North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Attention:

Area Mental Health Centers and Residential Treatment Providers (Level II-IV Services for Children Under the Age of 21)

HIPAA Code Conversions

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TABLE OF CONTENTS

INTRODUCTION 1

PROVIDER DESCRIPTIONS 2

AREA MENTAL HEALTH OUTPATIENT TREATMENT SERVICES 3
- Prior Approval 3
- Y2305 – Individual Services 3
- Y2306 – Group Services 5
- Y2307 – Case Management 6
- Y2311 and Y2312 – Day Treatment and Partial Hospitalization for Adults and Children 7
- Y2313 – Psychosocial Rehabilitation 7
- Y2314 – Assertive Community Treatment Team 7
- Y2315 – Facility-Based Crisis Service 8
- Y2364 through Y2372 – Community-Based Services 8

RESIDENTIAL SERVICES 10
- Area Mental Health Centers 10
- Direct-Enrolled Residential Child Care Providers 10

MEDICARE – F2 STAMP 11

THERAPEUTIC LEAVE 12

BILLING INSTRUCTIONS 13
- CMS-1500 Claim Form Instructions 13
- Place of Service Code Index 15
- Example of CMS-1500 Claim Form 17
- UB-92 Claim Form Instructions 18
- Examples of UB-92 Claim Forms 23

INTRODUCTION

Effective with dates of service January 1, 2004, all state-created codes for mental health and substance abuse services will be end-dated and converted to national codes to comply with the mandates of the Health Insurance Portability and Accountability Act (HIPAA). Many of the state-created codes have already been converted to national codes and have been published in past Medicaid bulletins. This special bulletin lists the national procedure codes pertaining to mental health and substance abuse services for outpatient mental health services provided by area mental health centers and residential treatment facilities, as recognized by the North Carolina Medicaid program. New/newly converted codes are indicated by bold font.

The following books and articles can be referenced for complete descriptions of codes and medical necessity criteria:

- American Medical Association's *Current Procedural Terminology 2003.* The *CPT 2003* provides a complete description of the CPT procedure codes referenced in this special bulletin.
- *HCPCS National Level II Codes 2003* for complete descriptions of the HCPCS procedure codes referenced in this special bulletin.
- *Medicaid Services Guidelines* for descriptions of services and medical necessity criteria. The documents are available on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' website at http://www.dhhs.state.nc.us/mhddsas/accountability/programassurance/index.htm.

PROVIDER DESCRIPTIONS

A **Qualified Professional** (QP) is defined as:

- a qualified mental health professional (QMHP)
- a qualified developmental disabilities professional (QDDP)
- a qualified substance abuse professional (QSAP)
- a qualified developmental addiction professional (QDAP)
- a qualified addiction professional (QAP)
- area program staff working toward qualified professional status who meet the education requirements and are working under the supervision of a qualified professional

An **Early Intervention Professional** is defined as:

- a Qualified Professional (as defined above)
- area program staff working toward qualified professional status who meet the education requirements and are working under the supervision of a qualified professional who holds an Infant/Toddler certification.

A **Paraprofessional** is defined as:

- area program staff who do not meet the requirements for a qualified professional but work under the supervision of a qualified professional.

AREA MENTAL HEALTH OUTPATIENT TREATMENT SERVICES

Outpatient treatment services include:

- therapy for mental health and substance abuse issues
- medication administration and monitoring
- behavioral counseling, contracts, programming
- methadone treatment

Prior Approval

Recipients Age 21 and Over

Effective January 1, 2002, Medicaid recipients age 21 and over receiving outpatient mental health services are required to obtain prior approval after the 8th visit. The 24-office visit limitation per year was removed and replaced by the requirement for prior approval after the 8th visit for mental health services subject to independent utilization review. Approval is based on medical necessity.

Recipients Under the Age of 21

Medicaid recipients under the age of 21 receiving outpatient mental health services are required to obtain prior approval after the 26 unmanaged visits in a calendar year.

Prior approval can be obtained by calling ValueOptions at 1-888-510-1150.

Y2305 – Individual Services

State-created code Y2305 will be end-dated and replaced with the following HCPCS and CPT codes. The language for H0002 and H0004 has been changed from substance abuse only to behavioral health for broader use. The remaining codes listed have been cross-walked over the past two years at different intervals.

