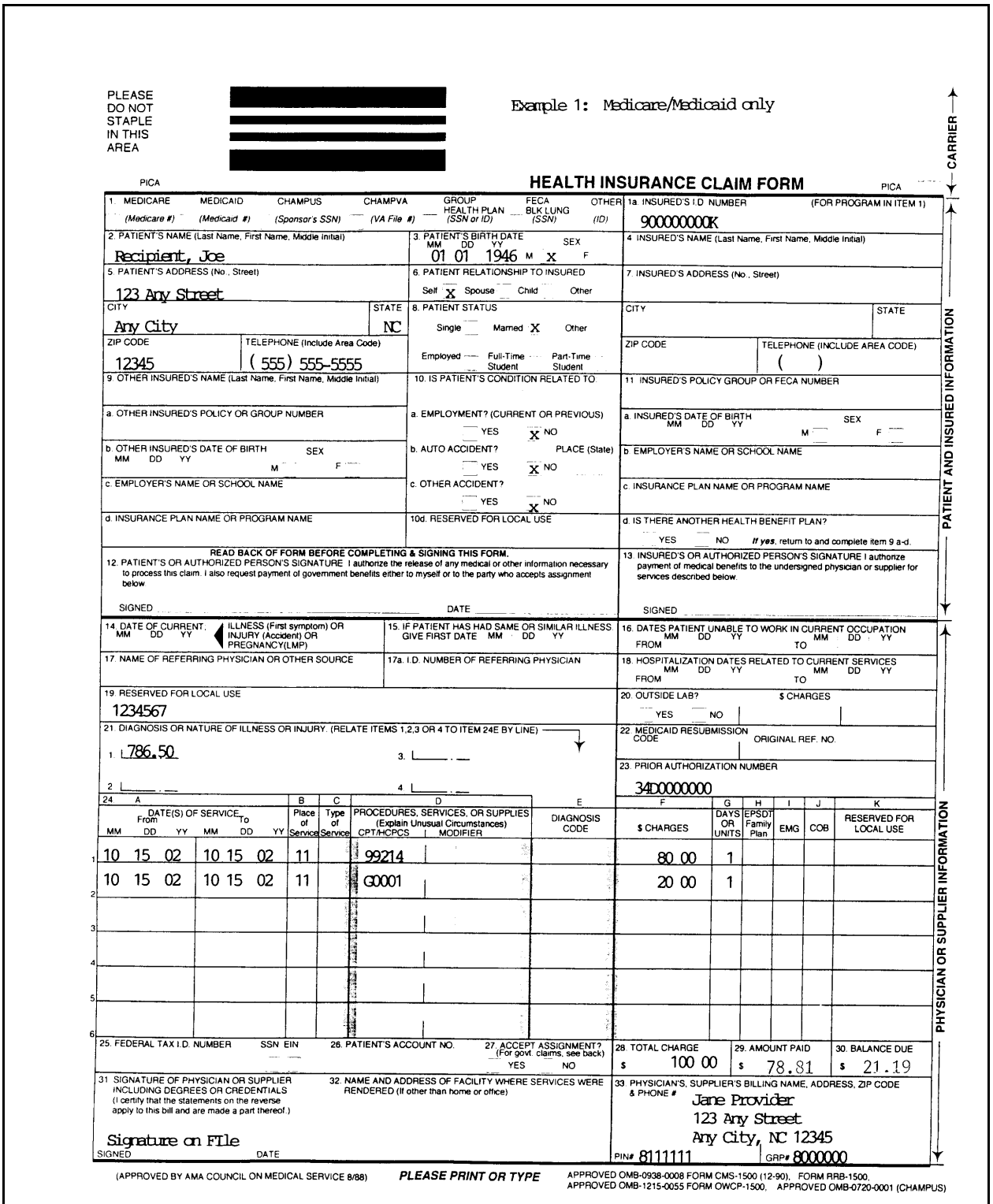
Payment Calculation

Procedure Code	Medicaid Allowable
99213	$ 45.05
Total Medicaid Allowed =	$ 45.05

Total Medicare Payment (block 29) = $0.00, Medicare voucher must be attached to the claim

Total Medicaid allowed		Total Medicare payment		Total Medicaid pays to the provider
$45.05	-	$0.00	=	$45.05

Therefore, the provider is paid $45.05 by Medicaid.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 1: Medicare/Medicaid only

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): 900000000K

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1946 SEX: M X F

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

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

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

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

CITY: Any City STATE: NC

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

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (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 X 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 X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES X 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: 1234567

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. L 786.50 3. L 2 L 4 L

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 34D0000000

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 15 02	10 15 02	11		99214			80 00	1				
2 10 15 02	10 15 02	11		G0001			20 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $ 78.81

30. BALANCE DUE $ 21.19

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 #

Jane Provider
123 Any Street
Any City, NC 12345

PIN# 8111111 GRP# 8000000

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 2: Medicare/TPL/Medicaid

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, Jane	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1946 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):	
5. PATIENT'S ADDRESS (No., Street): 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):	
CITY: Any City STATE: NC	8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: STATE:	
ZIP CODE: 12345 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 [X]
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 [X] PLACE (State):
b. EMPLOYER'S NAME OR SCHOOL NAME:	
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [X]
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: 1234567	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 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 10 30 02 10 30 02	12	E	E0260			160 00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ 160 00
29. AMOUNT PAID $ 106 53	30. BALANCE DUE $ 53 47		
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 # Joe Provider 123 Any Street Any City, NC 12345 PIN# GRP# 7700000

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Example 3: Medicare Non-covered Services

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

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): 900000000K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1946; SEX: M X F
5. PATIENT'S ADDRESS (No., Street): 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: Any City; STATE: NC	8. PATIENT STATUS: Single X Married Other; Employed Full-Time Student Part-Time Student
ZIP CODE: 12345; TELEPHONE (Include Area Code): (555) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX: M F	b. AUTO ACCIDENT? YES NO X; PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

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 _____

4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street)	
CITY; STATE	
ZIP CODE; TELEPHONE (INCLUDE AREA CODE) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY; SEX: M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

PATIENT AND INSURED INFORMATION

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
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
19. RESERVED FOR LOCAL USE	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 367.2	3. 4.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
20. OUTSIDE LAB? YES NO; $ CHARGES	
22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 02	11 01 02	11		92015			75 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 75 00
29. AMOUNT PAID $	30. BALANCE DUE $ 75 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 # Jane Provider 123 Any Street Any City, NC 12345 PIN# 8900000 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)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 4: Medicare Non-covered and TPL Payment

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)
(Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)	900000000K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane	3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1946 SEX M ☐ F ☒
5. PATIENT'S ADDRESS (No., Street): 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: Any City STATE: NC	8. PATIENT STATUS: Single ☒ Married ☐ Other ☐
ZIP CODE: 12345 TELEPHONE (Include Area Code): (555)555-5555	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☒
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CARRIER	
PATIENT AND INSURED INFORMATION	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.	

