

# North Carolina Medicaid Bulletin

*An Information Service of the Division of Medical Assistance*

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

**Number 12**

**December 1997**

## **Attention: All Providers**

### **Holiday Observance**

The Division of Medical Assistance (DMA) and Electronic Data Systems (EDS) will be closed on Wednesday, December 24, 1997, Thursday, December 25, 1997, and Friday, December 26, 1997, in observance of Christmas.

DMA and EDS will also be closed on Thursday, January 1, 1998, in observance of New Year's Day.

## **Attention: All Providers**

### **1998 Medicaid Fair**

The 1998 North Carolina Medicaid Fair is scheduled for Tuesday, May 19, 1998, at the Holiday Inn Four Seasons (Joseph S. Koury Convention Center) in Greensboro, North Carolina.

A special bulletin will be mailed in January that will include seminar information, booth information, and a registration form. Please watch for this important publication.

## **Attention: All Providers**

### **Adjustment and Inquiry Forms**

EDS has been receiving an increasing number of requests for the Adjustment and Inquiry forms. Attached are the instructions and a copy of each form that may be copied as needed. Additional guidelines for using these forms is in the January 1996 Special Bulletin.

### **EDS**

**1-800-688-6696 or 919-851-8888**

***Providers are responsible for informing their billing agency of information in this bulletin.***

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## **Adjustment Request Form**

The Adjustment Request Form should only be used to adjust a previously paid claim. This form should not be used to inquire about a claim or to submit a claim for services which exceed time limit. A copy of the adjustment form is on page 3.

Always attach the remittance advice (RA) related to the adjustment when filling out this form as well as any medical records which could justify the reason for paying a previously denied claim/detail.

The following are instructions for completing the Adjustment Request Form:

- Provider number - indicate the billing provider number
- Provider name - enter the name of the billing provider
- Recipient's name - enter the recipient name as it appears on the Medicaid card
- Recipient ID - enter the recipient ID number as it appears on the Medicaid card
- Date of service - indicate the specific date of service or span of dates covered on the original claim
- Claim number - enter the internal claim number (ICN) as indicated on the RA. Always reference the original ICN even if you have a subsequent denied adjustment
- Type of adjustment - indicate the reason for the adjustment, i.e., overpayment, under payment, full recoupment, or any other reason
- Billed amount - indicate the amount billed on the original claim
- Paid amount - enter the amount paid on the original claim
- RA date - enter the date the original claim was paid
- Changes or corrections to be made - indicate the reason for the adjustment i.e., incorrect units processed and paid, incorrect date of service, third party liability (TPL), etc.
- Specific reason for adjustment request - indicate the specific reason for adjustment request. If the adjustment is the result of procedures not being combined, indicate the codes which are being combined. If the adjustment is necessitated by incorrect units, indicate total number of correct units as it should have appeared on the original claim and the correct date(s) of service
- Signature of sender
- Phone number - enter daytime phone number
- Date - indicate the date the adjustment request is submitted/mailed

## **Resolution Inquiry Form**

The Medicaid Resolution Inquiry Form should be used only to submit claims for time limit overrides, TPL overrides, and other claims requiring overrides prior to processing, i.e., Medicare part A, Medicare part B, etc. A copy of this form is on page 4.

After completing this form you should attach your claim, RAs, and any other related information.

The following are instructions for completing the Medicaid Resolution Inquiry Form:

- Provider number - indicate the billing provider number
- Provider name and address - indicate the billing provider name and address
- Recipient name - enter the recipient name as it appears on the Medicaid card
- Recipient ID - enter the recipient ID as it appears on the Medicaid card
- Date of Service - indicate the specific date(s) of service
- Claim number - indicate the ICN if the claim was previously processed
- Billed amount - enter the total amount billed on the claim
- Signature of sender
- Phone number - enter daytime phone number

**MEDICAID ADJUSTMENT**

MAIL TO:  
EDS ADJUSTMENT UNIT  
P O BOX 300009  
RALEIGH, NC 27622

Provider Number: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Recipient Name: \_\_\_\_\_ Recipient ID: \_\_\_\_\_

Date of Service: From:    /    /    to    /    /    Claim Number: \_\_\_\_\_

Please Check (✓):	Billed Amount:	Paid Amount:	RA Date:
_____ Overpayment	_____	_____	_____

NOTE: **THIS FORM IS FOR CLAIM ADJUSTMENT ONLY.**

\_\_\_\_\_ Underpayment                      A CORRECTED CLAIM AND RA MUST BE ATTACHED.