The following table lists the HCPCS procedure codes for individual therapy services that are billable by Qualified Professional at area mental health centers.

HCPCS Procedure Code	HCPCS Code Description	Billing Units	Prior Approval
H0031	**Mental health assessment, by non-physician**	**1 unit = 15 min**	**Yes**
H0001	Alcohol and/or drug assessment	1 unit = 15 min	Yes
H0002	Behavioral health screening	1 unit = 15 min	Yes
H0004	Behavioral health counseling, each 15 minute unit	1 unit = 15 min	Yes
H0015	Alcohol and/or drug services	1 unit = 1 event per day (3 hours minimum)	Yes
H0020	Alcohol and/or drug services; methadone administration	1 unit = 1 event per day	No

The following table lists the CPT procedure codes for individual therapy services that are billable by physicians, licensed clinical social workers, psychologists, psychiatric nurses, nurse practitioners, physician assistants, licensed professional counselors, and licensed marriage and family practice counselors employed or contracted by the area mental health center. **The service that is billed must be within the scope of the provider's practice as indicated by their license.**

CPT Procedure Code	CPT Code Description	Billing Units	Prior Approval
90782	injection administration	1 unit = 1 event	No
90801	psychiatric interview	1 unit = 1 event	Yes
90802	interactive interview	1 unit = 1 event	Yes
Individual Psychotherapy			
90804	insight oriented 20 - 30 min	1 unit = 1 event	Yes
90805	with medical E/M services	1 unit = 1 event	Yes
90806	insight oriented 45 - 50 min	1 unit = 1 event	Yes
90807	with medical E/M services	1 unit = 1 event	Yes
90808	insight oriented 75 - 80 min	1 unit = 1 event	Yes
90809	with medical E/M services	1 unit = 1 event	Yes
90810	interactive 20 - 30 min	1 unit = 1 event	Yes
90811	with medical E/M services	1 unit = 1 event	Yes
90812	interactive 45 - 50 min	1 unit = 1 event	Yes
90813	with medical E/M services	1 unit = 1 event	Yes
90814	interactive 75 - 80 min	1 unit = 1 event	Yes
90815	with medical E/M services	1 unit = 1 event	Yes

The following table lists the CPT procedure codes for individual therapy services that are billable by physicians, licensed clinical social workers, psychologists, psychiatric nurses, nurse practitioners, physician assistants, licensed professional counselors, and licensed marriage and family practice counselors employed or contracted by the area mental health center. **These services are only billable when provided in an inpatient hospital, partial hospitalization, or residential care facility setting.**

CPT Procedure Code	CPT Code Description	Billing Units	Prior Approval
90816	insight oriented 20 - 30 min	1 unit = 1 event	Yes
90817	with medical E/M services	1 unit = 1 event	Yes
90818	insight oriented 45 - 50 min	1 unit = 1 event	Yes
90819	with medical E/M services	1 unit = 1 event	Yes
90821	insight oriented 75 - 80 min	1 unit = 1 event	Yes
90822	with medical E/M services	1 unit = 1 event	Yes
90823	interactive 20 - 30 min	1 unit = 1 event	Yes
90824	with medical E/M services	1 unit = 1 event	Yes
90826	interactive 45 - 50 min	1 unit = 1 event	Yes
90827	with medical E/M services	1 unit = 1 event	Yes
90828	interactive 75- 80 min	1 unit = 1 event	Yes
90829	with medical E/M services	1 unit = 1 event	Yes

The following table lists CPT procedure codes for cognitive and behavioral testing services.

CPT Procedure Code	CPT Code Description	Billing Units	Prior Approval
96100	Psychological, per hour	1 unit = 1 hour	Yes
96105	Assessment of aphasia, per hour	1 unit = 1 hour	Yes
96110	Developmental; limited	1 unit = 1 hour	Yes
96111	Developmental; extended, per hour	1 unit = 1 hour	Yes
96115	Neurobehavioral status, per hour	1 unit = 1 hour	Yes
96117	Neuropsychological, per hour	1 unit = 1 hour	Yes

The following table lists CPT evaluation and management (E/M) codes for physician services. These E/M codes are only billable by physicians or physician extenders employed or contracted by the area mental health. Prior approval is not required for any E/M codes.