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: 1234567	20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70.0 2. 3. 4.	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 34D0000000

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 12 02 10 12 02	11		99396			125 00					
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $ 125 00 / 29. AMOUNT PAID $ 83 21 / 30. BALANCE DUE $ 41 79
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 # 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)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 5: Medicare Paid and TPL Non-covered

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)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Joe	
3. PATIENT'S BIRTH DATE MM DD YY / SEX	
01 01 1946 M [X] F [ ]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
123 Any Street	Self [X] Spouse [ ] Child [ ] Other [ ]
CITY / STATE	8. PATIENT STATUS
Any City / NC	Single [ ] Married [X] Other [ ]
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
12345 / (555) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE)	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

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
1234567	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. L 428.0 3. L ___ . ___	23. PRIOR AUTHORIZATION NUMBER
2. L ___ . ___ 4. L ___ . ___	

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 04 02 11 04 02	12	E	E1390			310 00					
2											
3											
4											
5											
6											

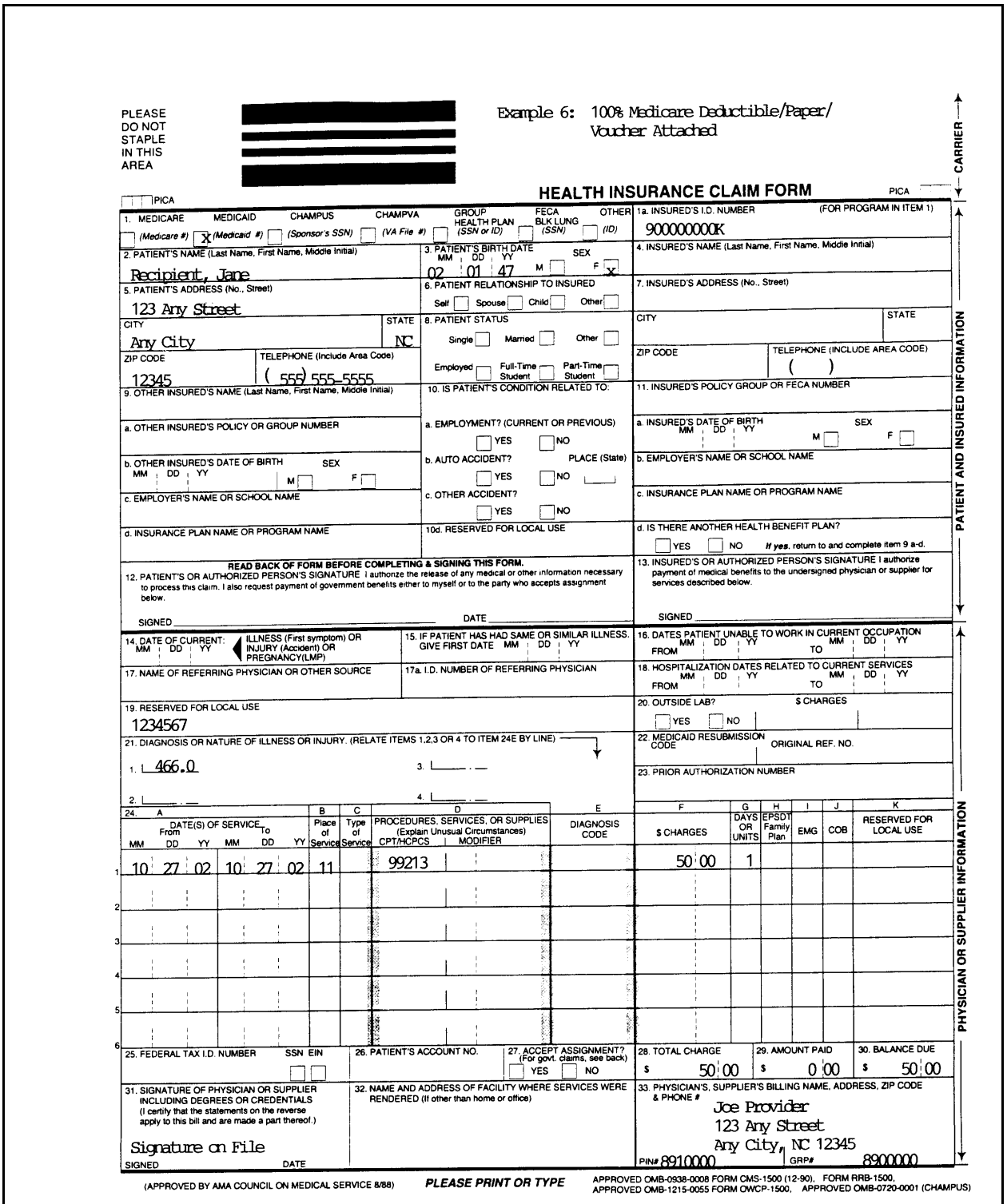
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ 310 00
29. AMOUNT PAID $ 167 60	30. BALANCE DUE $ 142 40		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Signature on File			Jane Provider 123 Any Street Any City, NC 12345
SIGNED DATE			PIN# GRP# 7700000

(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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 6: 100% Medicare Deductible/Paper/ Voucher Attached

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): 900000000K

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 01 47 SEX M F X

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

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

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

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

CITY: Any City STATE: NC

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

CITY: STATE:

ZIP CODE: 12345 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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 1234567

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 466.0 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 10 27 02	10 27 02	11		99213			50 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 50 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 50 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 #

Joe Provider
123 Any Street
Any City, NC 12345

PIN# 8910000 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

UB-92 Claim Forms

Refer to pages 17 through 22 for examples of claims filed on the UB-92 claim form.

Example 1: Medicare/Medicaid Only

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must enter the Medicare payer code in form locator 50 and Medicare payment amount including penalties and outpatient psychiatric reduction in form locator 54A. Medicaid will deduct the Medicare payment from the Medicaid maximum allowable amount and the difference is paid to the provider. These claims can be filed electronically.

Payment Calculation

Total Medicaid Allowed (based on provider RCC x .80) = $120.00

Total Medicare Payment (form locator 54) = $40.00

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$120.00	-	$40.00	=	$80.00

Therefore, the provider is paid $80.00 by Medicaid.

Example 2: Medicare/TPL/Medicaid

When the recipient has Medicare, commercial insurance, and Medicaid coverage, the provider must enter the Medicare payer code in form locator 50 and the Medicare payment amount including penalties and outpatient psychiatric reduction in form locator 54A. The provider must also enter the commercial insurance payer code in form locator 50B and other insurance payment amounts in form locator 54B. Medicaid will deduct the sum of both payments from the Medicaid maximum allowable amount and pay the difference to the provider. These claims can be filed electronically.

Payment Calculation

Total Medicaid Allowed (based on provider RCC x .80) = $110.00

Total Medicare/TPL Payment (form locator 54) = $46.26 + $57.65 = $103.91

Total Medicaid allowed	-	Total Medicare/TPL payment	=	Total Medicaid pays to the provider
$110.00	-	$103.91	=	$6.09

Therefore, the provider is paid $6.09 by Medicaid.

Example 3: Medicare Non-Covered Services
When the recipient has both Medicare and Medicaid coverage and Medicare denies the claim, the provider must enter condition code 89 in form locator 24. These claims can be filed electronically.

Payment Calculation
Total Medicaid Allowed (based on provider RCC x .80) = $400.00

Total Medicare Payment (form locator 54) = $0.00

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$400.00	-	$0.00	=	$400.00

Therefore, the provider is paid $400.00 by Medicaid.

Example 4: Medicare Non-Covered and TPL Payment
When the recipient has Medicare, commercial insurance, and Medicaid coverage and Medicare does not make a payment, the provider must enter condition code 89 in form locator 24. The provider must also enter the commercial insurance payer code in form locator 50B and other insurance payment amount in form locator 54B. Medicaid will deduct the TPL payment amount from the Medicaid payment amount and pay the balance to the provider. These claims can be filed electronically.

Payment Calculation
Total Medicaid Allowed (based on provider RCC x .80) = $300.00

Total Medicare/TPL Payment (form locator 54) = $0.00 + $130.00 = $130.00

Total Medicaid allowed	-	Total Medicare/TPL payment	=	Total Medicaid pays to the provider
$300.00	-	$130.00	=	$170.00

Therefore, the provider is paid $170.00 by Medicaid.

Example 5: Medicare Paid and TPL Non-Covered
When the recipient has Medicare, commercial insurance, and Medicaid coverage and the commercial insurance denies the service, the provider must enter occurrence code 24 or 25 in form locator 32 with the date of the insurance denial. The provider must also enter the Medicare payer code in form locator 50A and the Medicare payment amount including penalties and outpatient psychiatric reduction in form locator 54A. Medicaid will deduct the Medicare payment amount from the Medicaid payment amount and pay the balance to the provider. These claims can be filed electronically.