\_\_\_\_\_ Full Recoupment

\_\_\_\_\_ Other

***CLAIM INQUIRIES ( i.e., time limit overrides) WILL NOT BE PROCESSED FROM THIS FORM***

Please Check (✓) changes or corrections to be made:

_____ Units	_____ Procedure/Diagnosis Code	_____ Billed Amount
_____ Dates of Service	_____ Patient Liability	_____ Further Medical Review
_____ Third Party Liability	_____ Medicare Adjustments	

Please Specify Reason for Adjustment Request:

Signature of Sender: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

**TO BE USED BY EDS ONLY**

**Remarks:**

# MEDICAID RESOLUTION INQUIRY

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

Please Check:  Claim Inquiry  Time Limit Override

NOTE: PLEASE USE THIS FORM FOR **TIME 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:

**Attention: Dental Providers****Additional CPT Surgeries Covered Under the Dental Program**

Effective October 1, 1997, the following list of CPT codes were available for dental providers:

Procedure Code	Description	Indicator	Maximum Allowed
40840	Vestibuloplasty; anterior	PA	\$709.55
40842	Vestibuloplasty; posterior, unilateral	PA	\$711.83
40843	Vestibuloplasty; posterior, bilateral	PA	\$889.78
40844	Vestibuloplasty; entire arch	PA	\$949.09



Note that on page 25 of the North Carolina Medicaid Dental Services Manual (August 1996), there are already two available ADA vestibuloplasty codes (07340, 07350). These codes are still covered by Medicaid. Continue to use 07340 for simple vestibuloplasty, labial or buccal frenectomy, and surgical exposure and ligation of a soft tissue impacted tooth. Continue to use 07350 for a complex vestibuloplasty. The additional CPT codes will allow for more specific reporting. These surgeries require prior approval (PA) from the EDS Prior Approval Unit before rendering treatment. On the ADA form, include a narrative documenting treatment rationale, the exact procedure to be performed, and the estimated fee for service.

**EDS**

**1-800-688-6696 or 919-851-8888**

**Attention: All Electronic Billers****Discontinued EDS Electronic Formats**

Effective January 1, 1998, in order to keep our system up to date with current formats, EDS will require the following electronic formats for direct data transmissions and diskette submissions:

-  Pharmacy electronic formats beginning with a header record of 1RD (this format is replacing header record beginning with 1HD)
-  Dental electronic formats beginning with a header record of 1RK (this format is replacing header record beginning with 1HK)

***Claims received in these older formats will not be processed as of January 1, 1998.***

If you use software provided by a vendor, inform them of the requirements to use the current formats by January 1, 1998. The vendor may contact the ECS unit at EDS to obtain these specifications.

If you are using the old EDS software, MicroECS, you will be affected. We encourage all providers currently using MicroECS to contact EDS to obtain a vendor list or a copy of the NECS software.

Contact the EDS ECS unit if you have questions.

**ECS Unit, EDS**

**1-800-688-6696 or 919-851-8888, menu option #1**

**Attention: Hospice Providers****Hospice Rates**

Effective with date of service January 1, 1998, hospice rates are as follows:

		<b>Routine Home Care</b>	<b>Continuous Home Care</b>	<b>Inpatient Respite Care</b>	<b>General Inpatient Care</b>	<b>Hospice Intermediate R &amp; B</b>	<b>Hospice Skilled R &amp; B</b>
Metropolitan Statistical Area	SC	RC 651 Daily	RC 652 Hourly (1)	RC 655 Daily (2) (3) (4)	RC 656 Daily (3) (4)	RC 658 Daily (5)	RC 659 Daily (5)
Asheville	39	93.56	22.73	102.28	416.40	82.66	110.22
Burlington	40	88.95	21.61	98.33	397.31	82.66	110.22
Charlotte	41	95.40	23.18	103.86	424.03	82.66	110.22
Fayetteville	42	92.00	22.36	100.95	409.96	82.66	110.22
Greensboro/WS/HP	43	93.87	22.81	102.55	417.68	82.66	110.22
Hickory	44	91.95	22.34	100.90	409.74	82.66	110.22
Jacksonville	45	86.43	21.00	96.18	386.92	82.66	110.22
Raleigh/Durham	46	97.27	23.64	105.47	431.78	82.66	110.22
Wilmington	47	90.70	22.04	99.84	404.59	82.66	110.22
Rural	53	85.95	20.88	95.76	384.90	82.66	110.22

*Note: Because providers are expected to bill their charges, no adjustments will be accepted.*