90862	99205	99215	99232	99238	99244	99254
99201	99211	99221	99233	99239	99245	99255
99202	99212	99222	99234	99241	99251	99261
99203	99213	99223	99235	99242	99252	99262
99204	99214	99231	99236	99243	99253	99263

Y2306 – Group Services

State-created code Y2306 will be end-dated and replaced with the following HCPCS and CPT codes.

The following table lists the CPT procedure codes for family or group outpatient services that are billable by physicians, licensed clinical social workers, psychologists, psychiatric nurses, nurse practitioners, physician assistants, licensed professional counselors, and licensed marriage and family practice counselors employed or contracted by the area mental health center. **The service that is billed must be within the scope of the provider's practice as indicated by their license.**

Procedure Code	CPT Code Description	Billing Units	Prior Approval
Family			
90846	without the patient present	1 unit = 1 event	Yes
90847	with patient present	1 unit = 1 event	Yes
90849	multifamily group psychotherapy	1 unit = 1 event	Yes
Group			
90853	group other then multifamily	1 unit = 1 event	Yes
90857	interactive	1 unit = 1 event	Yes

The following table lists the HCPCS procedure codes for group therapy services that are billable by qualified professionals.

Modifiers that are to be used are:
HR – Family/couple with client present
HS – Family/couple without client present
HQ – Group setting

HCPCS Procedure Code	HCPCS Code Description	Bill with Modifier	Billing Units	Prior Approval
H0004	Behavioral health counseling, per 15 minutes	HR – denotes family therapy with client present HS – denotes family therapy without client present HQ – denotes any other group	1 unit = 15 min	Yes

Y2307 – Case Management
State-created code Y2307 will be end-dated and replaced with the following HCPCS code.

HCPCS Procedure Code	HCPCS Code Description	Bill with Modifier	Billing Units	Prior Approval
T1017	**Targeted case management, each 15 minutes**	**HE – denotes mental health case management**	**1 unit = 15 min**	**No**

Y2311 and Y2312 – Day Treatment and Partial Hospitalization for Adults and Children

State-created codes Y2311 and Y2312 will be end-dated and replaced with the following HCPCS codes.

Modifiers to be used with this code are:
HA – Child/adolescent program
HB – Adult program, non-geriatric

HCPCS Procedure Code	HCPCS Code Description	Bill with Modifier	Billing Units	Prior Approval
H2012	**Behavioral health day treatment**	**HA – denotes that the service was provided to a child** **HB – denotes that the service was provided to an adult**	**1 unit = 1 hour (not to exceed 6 hours per day)**	**No**
H0035	**Mental health partial hospitalization, treatment, less than 24 hours**	**HA – denotes that the service was provided to a child** **HB – denotes that the service was provided to an adult**	**1 unit = 1 event (3 hours minimum)**	**No**

Y2313 – Psychosocial Rehabilitation

State-created code Y2313 will be end-dated and replaced with the following HCPCS code.

HCPCS Procedure Code	HCPCS Code Description	Billing Units	Prior Approval
H2017	**Psychosocial rehabilitation**	**1unit = 15 min**	**No**

Y2314 – Assertive Community Treatment Team (ACTT)

State-created code Y2314 will be end-dated and replaced with the following HCPCS code.

HCPCS Procedure Code	HCPCS Code Description	Billing Units	Prior Approval
H0040	**Assertive community treatment program, per diem**	**1 unit = 1 day (not to exceed 4 per calendar month)**	**No**

Y2315 – Facility-Based Crisis Service

State-created code Y2315 will be end-dated and replaced with the following HCPCS code. The facility-based program must meet all licensure and staffing requirements. Services must be billed on a daily basis. This service is only payable once daily. Services are limited to15 consecutive days.

HCPCS Procedure Code	HCPCS Code Description	Billing Units	Prior Approval
S9485	**Crisis intervention mental health services, per diem**	**1 unit = 1 event**	**No**

Y2364 through Y2372 – Community-Based Services

State-created codes Y2364 through Y2372 will be end-dated and replaced with the following HCPCS codes.