Payment Calculation
Total Medicaid Allowed (based on provider RCC x .80) = $320.00

Total Medicare/TPL Payment (form locator 54) = $150.00 + $0.00 = $150.00

Total Medicaid allowed	-	Total Medicare/TPL payment	=	Total Medicaid pays to the provider
$320.00	-	$150.00	=	$170.00

Therefore, the provider is paid $170.00 by Medicaid.

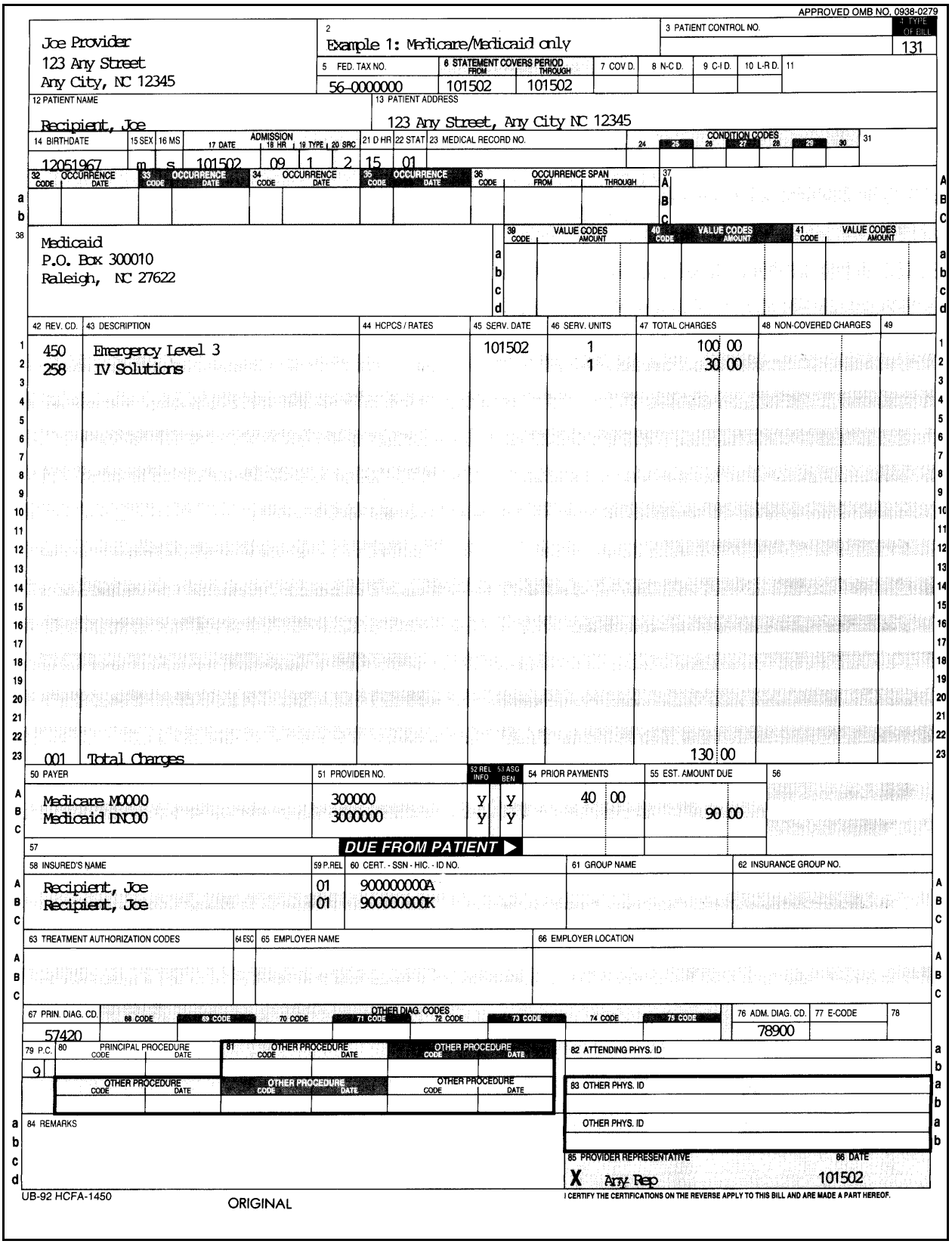
Example 6: Medicare Applies 100 Percent of Payment Towards the Deductible
When the recipient has both Medicare and Medicaid coverage and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the provider must submit a paper claim with the Medicare voucher attached to the claim. The claim will then pay up to the Medicaid allowable.

Payment Calculation
Total Medicaid Allowed (based on provider RCC x .80) = $250.00

Total Medicare Payment (form locator 54) = $0.00, Medicare voucher must be attached to the claim.

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$250.00	-	$0.00	=	$250.00

Therefore, the provider is paid $250.00 by Medicaid.



APPROVED OMB NO. 0938-0279

Joe Provider 123 Any Street Any City, NC 12345	2 Example 1: Medicare/Medicaid only	3 PATIENT CONTROL NO.	4 TYPE OF BILL: 131

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
56-0000000	101502	101502					

12 PATIENT NAME	13 PATIENT ADDRESS
Recipient, Joe	123 Any Street, Any City NC 12345

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 25	26	27	28	29	30	31
12051967	m	s	101502	09	1	2	15	01									

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
Medicaid P.O. Box 300010 Raleigh, NC 27622	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	Emergency Level 3		101502	1	100 00		
2	258	IV Solutions			1	30 00		
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				130 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicare M0000	300000	y	y	40 00		
B Medicaid DNC00	3000000	y	y		90 00	
C						
57	DUE FROM PATIENT ▶					

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

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
57420									78900		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
9							

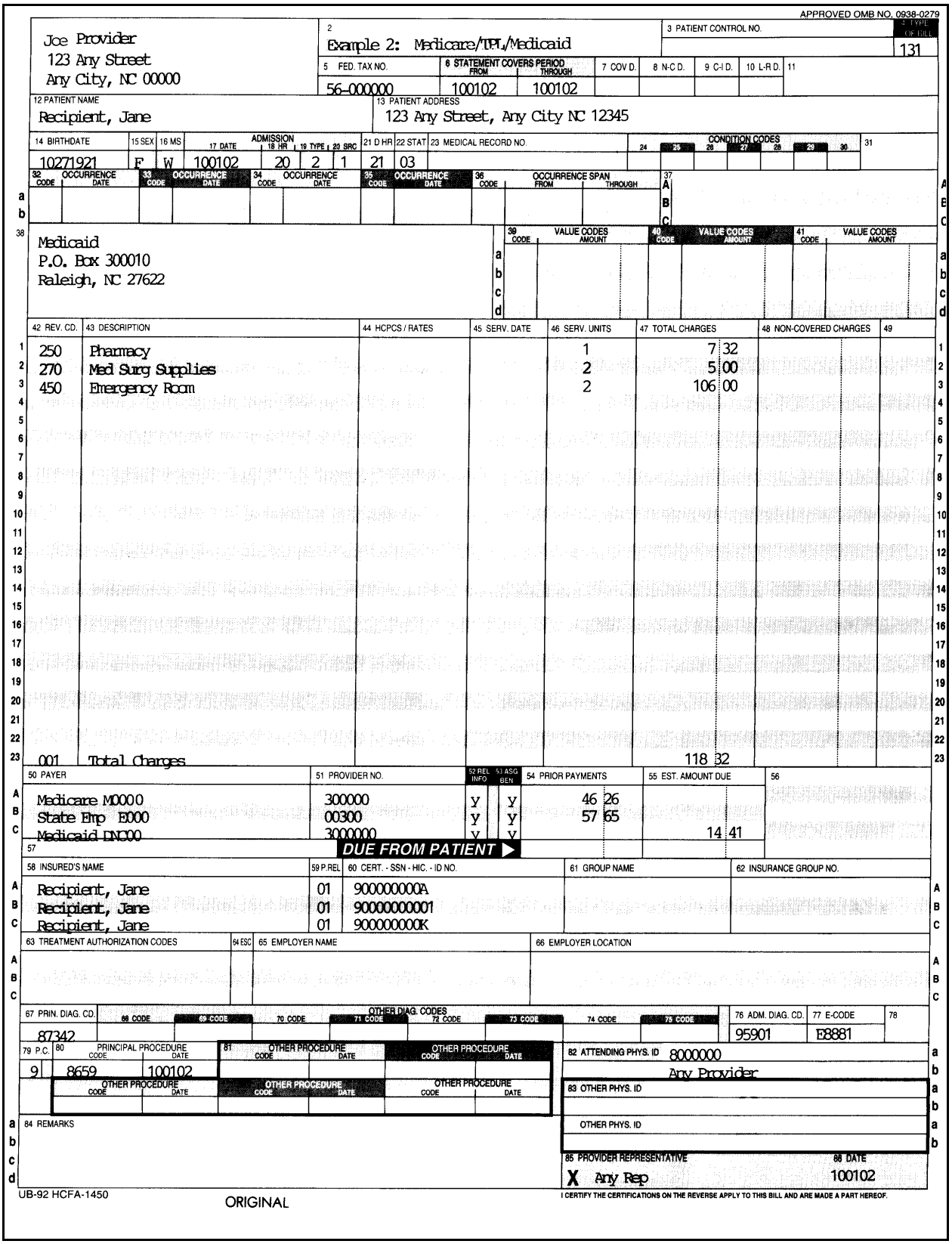
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE	86 DATE
X Any Rep	101502