Key to Hospice Rate Table:

SC = Specialty Code
RC = Revenue Code

1. A minimum of eight hours of Continuous Home Care must be provided
2. There is a maximum of five consecutive days including the date of admission but not the date of discharge for Inpatient Respite Care. Bill for the sixth and any subsequent days at the routine home care rate.
3. Payments to a hospice for inpatient care are limited in relation to all Medicaid payments to the agency for Hospice care. During the 12 month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, inpatient respite, and general inpatient, may not exceed 20 percent of the aggregate total number of days of Hospice care provided during the same time period for all the hospice's Medicaid patients. Hospice care provided for patients with acquired immune deficiency syndrome (AIDS) is excluded in calculating the inpatient care limit. The hospice refunds any overpayments to Medicaid.

4. Date of Discharge: For the day of discharge from an inpatient unit, the appropriate home care rate should be billed instead of the inpatient care rate unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is billed for the discharge date.
5. When a **Medicare/Medicaid** recipient is in a nursing facility, Medicare is billed for the routine or continuous home care, as appropriate, and Medicaid is billed for the appropriate long term care rate. When a **Medicaid only** hospice recipient is in a nursing facility, the hospice may bill for the appropriate long term care (SNF/ICF) rate in addition to the home care rate provided in revenue code 651 or 652. See section 8.15.1, page 8-11, of the Medicaid Community Care Manual for details.

*Debbie Barnes, Financial Operations  
DMA, 919-733-6784*

## **Attention: Ambulance and Nursing Facility Providers**

### **Nonemergency Medically Necessary Transport**

Nursing facility transportation policy changes in 1994 were created in order to meet the needs and better define responsibilities of nursing facilities, ambulance providers and nursing facility residents and their families. This article serves as a reminder of those policy changes.

Effective October 1, 1994, DMA began directly reimbursing long-term care facilities for nonambulance transportation of Medicaid eligible recipients to receive medical care that cannot be provided in the facility. Family members are encouraged to provide transportation as a means to provide important family and social support to the recipient. The facility can not charge (or assess) the family or the patient's funds for the cost of this routine transportation.

#### Nursing facility responsibility for nonambulance transportation

The facility is responsible for arranging or providing nonambulance transportation for all Medicaid recipients. The facility may contract with providers (including county coordinated transportation systems) to provide transportation or may provide transportation services using its' own vehicles, whichever is more cost effective.

#### Nonemergency medically necessary ambulance transportation criteria

Ambulance transportation is covered when any other means of transportation would endanger the recipient's health and it is medically necessary that the recipient be transported via stretcher due to a medical/physical condition.

#### Denied nonemergency ambulance transportation

Claims for ambulance transportation are subject to medical review through the Medicaid claims processing system. Denied services can not be billed to the recipient or the family.

When a claim is denied due to lack of justification for medical necessity, (i.e., the individual could have been transported by the facility utilizing routine transportation because the individual's medical/physical condition did not warrant transport via stretcher) the ambulance provider should ensure that the claim was coded properly by reviewing the ambulance call report and contacting EDS Provider Services.

**EDS**  
**1-800-688-6696 or 919-851-8888**

**Attention: Dental and Physician Providers****Rate Adjustments**

Effective with date of service October 1, 1997, Medicaid has adjusted the following fees to conform with Medicare allowables. Providers are instructed to bill their usual and customary charge; therefore, no adjustments will be made. These same fees are reimbursed for physicians and dentists.

Procedure Code	New Allowable
21181	\$624.97
21282	\$302.93
42650	\$43.46
64400	\$49.10
64505	\$61.13
64600	\$157.47
64605	\$220.88
95868	\$97.42
97014	\$11.93

*EDS*

*1-800-688-6696 or 919-851-8888*

**Attention: Physicians Who Treat Children Under Age 21****Physicians Who Provide Services to Pregnant Women****Physician Qualifications for Medicaid Payment**

Physician qualifications mandated by Section 1903 (i)(12) of the Social Security Act for provision of services to children under age 21 or to pregnant women have been repealed by the Balanced Budget Act of 1997.

The qualifications specified by the Act were last published in the October 1996 Provider Bulletin.

*EDS*

*1-800-688-6696 or 919-851-8888*

**Attention: Ambulatory Surgical Centers (includes Dental in ASC)****New Payment Rates**

Effective with date of service October 1, 1997, the ambulatory surgical center rates were updated to reflect revisions made by Medicare. The new rates based on the average Medicare wage index for North Carolina are as follows:

Payment Group	Rate
1	\$301
2	\$405
3	\$462
4	\$570
5	\$650
6	\$763
7	\$902
8	\$896

Groups 6 and 8 are cataract procedures and include a \$150.00 allowance for a single intraocular lens. Separate payments for such lens will not be made.