Modifiers to be used with these codes are:
HI – Integrated mental health/mental retardation/developmental disabilities program
HM – Less than bachelor's degree level (will use for paraprofessional)
TL – Early Intervention
HQ – Group setting
U1 – Group service by a paraprofessional

Old Code	HCPCS Procedure Code	HCPCS Code Description	Bill with Modifier	Billing Units	Prior Approval
Early Intervention					
Y2364	**H0036**	**Community psychiatric supportive treatment, face-to-face, per 15 minutes**	**HI – denotes an integrated mental health/mental retardation/ developmental disability program provided by individual early intervention (EI) professional**	**1 unit = 15 min (not to exceed 8 hours per day)**	**No**
Y2365 Y2366	**H0036**	**Community psychiatric supportive treatment, face-to-face, per 15 minutes**	**TL – denotes an early intervention service**	**1 unit = 15 min (not to exceed 8 hours per day)**	**No**

Old Code	HCPCS Procedure Code	HCPCS Code Description	Bill with Modifier	Billing Units	Prior Approval
Paraprofessional					
Y2370	**H0036**	**Community psychiatric supportive treatment, face-to-face, per 15 minutes**	**HM – denotes service provided by a paraprofessio n-al**	**1 unit = 15 min (not to exceed 8 hours per day)**	**No**
Y2371 Y2372	**H0036**	**Community psychiatric supportive treatment, face-to-face, per 15 minutes**	**U1 – denotes service provided by a paraprofessio n-al to a group**	**1 unit = 15 min (not to exceed 8 hours per day)**	**No**
Professional					
Y2367	**H0036**	**Community psychiatric supportive treatment, face-to-face, per 15 minutes**	**No modifier is required when the service is provided by an individual professional**	**1 unit = 15 min (not to exceed 8 hours per day)**	**No**
Y2368 Y2369	**H0036**	**Community psychiatric supportive treatment, face-to-face, per 15 minutes**	**HQ – denotes service provided by an individual professional in a group setting**	**1 unit = 15 min (not to exceed 8 hours per day)**	**No**

RESIDENTIAL SERVICES

Area Mental Health Centers

Y2347, Y2348, Y2362, Y2363 – Residential Services

These state-created codes can no longer be billed and must be replaced with the following HCPCS codes. These services are only payable once daily.

Old Code	Description	New HCPCS Procedure Code	HCPCS Code Description	Billing Units
Y2347	**Level I**	**H0046**	**Mental health service, not otherwise specified**	**1 unit = 1 event per day**
Y2362	**Level II therapeutic family**	**S5145**	**Foster care therapeutic child**	**1 unit = 1 event per day**
Y2363	**Level II**	**H2020**	**Therapeutic behavioral service**	**1 unit = 1 event per day**
Y2348	**Level III – IV**	**H0019**	**Behavioral health; long-term residential (non-medical, non-acute care), per diem**	**1 unit = 1 event per day**

Direct-Enrolled Residential Child Care Providers

Y2348, Y2349, Y2360, Y2361, Y2363 – Residential Services

These state-created codes can no longer be billed and must be replaced with the following HCPCS codes. Revenue code 902 will continue to be billed with the corresponding HCPCS code. These services are only payable once daily.

Old Code	Description	New HCPCS Procedure Code	HCPCS Code Description	Billing Units
Y2363	**Level II**	**H2020**	**Therapeutic behavioral services***	**1 unit = 1 event per day**
Y2348 Y2349 Y2360 Y2361	**Level III-IV**	**H0019**	**Behavioral health; long-term residential (non-medical, non-acute care), per diem****	**1 unit = 1 event per day**

Note:

* Prior approval is required for this service.

** Prior approval is required for this service. Level II, III, and level IV are identified on the request for authorization and linked to the prior approval process.

MEDICARE – F2 STAMP

When overriding Medicare, the provider must obtain written notification from Medicare that the benefits are exhausted, noncovered or do not meet Medicare criteria. Written notification, except in the case of benefits exhausted, may be documented from Medicare in the form of Medicare Notices or Medicare Provider Manuals. In the case where Medicare benefits have exhausted, a written denial must be obtained from Medicare.