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

Joe Provider 123 Any Street Any City, NC 00000	2 Example 2: Medicare/TPL/Medicaid	3 PATIENT CONTROL NO.	4 TYPE OF BILL 131
	5 FED. TAX NO. 56-000000	6 STATEMENT COVERS PERIOD FROM 100102 THROUGH 100102	7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11

12 PATIENT NAME	13 PATIENT ADDRESS
Recipient, Jane	123 Any Street, Any City NC 12345

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
10271921	F	W	100102	20	2	1	21	03			

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
Medicaid P.O. Box 300010 Raleigh, NC 27622	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	Pharmacy			1	7 32		
2	270	Med Surg Supplies			2	5 00		
3	450	Emergency Room			2	106 00		
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				118 32		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare M0000	300000	y	y	46 26		
B	State Emp E000	00300	y	y	57 65		
C	Medicaid MC00	3000000	y	y		14 41	
	57		DUE FROM PATIENT ▶				

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Recipient, Jane	01	900000000A		
B	Recipient, Jane	01	900000000001		
C	Recipient, Jane	01	900000000K		

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
87342									95901	E8881	

79 P.C.	80 PRINCIPAL PROCEDURE CODE	80 PRINCIPAL PROCEDURE DATE	81 OTHER PROCEDURE CODE	81 OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE
9	8659	100102				
	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE

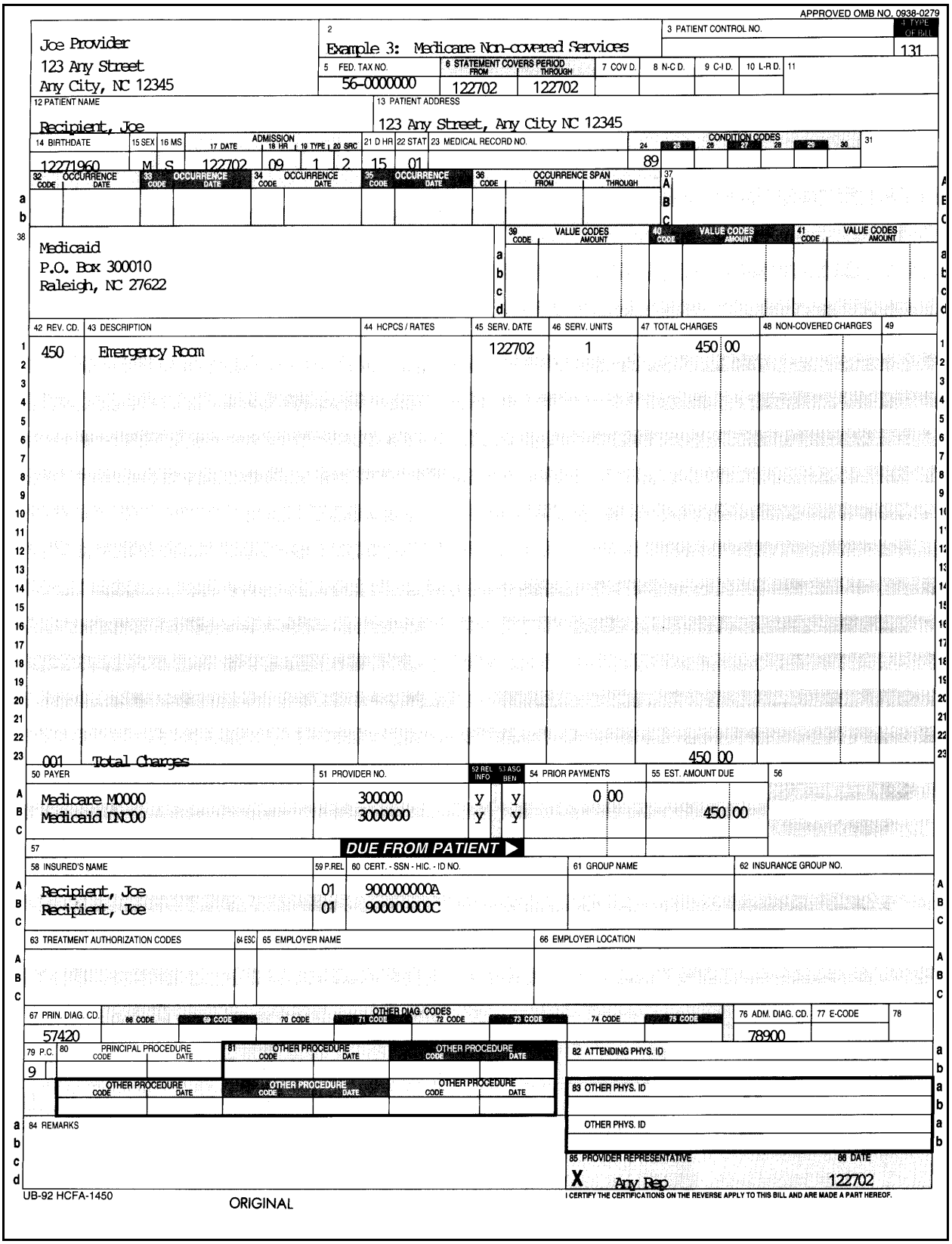
	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	OTHER PHYS. ID
a	8000000		
b	Any Provider		

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE	86 DATE
X Any Rep	100102

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

Joe Provider 123 Any Street Any City, NC 12345	2 Example 3: Medicare Non-covered Services								3 PATIENT CONTROL NO.		4 TYPE OF BILL 131
	5 FED. TAX NO. 56-0000000	6 STATEMENT COVERS PERIOD FROM 122702	THROUGH 122702	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11			
12 PATIENT NAME Recipient, Joe		13 PATIENT ADDRESS 123 Any Street, Any City NC 12345									

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES	31
12271960	M	S	122702	09	1	2	15	01		89	

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a												A
b												B
												C