If the area mental health center is not considered to be physician-directed according to Medicare criteria, claims should be submitted to Medicaid and should be stamped "F-2" along with the statement, "Physician not on premises when services rendered." Claims can be filed electronically with the Medicare override indicated.

If there is no enrolled Medicare provider in the local Area Mental Health Center, the program will inform the client of other alternatives to treatment by Medicare-enrolled providers. If there are no enrolled Medicare providers within a 30-mile radius of the facility, the local Area Mental Health Center is allowed to serve the client and bill Medicaid.

Claims submitted with insufficient statements or with a block on the F2 stamp that is not checked will deny. The EOB will state "Bill Part B Medicare carrier." The F2 stamp should be used to indicate the applicable Medicare override statement:

- "Annual Medicare Limits Exhausted."
- "This is a Medicare noncovered service."
- "Service does not meet Medicare criteria."
- "No enrolled Medicare provider in the area."

THERAPEUTIC LEAVE

The purpose of therapeutic leave is to allow the resident time away from the facility to be with family members or significant others, while reserving the resident's bed in the home. Therapeutic leave may not be taken for purposes of receiving inpatient services, provided either elsewhere or at a different level of care in the facility of residence, when such services are or will be paid for by Medicaid. Document each period of therapeutic leave in the resident's records including the date and time the resident, or resident's representative, sign the resident out from and back into the facility. When billing for therapeutic leave, remember that:

- Medicaid allows reimbursement for 15 days in a quarter and not to exceed 45 days in a calendar year. Unused days do not carry over from quarter to quarter.
- The days follow the child from facility to facility.
- Therapeutic leave must be planned and incorporated in the treatment plan and documented in the medical record.
- Therapeutic leave is only to be used when the child goes home on a trial visit or as part of reunification.
- It must **not** be used for children in detention, runners, respite or any other absence not listed in above.
- Continue to bill with RC 183 and the corresponding HCPCS code.

BILLING INSTRUCTIONS

CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	**Type of Coverage**	Place an (X) in the Medicaid block**.**
1a.	**Insured's ID Number**	Enter the recipient's ten-character identification number found on the MID card.
2.	**Patient's Name**	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	**Patient's Birth Date**	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
	Sex	Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).
5.	**Patient's Address**	Enter the recipient's street address including city, state, and zip code.
	Telephone	Entering the recipient's telephone number is optional.
9.	**Other Insured's Name**	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
19.	**Reserved for Local Use**	**For Area Mental Health Providers ONLY:** Enter the area mental health program reference number when applicable.
24A.	**Date(s) of Service "From" and "To"**	Enter the eight-digit date of service in the "From" block. **Example:** Record the date of service January 31, 2003 as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
24B.	**Place of Service**	Enter the appropriate code from the **Place of Service Code Index** on pages 15 and 16.
24D.	**Procedures, Services, or Supplies**	Enter the appropriate five-digit CPT or HCPCS code and appropriate modifier, if applicable.
24F.	**Charges**	Enter the usual and customary charge for each service rendered.
24G.	**Days or Units**	Enter the number of visits or units.

CMS-1500 Claim Form Instructions, continued

Block	Block Name	Explanation
26.	**Patient's Account No.**	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
28.	**Total Charge**	Enter the total charges.
29.	**Amount Paid**	**For dates of services before October 1, 2002**, enter the total amount received from third party payment source(s). No TPL voucher is needed when payment is entered. **Do not enter Medicare payments, copayment amounts or previous Medicaid payments.** These are automatically deducted at the time the claim is processed for payment. **For dates of service after October 1, 2002**, enter the total amount received from Medicare, including penalties and outpatient psychiatric reductions, and other third party payment source(s). 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 in block 29 and submit a paper claim with both the Medicare voucher and the commercial insurance voucher attached. Do not enter copayment amounts or previous Medicaid payments. Refer to the **September 2002 Draft Special Bulletin IV (Revised November 14, 2002)** ***Medicare Part B Billing Guidelines*** (http://www.dhhs.state.nc.us/dma/bulletin.htm) for detailed instructions on billing for Medicare Part B.
30.	**Balance Due**	Enter the difference between blocks 28 and 29.
31.	**Signature of Physician or Supplier Including Degrees or Credentials**	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a **Provider Certification for Signature on File form** has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
33.	**Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.**	Enter the billing provider's name, street address including zip code, and phone number. **PIN #:** Enter the attending physician's seven-character Medicaid provider number. **GRP #:** Enter the seven-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
11	**Office**	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home**	Home is considered the recipient's private residence, which also includes an adult care home facility.
21	**Inpatient Hospital**	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to recipients admitted for a variety of medical conditions.
22	**Outpatient Hospital**	A section of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	**Emergency Department - Hospital**	A section of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	**Ambulatory Surgical Center**	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	**Free-Standing Birthing Center**	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
26	**Military Treatment Facility**	A medical facility operated by one or more of the Uniformed Services Military Treatment Facilities (MTF). Also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
32	**Nursing Facility**	A facility that primarily provides skilled and intermediate nursing care to residents and provides related services for the rehabilitation of injured, disabled or sick persons or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	**Custodial Care Facility**	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component.
34	**Hospice**	A facility, other than a recipient's home, in which palliative and supportive care for terminally ill recipients and families are provided.

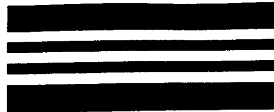
Place of Service Code Index, continued

POS Code	Description	Explanation
51	**Inpatient Psychiatric Facility**	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
53	**Community Mental Health Center**	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	**Intermediate Care Facility/Mentally Retarded**	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or nursing facility.
61	**Comprehensive Inpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	**Comprehensive Outpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	**End Stage Renal Disease Treatment Facility**	A facility other than a hospital, that provides dialysis treatment, maintenance or training to recipients or caregivers on an ambulatory or home-care basis.
71	**State or Local Public Health Clinic**	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	**Rural Health Clinic**	A certified facility that is located in a medically underserved rural area that provides ambulatory primary medical care under the general direction of a physician.
81	**Independent Laboratory**	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
99	**Other Unlisted Facility**	Other unlisted facilities not identified above, such as a school.

Refer to the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* for additional billing information. The guide is available at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm

Example of the CMS-1500 Claim Form

PLEASE
DO NOT
STAPLE
IN THIS
AREA



PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900 12 3456K

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 90 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 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): (919) 123 4567

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

PATIENT AND INSURED INFORMATION

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

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

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

19. RESERVED FOR LOCAL USE

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

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

1. 291 81
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C 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
10 01 03	10 01 03	11		H2012	HA	1	150 00	1				

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 $ 150 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

Signature on file 10/6/03

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 #
Any Provider
123 Any Street
Any City, NC 12345

PIN# GRP# 3404900

(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)