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
Medicaid P.O. Box 300010 Raleigh, NC 27622	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	Emergency Room		122702	1	450 00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				450 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare M0000	300000	y	y	0 00	450 00	
B	Medicaid DNC00	3000000	y	y			
C							

57 **DUE FROM PATIENT** ▶

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

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
57420									78900		

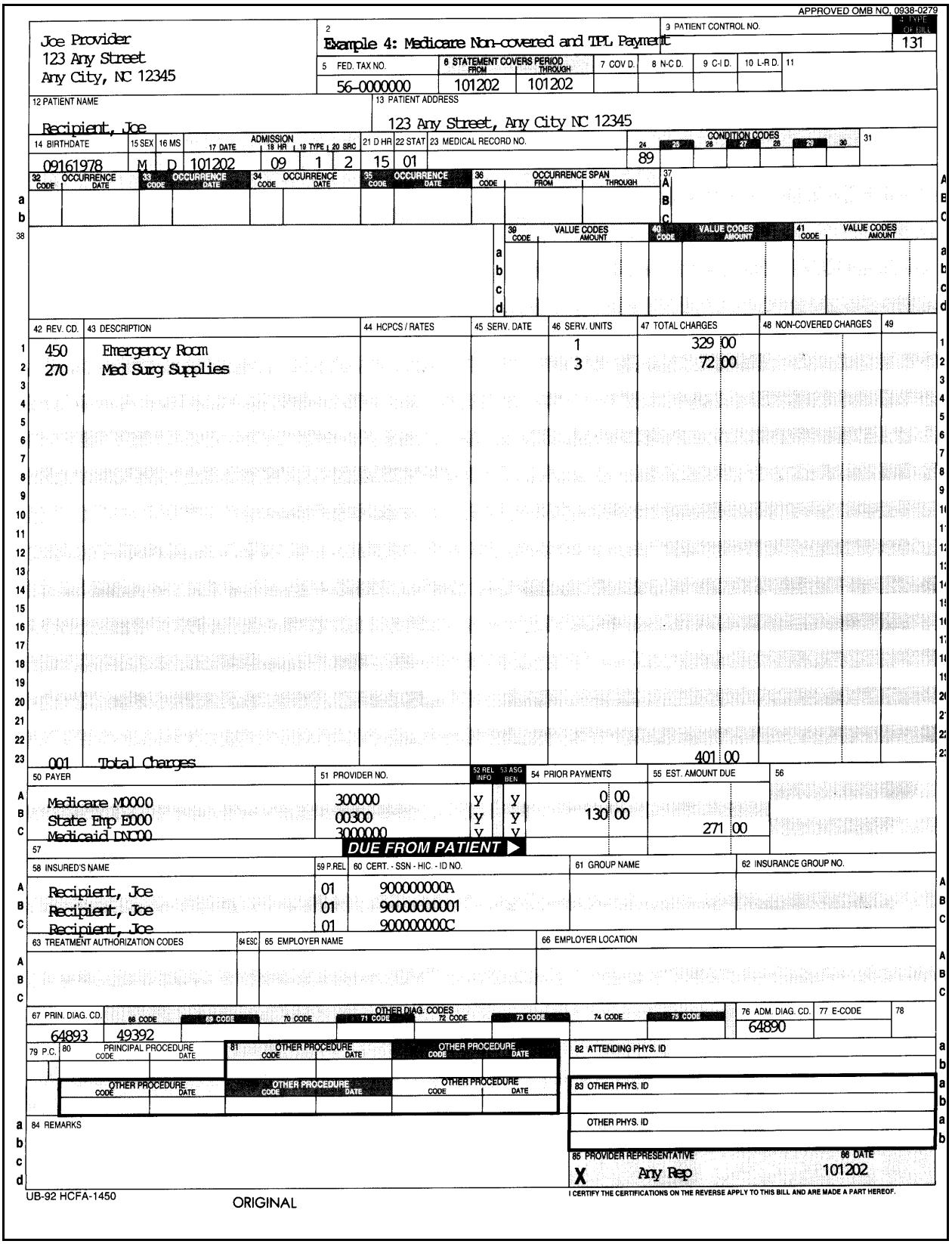
79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
9							

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
						OTHER PHYS. ID

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b			
c		X Any Rep	122702
d			

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



APPROVED OMB NO. 0938-0279

Joe Provider 123 Any Street Any City, NC 12345	2 Example 4: Medicare Non-covered and TPL Payment
3 PATIENT CONTROL NO.	4 TYPE OF BILL: 131
5 FED. TAX NO.: 56-0000000	6 STATEMENT COVERS PERIOD FROM: 101202 THROUGH: 101202
7 COV D.	8 N-C D.
9 C-I D.	10 L-R D.
11	
12 PATIENT NAME: Recipient, Joe	13 PATIENT ADDRESS: 123 Any Street, Any City NC 12345
14 BIRTHDATE: 09161978	15 SEX: M
16 MS: D	ADMISSION 17 DATE: 101202
18 HR: 09	19 TYPE: 1
20 SRC: 2	21 D HR: 15
22 STAT: 01	23 MEDICAL RECORD NO.
24 CONDITION CODES: 89	31
32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE
34 OCCURRENCE CODE / DATE	35 OCCURRENCE CODE / DATE
36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
38	39 VALUE CODES CODE / AMOUNT
40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	Emergency Room			1	329 00		
2	270	Med Surg Supplies			3	72 00		
23	001	Total Charges				401 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare M0000	300000	y	y	0 00		
B	State Emp E000	00300	y	y	130 00		
C	Medicaid DNC00	3000000	y	y		271 00	
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Recipient, Joe	01	900000000A		
B	Recipient, Joe	01	900000000001		
C	Recipient, Joe	01	900000000C		

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
64893	49392								64890		

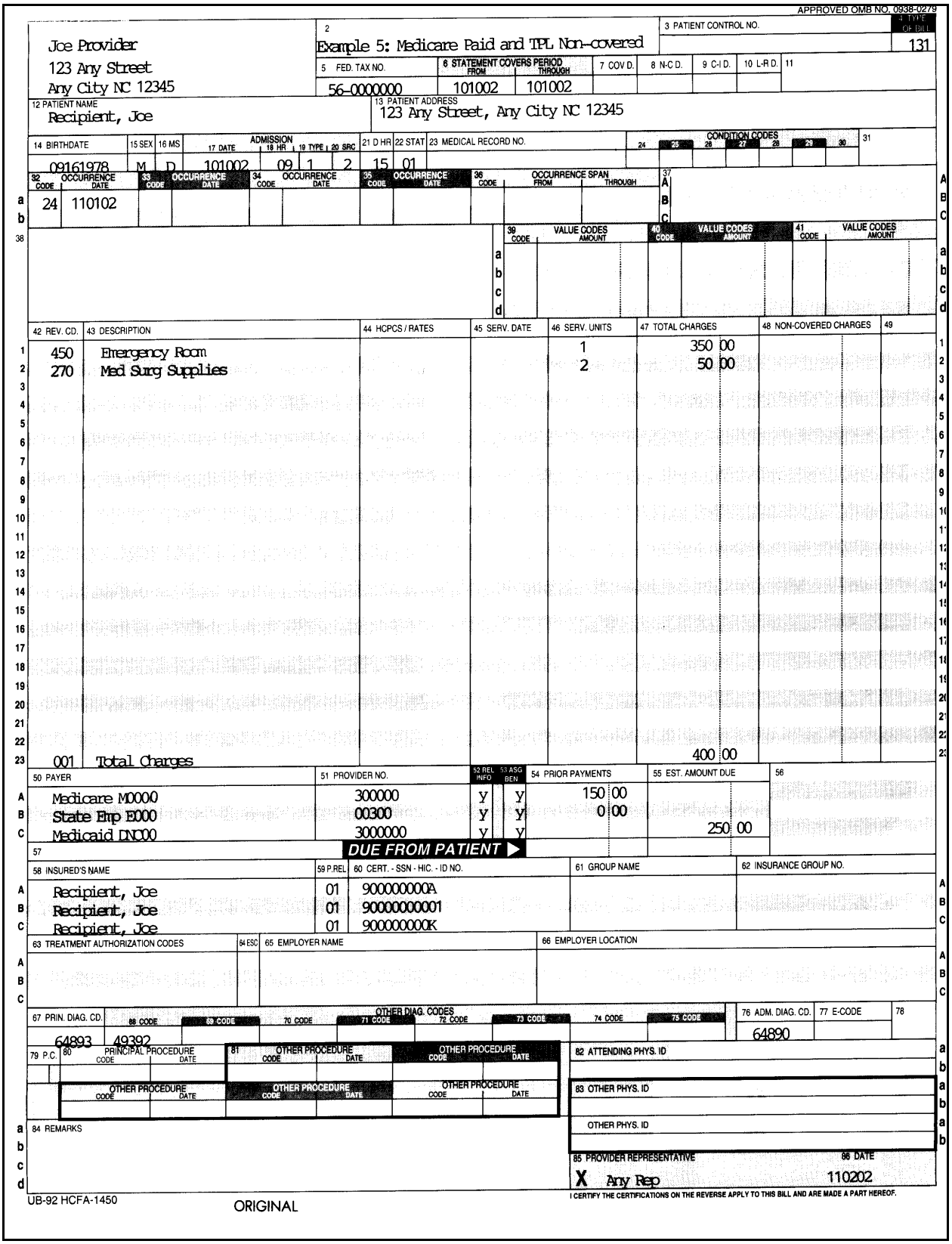
79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE

	84 REMARKS	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	OTHER PHYS. ID
a				
b				
c				
d				

85 PROVIDER REPRESENTATIVE: X Any Rep — 86 DATE: 101202

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 ORIGINAL



APPROVED OMB NO. 0938-0279

Joe Provider 123 Any Street Any City NC 12345	2 Example 5: Medicare Paid and TPL Non-covered	3 PATIENT CONTROL NO.	4 TYPE OF BILL: 131
	5 FED. TAX NO.: 56-0000000	6 STATEMENT COVERS PERIOD FROM: 101002 THROUGH: 101002	7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11
12 PATIENT NAME: Recipient, Joe	13 PATIENT ADDRESS: 123 Any Street, Any City NC 12345		

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
09161978	M	D	101002	09	1	2	15	01			

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a	24	110102										A
b												B
												C

38

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	Emergency Room			1	350 00		
2	270	Med Surg Supplies			2	50 00		
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				400 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare M0000	300000	y	y	150 00		
B	State Emp E000	00300	y	y	0 00		
C	Medicaid DN000	3000000	y	y		250 00	

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Recipient, Joe	01	900000000A		
B	Recipient, Joe	01	900000000001		
C	Recipient, Joe	01	900000000K		

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
64893	49392								64890		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS. ID

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE: X Any Rep

86 DATE: 110202

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0279

Joe Provider
123 Any Street
Any City, NC 12345

2 Example 6: 100% Medicare Deductible/Paper/Attach Voucher

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 131

5 FED. TAX NO.: 56-0000000

6 STATEMENT COVERS PERIOD — FROM: 110102 THROUGH: 110102

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

12 PATIENT NAME: Recipient, Jane

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

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
01191952	F	D	110102	07	1	2	17	01	

24–30 CONDITION CODES | 31

32–35 OCCURRENCE CODE / DATE | 36 OCCURRENCE SPAN FROM / THROUGH | 37 A B C

38

39–41 VALUE CODES — CODE / AMOUNT (a, b, c, d)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
450	Emergency Room			1	300 00		
001	Total Charges				300 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicare M0000	300000	Y	Y	0 00		
B Medicaid DNC00	3000000	Y	Y		300 00	
C						

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Recipient, Jane		200000000A		
B Recipient, Jane		900000000K		
C				

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

67 PRIN. DIAG. CD.: 49392

68–75 OTHER DIAG. CODES

76 ADM. DIAG. CD.: 49392

77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Any Rep

86 DATE: 11/1/02

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 ORIGINAL

ADA Claim Forms

Refer to pages 26 through 31 for examples of claims filed on the ADA claim form.

Example 1: Medicare/Medicaid Only

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must enter the Medicare payment amount including penalties and outpatient psychiatric reduction in field 59 in the block labeled "Payment by other plan." Medicaid deducts the Medicare payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider. These claims can be filed electronically.

Payment Calculation

Procedure Code	Medicaid Allowable
11440	$112.36
Total Medicaid Allowed =	$112.36

Total Medicare Payment (field 59) = $117.98

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$112.36	-	$117.98	=	Less than zero

Therefore, the provider is paid zero by Medicaid.

Example 2: Medicare/TPL/Medicaid

When the recipient has both Medicare and Medicaid coverage and another insurance primary to Medicaid, the provider must total both the Medicare payment and the commercial insurance payment and enter the total payment amount including penalties and outpatient psychiatric reduction in field 59 in the block labeled "Payment by other plan." Medicaid deducts the total payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider. The provider must submit a paper claim with both the Medicare voucher and the commercial insurance voucher attached.

Payment Calculation

Procedure Code	Medicaid Allowable
11441	$142.55
Total Medicaid Allowed =	$142.55

Total Medicare/TPL Payment (field 59) = $166.45

Total Medicaid allowed	-	Total Medicare/TPL payment	=	Total Medicaid pays to the provider
$142.55	-	$166.45	=	Less than zero

Therefore, the provider is paid zero by Medicaid.

Example 3: Medicare Non-Covered Services

When a claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. 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 on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

Payment Calculation

Procedure Code	Medicaid Allowable
D2933	$104.88
D0120	$ 23.07
Total Medicaid Allowed =	$127.95

Total Medicare Payment (field 59) = $0.00

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$127.95	-	$0.00	=	$127.95

Therefore, the provider is paid $127.95 by Medicaid.

Example 4: Medicare Non-Covered and TPL Payment

When a recipient has Medicare, commercial insurance, and Medicaid coverage and the claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. 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 on paper with the commercial payment amount entered in field 59 in the block labeled "Payment by other plan" and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

Payment Calculation

Procedure Code	Medicaid Allowable
D3330	$330.36
D2336	$ 71.60
D2336	$ 71.60
Total Medicaid Allowed =	$473.56

Total TPL Payment (field 59) = $1,576.00

Total Medicaid allowed	-	Total TPL payment	=	Total Medicaid pays to the provider
$473.56	-	$1,576.00	=	Less than zero

Therefore, the provider is paid zero by Medicaid.

Example 5: Medicare Paid and TPL Non-Covered
When the recipient has Medicare, commercial insurance, and Medicaid coverage and the commercial insurance denies the service, the provider must submit a paper claim with the Medicare payment amount including penalties and outpatient psychiatric reduction in field 59 in the row labeled "Payment by other plan" with the commercial insurance denial attached to the claim.

Payment Calculation

Procedure Code	Medicaid Allowable
21240	$869.68
Total Medicaid Allowed =	$869.68

Total Medicare Payment (field 59) = $913.16

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$869.68	-	$913.16	=	Less than zero

Therefore, the provider is paid zero by Medicaid.

Example 6: Medicare Applies 100 Percent of Payment Towards the Deductible
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 paper claim with the Medicare voucher attached to the claim. The claim will then pay up to the Medicaid allowable.

Payment Calculation

Procedure Code	Medicaid Allowable
D7920	$345.03
Total Medicaid Allowed =	$345.03

Total Medicare Payment (field 59) = $0.00, Medicare voucher must be attached to the claim.

Total Medicaid allowed	-	Total Medicare payment	=	Total Medicaid pays to the provider
$345.03	-	$0.00	=	$345.03

Therefore, the provider is paid $345.03 by Medicaid.