UB-92 Claim Form Instructions

Form Locator/Description	Requirements	Explanation
1. Provider Name/Address	Required	Enter the provider's name as it appears on the RA and up to three lines of the address. **Note:** Do not abbreviate the provider's name.
3. Patient Control Number	Required	Enter either the recipient control number or medical record number, which the provider has selected to appear on their RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA. **Note:** This form locator is optional for paper billing.
4. Type of Bill	Required Three Digits	Enter the appropriate revenue code: Admit Through Discharge 841 First Interim Claim 842 Continuing Claim 843 Last Claim 844
5. Federal Tax Number	Required, where applicable	
6. Statement Covers Period "From" and "Through"	Required	Enter the eight-digit beginning service date in the "From" block. Enter the eight-digit ending service date in the "Through" block. **Example:** Record the date of service January 31, 2003 as 01312003. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
17. Admission Date	Required	Enter the eight-digit date that the recipient was admitted. **Example:** Record the date January 31, 2003 as 01312003. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
19. Admission Type	Required	Indicate the applicable code for all inpatient visits. A "1" must be used to indicate an emergency department visit that meets emergency criteria to ensure that a copayment amount is not deducted during the claim processing. 1 **Emergency:** The patient requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency department. 2 **Urgent:** The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. 3 **Elective:** The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4 **Newborn:** Any newborn infant admitted to the hospital within the first 24 hours of life.
22. Patient Status	Required (except for ambulance and personal care services)	01 Discharged to home or self care (routine discharge). 02 Discharged/transferred to another short-term general hospital. 03 Discharged/transferred to skilled nursing facility. 04 Discharged/transferred to an intermediate care facility. 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired. 30 Still a patient or expected to return for outpatient services. 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
22. Patient Status, continued	Required (except for ambulance and personal care services)	62 Discharged/transferred to another rehabilitation facility including rehabilitation-distinct part units of a hospital. 63 Discharged/transferred to a long-term care hospital. 64 Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.
42. Revenue Code	Required	Enter the appropriate revenue code. Enter revenue code 902 when billing Psychiatric/psychol Treat-milieu therapy. Enter revenue code 183 when billing Theupeutic Leave.
44. HCPCS/Rates	Required	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes.
45. Service Date	Required	Enter an eight-digit service date for each line item billed. Required if multiple dates of services are billed on one outpatient claim. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
46. Unit of Service	Required	Enter the number of units for each detail line. **Note:** Level II - IV services will enter only one (1) unit per day.
47. Total Charges	Required	Enter the total of the amounts in this column. Enter the revenue code 001 on the corresponding line in form locator 42.
50. A, B, C Payer	Required	**Enter the Payer Classification Code and Specific Carrier Identification Code for each of up to three payers. List the payers in order of priority:** A Primary payer B Secondary payer C Tertiary payer The information entered on lines A, B, and C must correspond with the information in form locators 37, and 52 through 66. **Note:** Effective with date of service October 1, 2002, Medicare Part B payer codes M0000 must be indicated.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
50. A, B, C Payer, continued	Required	**Payer Classification Codes** Medicare M Medicaid D Blue Cross B Commercial Insurance I Tricare C NC DHHS-Purchase of Care N Worker's Compensation W State Employee Health Plan E Administered Plans S Health Maintenance Organization H Self-Pay/Indigent/Charity P Other O
		Specific Carrier Identification Codes

Payer Classification	Carrier Code	Explanatory Notes
Medicare (M)	0000	4 zeros
Medicaid (D)	XX00	Where XX = postal state code (example: NC00)
Blue Cross (B)	0XXX	Where XXX = Blue Cross Plan Code or FEP
Commercial Insurer (I)	XXXX	Where XXXX = Docket Number
Commercial Insurer (I)	9999	When Docket Number is unassigned
Tricare (C)	0000	4 zeros
NC DHHS – Purchase of Care	0000	4 zeros
Worker's Compensation	XXXX	Where XXXX = Docket Number
Worker's Compensation	9999	When Docket Number is unassigned
State Employees Health Plan	0000	4 zeros
Administered Plan (S)	0000	4 zeros
Health Maintenance Organization (H)	XXXX	Where XXXX = Docket Number
Health Maintenance	9999	When Docket Number is unassigned
Self-Pay/Indigent/ Charity (P)	6666	Self-pay-hospital bills patient and expects payment

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
51. A, B, C Provider Number	Required	Enter the Medicaid number as shown on the RA. Do not use extra zeros or dashes.
54. A, B, C Prior Payments (from Payers)	Required	For dates of service **before October 1, 2002**, enter any applicable third party amount. Enter the Medicare Part B payment amount in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim.
60. A, B, C Certificate/Social Security/ Health Insurance Claim/ Identification Number.	Required	Enter the ten-character MID number as indicated on the recipient's MID card.
67. Principal Diagnosis Code	Required	Enter the applicable ICD-9-CM diagnosis code.
68. - 75. Other Diagnosis Codes	Required	Enter any additional diagnosis codes.
85. Provider Representative Signature	Required	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Certificate of Signature on File has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.

Refer to the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* for additional billing information. The guide is available at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm

Example of UB-92 Claim Form – Residential Services

APPROVED OMB NO. 0938-0279

Joe Provider
123 Any Street
Any City, NC 00000

3 PATIENT CONTROL NO. XX1234

4 TYPE OF BILL 842

5 FED. TAX NO. 56-0000000

6 STATEMENT COVERS PERIOD FROM 10 01 03 THROUGH 10 05 03

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: 01 01 1995 | 15 SEX: M | 16 MS: S | ADMISSION 17 DATE: 10 01 03 | 18 HR | 19 TYPE: 3 | 20 SRC: 1 | 21 D HR | 22 STAT: 30 | 23 MEDICAL RECORD NO.

CONDITION CODES 24 25 26 27 28 29 30 | 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
Medicaid
P.O. Box 300010
Raleigh, NC 27622

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	902	Long-term residential	H0019	10 01 03	1	250 00		
2	902	Long-term residential	H0019	10 02 03	1	250 00		
3	902	Long-term residential	H0019	10 03 03	1	250 00		
4	902	Long-term residential	H0019	10 04 03	1	250 00		
5	902	Long-term residential	H0019	10 05 03	1	250 00		
23	001					1250 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid DNC00	6600000	Y	Y	0	1250 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	987 65 4321 N		

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

67 PRIN. DIAG. CD.: 3131 | 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

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

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

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Any Provider | 86 DATE: 10-6-03

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

UB-92 HCFA-1450 ORIGINAL

Example of UB-92 Claim Form – Residential Services-Therapeutic Leave

APPROVED OMB NO. 0938-0279

Joe Provider
123 Any Street
Any City, NC 00000

2

3 PATIENT CONTROL NO.: XX1234
4 TYPE OF BILL: 843

5 FED. TAX NO.: 56-0000000
6 STATEMENT COVERS PERIOD FROM: 10 6 03 THROUGH: 10 07 03
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 DATE (ADMISSION)	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
01011995	M	S	10 01 03		3	1		30	

24–30 CONDITION CODES 31

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

38
Medicaid
P.O. Box 300010
Raleigh, NC 27622

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	183	Long-term residential	H0019	10 06 03	1	250 00		
2	183	Long-term residential	H0019	10 07 03	1	250 00		
23	001					500 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid DNC00	6600000	Y	Y	0	500 00	
B							
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	987 65 4321 N		
B					
C					

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

67 PRIN. DIAG. CD.: 3131
68 CODE; 69 CODE; 70 CODE; 71 CODE; 72 CODE; 73 CODE; 74 CODE; 75 CODE (OTHER DIAG. CODES); 76 ADM. DIAG. CD.; 77 E-CODE; 78

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

85 PROVIDER REPRESENTATIVE: X Any Provider
86 DATE: 10-8-03

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

UB-92 HCFA-1450 ORIGINAL

Example of UB-92 Claim Form – Area Mental Health Center - Therapeutic Leave

APPROVED OMB NO. 0938-0279

Joe Provider
123 Any Street
Any City, NC 00000

3 PATIENT CONTROL NO.: XX1234

4 TYPE OF BILL: 841

5 FED. TAX NO.: 56-0000000

6 STATEMENT COVERS PERIOD FROM: 10 11 03 THROUGH: 10 15 03

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 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
01 01 1995	M	S	10 01 03		3	1		30	

CONDITION CODES 24 25 26 27 28 29 30 | 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
Medicaid
P.O. Box 300010
Raleigh, NC 27622

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	183	Therapeutic Leave	H0019	10 11 03	1	250 00		
2	183	Therapeutic Leave	H0019	10 12 03	1	250 00		
3	183	Therapeutic Leave	H0019	10 13 03	1	250 00		
4	183	Therapeutic Leave	H0019	10 14 03	1	250 00		
5	183	Therapeutic Leave	H0019	10 15 03	1	250 00		
23	001					1250 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid DNC00	3404000	Y	Y	0	1250 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.
Recipient, Joe	01	987 65 4321 N		

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

67 PRIN. DIAG. CD.: 3131

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

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

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

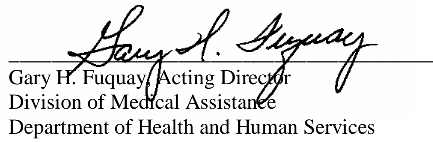
OTHER PHYS. ID

84 REMARKS

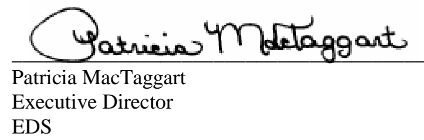
85 PROVIDER REPRESENTATIVE: X Any Provider | 86 DATE: 10 16 03

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

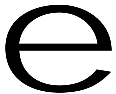
UB-92 HCFA-1450 ORIGINAL



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



Patricia MacTaggart
Executive Director
EDS



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