Dental Claim Form

Example 1: Medicare/Medicaid only

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside): 7900000
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Jane
9. Address: 123 Any Street
10. City: Any City
11. State: NC
12. Date of Birth (MM/DD/YYYY): 02 / 25 / 1955
13. Patient ID #: 900000000N
14. Sex: ☐M ☒F
15. Phone Number: ( ) 555 555-5555
16. Zip Code: 12345
17. Relationship to Subscriber/Employee: ☒Self ☐Spouse ☐Child ☐Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan: ☐No (Skip 32–37) ☐Yes. ☐Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Joe Dentist
43. Phone Number: (555) 555-5555
44. Provider ID #: 8900000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 Any Street
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other
50. City: Any City
51. State: NC
52. Zip Code: 12345
53. Radiographs or models enclosed? ☐Yes. How many? _____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No. If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No. If no, reason for replacement: _____ Date of prior placement _____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes. Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither. Brief description and dates

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
10 05 2002				11440	1	Removal skin lesion	457.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	457.00
Payment by other plan	117.98
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X Joe Dentist, DDS — Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999
J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746

Dental Claim Form

Example 2: Medicare/TPL/Medicaid

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside): 7900000
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Jane
9. Address: 123 Any Street
10. City: Any City
11. State: NC
12. Date of Birth (MM/DD/YYYY): 02 / 22 / 1955
13. Patient ID #: 900000000K
14. Sex: ☐M ☒F
15. Phone Number: (555)555-5555
16. Zip Code: 12345
17. Relationship to Subscriber/Employee: ☒ Self ☐ Spouse ☐ Child ☐ Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status: ☐ Married ☐ Single ☐ Other
30. Sex: ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan: ☐ No (Skip 32–37) ☐ Yes ☐ Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status: ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Joe Dentist
43. Phone Number: (555) 555-5555
44. Provider ID #: 8900000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 Any Street
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒ Office ☐ Hosp. ☐ ECF ☐ Other
50. City: Any City
51. State: NC
52. Zip Code: 12345
53. Radiographs or models enclosed? ☐ Yes, How many?_____ ☐ No
54. Is treatment for orthodontics? ☐ Yes ☐ No
If service already commenced:
Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No
If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes
Brief description and dates _____
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither
Brief description and dates _____

58. Diagnosis Code Index (optional)
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
10 05 2002				11441	1	Excision, other benign other	350.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent

1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17

Primary

A B C D E	F G H I J
T S R Q P	O N M L K

Total Fee	350.00
Payment by other plan	166.45
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures
X Joe Dentist, DDS _____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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To Reorder, call 1-800-947-4746

Dental Claim Form

Example 3: Medicare Non-covered Services

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside): 7900000
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Jane
9. Address: 123 Any Street
10. City: Any City
11. State: NC
12. Date of Birth (MM/DD/YYYY): 10/ 15 /1998
13. Patient ID #: 900000000W
14. Sex: ☐M ☒F
15. Phone Number: (555) 555-5555
16. Zip Code: 12345
17. Relationship to Subscriber/Employee: ☒ Self ☐ Spouse ☐ Child ☐ Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs /Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY)
29. Marital Status: ☐ Married ☐ Single ☐ Other
30. Sex: ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X ____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan: ☐ No (Skip 32–37) ☐ Yes ☐ Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status: ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X ____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Joe Dentist
43. Phone Number: (555) 555-5555
44. Provider ID #: 7900000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 Any Street
47. Dentist License #
48. First visit date of current series
49. Place of treatment: ☒ Office ☐ Hosp. ☐ ECF ☐ Other
50. City: Any City
51. State: NC
52. Zip Code: 12345
53. Radiographs or models enclosed? ☐ Yes. How many?_____ ☐ No
54. Is treatment for orthodontics? ☐ Yes ☐ No. If service already commenced: Date appliances placed ____ Total mos. of treatment remaining ____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No. If no, reason for replacement: ____ Date of prior placement ____
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes. Brief description and dates ____
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither. Brief description and dates ____

58. Diagnosis Code Index (optional) 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
04 02 2002	16			D2933	1	Prefab SS crown	334.00
04 02 2002				D0120		Periodic Oral Eval	125.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

61. Remarks for unusual services

Total Fee	459.00
Payment by other plan	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Joe Dentist, DDS ____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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Dental Claim Form

Example 4: Medicare Non-covered and TPL Payment

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1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside): 7900000
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Jane
9. Address: 123 Any Street
10. City: Any City
11. State: NC
12. Date of Birth (MM/DD/YYYY): 10 / 15 / 1958
13. Patient ID #: 900000000K
14. Sex: ☐M ☒F
15. Phone Number: (555) 555-5555
16. Zip Code: 12345
17. Relationship to Subscriber/Employee: ☒Self ☐Spouse ☐Child ☐Other
18. Employer/School Name ____ Address ____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY)
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan: ☐No (Skip 32–37) ☐Yes. ☐Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name ____ Address ____

38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X ____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School Name ____ Address ____

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X ____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Joe Dentist
43. Phone Number: (555) 555-5555
44. Provider ID #: 8900000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 Any Street
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☐Office ☐Hosp. ☐ECF ☐Other
50. City: Any City
51. State: NC
52. Zip Code: 12345
53. Radiographs or models enclosed? ☐Yes. How many? ____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No. If service already commenced: Date appliances placed ____ Total mos. of treatment remaining ____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No. If no, reason for replacement: ____ Date of prior placement: ____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes. Brief description and dates ____
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither. Brief description and dates ____

58. Diagnosis Code Index (optional) 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
10 05 2002				D3330	1		3594.00
10 05 2002				D2336	1		1545.00
10 05 2002				D2336	1		1545.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	6684.00
Payment by other plan	1576.00
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Joe Dentist, DDS ____ Signed (Treating Dentist) License # ____ Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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Dental Claim Form

Example 5: Medicare Paid and TPL Non-covered

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1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside): 7900000
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Jane
9. Address: 123 Any Street
10. City: Any City
11. State: NC
12. Date of Birth (MM/DD/YYYY): 2/ 22 / 1955
13. Patient ID #: 900000000K
14. Sex: ☐M ☒F
15. Phone Number: ( ) 555 555-5555
16. Zip Code: 12345
17. Relationship to Subscriber/Employee: ☒Self ☐Spouse ☐Child ☐Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan: ☐No (Skip 32–37) ☐Yes ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Joe Dentist
43. Phone Number: ( ) 555 555-5555
44. Provider ID #: 8900000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 Any Street
47. Dentist License #
48. First visit date of current series
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other
50. City: Any City
51. State: NC
52. Zip Code: 12345
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No — If service already commenced: Date appliances placed / Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement / Date of prior placement
56. Is treatment result of occupational illness or injury? ☐No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither — Brief description and dates

58. Diagnosis Code Index (optional) 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
10 10 2002				21240	1		1100.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	1100.00
Payment by other plan	913.16
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
x Joe Dentist, DDS — Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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Dental Claim Form

Example 6: 100% Medicare Deductible/Paper/Voucher Attached

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1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside): 7900000
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Jane
9. Address: 123 Any Street
10. City: Any City
11. State: NC
12. Date of Birth (MM/DD/YYYY): 2/ 22/ 1947
13. Patient ID #: 900000000K
14. Sex: ☐M ☒F
15. Phone Number: (555) 555-5555
16. Zip Code: 12345
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY)
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan: ☐No (Skip 32–37) ☐Yes ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address

38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School Name / Address

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Joe Dentist
43. Phone Number: (555) 555-5555
44. Provider ID #: 8900000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 Any Street
47. Dentist License #
48. First visit date of current series
49. Place of treatment: ☒Office ☐Hosp ☐ECF ☐Other
50. City: Any City
51. State: NC
52. Zip Code: 12345
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No. If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No. If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐No ☐Yes. Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither. Brief description and dates

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
11 12 2002				D7920	1	Skin Graft	350.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	350.00
Payment by other plan	0.00
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Joe Dentist, DDS _____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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Medicaid Claim Resolution Inquiries

Instructions for Completing the Medicaid Resolution Inquiry Form

The Medicaid Resolution Inquiry form is used **only** to submit claims for time limit overrides, TPL overrides, and other claims requiring overrides prior to processing (e.g., Medicare Part A, Medicare Part B, etc.). Send the completed form along with the claim, copies of the Remittance and Status Reports (RAs), and any other related information to the address listed on the form.

Include the following information on the form:

1. Provider number – indicate the billing provider number.
2. Provider name and address – indicate the billing provider name and address.
3. Recipient name – enter the recipient's name exactly as it appears on the MID card.
4. Recipient ID – enter the recipient ID as it appears on the MID card.
5. Date of Service – indicate the specific date(s) of service.
6. Claim number – indicate the internal control number (ICN) if the claim was previously processed.
7. Billed amount – enter the total amount billed on the claim.
8. Paid amount – enter the amount paid on the original claim (if applicable).
9. RA date – enter the date the original claim was paid (if applicable).
10. Specific reason for inquiry – this is the area to note your request, such as time limit override, or TPL and Medicare overrides. This space is also used to indicate any attachments such as RAs, medical records, TPL or Medicare insurance vouchers, etc.
11. Signature of sender.
12. Date – indicate the date the adjustment request is submitted (mailed).
13. Phone number – indicate the area code and telephone number of the person completing form.

Refer to page 29 for a copy of the Medicaid Resolution Inquiry form. The form is also available on DMA's website at http://www/dhhs.state.nc.us/dma.

MEDICAID RESOLUTION INQUIRY

MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: ☐ Claim Inquiry ☐ 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:

Remittance and Status Reports

Changes have been made to the location of crossover claims listed on the Remittance and Status Report (RA). Medicare Part B claims filed on the CMS-1500 claim form with dates of service on or after October 1, 2002 are no longer listed under the *Paid Claims Professional Crossovers* or *Denied Claims Professional Crossovers* sections of the RA. These claims are now listed under the *Paid Claims Medical* or *Denied Claims Medical* sections.

Medicare Part B claims filed on the UB-92 claim form with dates of service on or after October 1, 2002 no longer appear under the *Paid Claims Outpatient Crossovers* or *Denied Claims Outpatient Crossovers* sections. These claims are now listed under *Paid Claims Outpatient* or *Denied Claims Outpatient* sections.

Medicare Part B claims filed on the ADA claim form with dates of service on or after October 1, 2002 no longer appear under the *Paid Claims Dental Crossovers* or *Denied Claims Dental Crossovers* sections. These claims are now listed under *Paid Claims Dental* or *Denied Claims Dental* sections.

The RA also shows the complete payment amount for both Medicare and commercial insurance on the *TPL=* footer of the claim information section. Refer to page 35 and 36 for examples of these changes.

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

RECIPIENT, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER **7700000** REPORT SEQ. NUMBER DATE **10/01/2002** 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	**CO=92**		**RCC=**	**CLAIM NUMBER= 252002001001001NCXIX**								
900000000k						**MED REC= 123456**				**ATTN PROV= 7700000**		
NCXIX	**10302002**	**10302002**	**1 B**	**E0260 HOSPI BED W/ANY**	**160 00**	**40 00**	**120 00**	**00**	**120 00**	**10653**	**13 47**	**97**
DEDUCTBLE= .00	*PAT LIAB= .00*		*CO PAY= .00*	*TPL= 106.53*	*160 00*	*40 00*	*120 00*	*00*	*120 00*	*10653*	*13 47*	
ORIGINAL BILLED AMOUNT= 160.00			*ORIGINAL DETAIL COUNT = 1*			*TOTAL FINANCIAL PAYERS= 1*						

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

RECIPIENT, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER **7700000** REPORT SEQ. NUMBER DATE **10/01/2002** 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
Denied Claims												
Medical												
RECIPIENT JOE A	**CO=92**	**RCC=**	**CLAIM NUMBER= 252002001001001NCXIX**									
900000000k						**MED REC= 123456**				**ATTN PROV= 7700000**		
NCXIX	**10302002**	**10302002**	**1 B**	**E0260 HOSPI BED W/ANY**	**160 00**	**40 00**	**120 00**	**00**	**00**	**00**	**00**	**68**
DEDUCTBLE= .00	*PAT LIAB= .00*	*CO PAY= .00*	*TPL= .00*		*160 00*	*40 00*	*120 00*	*00*	*00*	*00*	*00*	
ORIGINAL BILLED AMOUNT= 160.00		*ORIGINAL DETAIL COUNT = 1*				*TOTAL FINANCIAL PAYERS= 1*						

North Carolina Medicaid Program Automated Voice Response System

24 Hours Per Day
1-800-723-4337
Except 1:00 a.m. to 5:00 a.m. on the 1st, 2nd, 4th, & 5th Sunday,
and 1:00 a.m. to 7:00 a.m. on the 3rd Sunday

The Automated Voice Response (AVR) system allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid program. Using a touch-tone telephone, providers may inquire about the following:

- ☎ Current Claim Status
- ☎ Procedure Code Pricing
- ☎ Hospice Participation
- ☎ Managed Care Enrollment *(Carolina ACCESS or HMO)*
- ☎ Checkwrite Information
- ☎ Prior Approval Information
- ☎ Refraction Benefit Limitation
- ☎ Drug Coverage Information
- ☎ Recipient Eligibility Verification
- ☎ Dental Benefit Limitations

Refer to the following transaction codes and information before placing your call. (**Note**: Providers will be allowed up to 15 transactions per call.)

Transaction	**Description**	**Required Information**
1	Verify Claim Status	Provider number, MID, "FROM DOS," total billed amount
2	Checkwrite Information	Provider Number
3	Drug Coverage	Provider Number, Drug Code, and DOS
4	Procedure Code Pricing and Modifier Information	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code and MID
6	Recipient Eligibility and Coordination of Benefits and Managed Care Status	Provider Number, MID or SSN#, DOS, and "FROM DOS" **Note: Response includes: HMO or Carolina ACCESS PCP Name, Phone Number**
7	Sterilization Consent or Hysterectomy Statement	Provider Number, MID, and DOS
9	To Repeat Options 1-7	

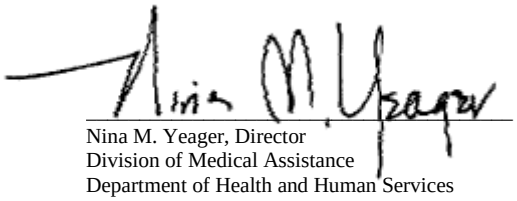
Quick Keys Are No Longer Valid

Alphabetic Data Table
The following table is a reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to place an * before entering the numeric codes.

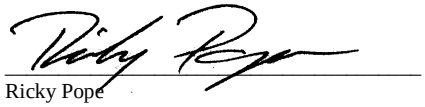
A- *21	E- *32	I- *43	M- *61	Q- *11	U- *82	Y- *93
B- *22	F- *33	J- *51	N- *62	R- *72	V- *83	Z- *12
C- *23	G- *41	K- *52	O- *63	S- *73	W- *91	
D- *31	H- *42	L- *53	P- *71	T- *81	X- *92	

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone keypad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key #8 in the third position, thus 83.

Note: Refer to the July 2001 Medicaid Special Bulletin for detailed instructions. This Special Bulletin can also be accessed through the Internet on DMA's website at **http://www.dhhs.state.nc.us/dma**.



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



Ricky Pope
Executive Director
EDS

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