*Pam Sanders, Financial Operations  
DMA, 919-733-6784*

**Attention: DME Providers****Prior Approval Requirements for HCPCS Code E0935**

Effective with claims processed beginning December 1, 1997, prior approval will be required for HCPCS code E0935 "passive motion exercise device." The following criteria will be used in establishing medical necessity:

HCPCS code E0935 will be covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within two days following surgery. In addition, coverage is limited to that portion of the three-week period following surgery during which the device is used in the patient's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications. Block 24 on the Certificate of Medical Necessity and Prior Approval form must be checked, indicating that the patient's status will be monitored by the physician while this equipment is provided.

*Melody B. Yeargan, P.T., Medical Policy  
DMA, 919-733-9434*



## **Attention: Physician, Optometric, Chiropractic, Podiatric, and Dental Providers**

### **Provider Information Changes**

The Division of Medical Assistance (DMA) is receiving an increasing amount of returned mail due to incorrect addresses. Please notify the DMA Provider Enrollment Unit in writing of any change in ownership, tax ID number, address, or group members.

For purposes of authenticity, notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Requests signed by billing agents or management consultants are not acceptable. Include the following information in the letter:

#### **I. ALL CHANGES:**

1. Name and provider number of all providers to whom the change applies
2. Effective date of the change
3. Contact person and telephone number in case Provider Enrollment has questions

#### **II. ADDRESS CHANGE:**

1. Street address where services are rendered
2. Office telephone number
3. Mailing address for payment if different from the street address

#### **III. CHANGE OF OWNERSHIP (CHOW):**

1. Name of previous owners
2. Name of new owners

Note: Notify DMA Provider Enrollment within 30 days of a change of ownership. An ownership change requires enrollment of the new owner, assignment of a new provider number and termination of the former owner's provider number.

#### **IV. GROUP MEMBER CHANGES:**

1. Physician's individual provider number
2. New group name and number
3. New address and phone number
4. Effective date the physician is joining the new group
5. Indicate if the physician is full-time or part-time

V. TAX ID NUMBER (Federal Employer Identification Number)

1. Old tax ID number
2. New tax ID number
3. Tax name as registered with the IRS

Note: DMA must have correct tax information to ensure that the 1099 MISC forms are correctly issued each year and that the correct tax information is provided to the IRS. The last page of the Medicaid Remittance and Status Report (RA) indicates the provider's tax name and tax ID number currently on file. Tax information must be provided on a W-9 form available from the IRS or on a special W-9 form provided by Medicaid. Refer to the November, 1997 North Carolina Medicaid Bulletin for a copy of the special W-9 form and detailed instructions on how to complete it.

SEND ALL CHANGES TO THE FOLLOWING ADDRESS:

Division of Medical Assistance  
Provider Enrollment  
P.O. Box 29529  
Raleigh, NC 27626-0529

***DMA Provider Enrollment***  
***919- 733-2130***

**Attention: DME Providers**

**New Criteria for HCPCS Code E0202**

Effective with date of receipt December 1, 1997, requests for prior approval for HCPCS code E0202 “phototherapy (bilirubin) light with photometer” will be subject to the following new criteria:

Code E0202 will be covered for treatment of hyperbilirubinemia within the first 30 days of life for a maximum of seven consecutive days. The family members and/or caregivers must be trained in the use of the equipment and any medically necessary follow-up must be provided by the supplier. In addition, Block 24 on the Certificate of Medical Necessity and Prior Approval form must be checked, indicating that the patient’s status will be monitored by the physician while the equipment is provided.

***Melody B. Yeargan, P.T., Medical Policy***  
***DMA, 919-733-9434***

**Attention: Home Health Providers**

**Seminar Schedule**

Seminars for Home Health providers will be held in January 1998. Each provider is encouraged to send appropriate administrative, clinical, and clerical personnel. Coverage issues for home health, service limitations and plan of care (HCFA-485) will be discussed. In addition, procedures for filing home health claims, common billing errors, and follow-up procedures will be reviewed.

Please select the most convenient site and return the completed registration form to EDS as soon as possible. Seminars begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. **Preregistration is strongly recommend.**

**Note: Providers are requested to bring their Community Care Manuals. Additional manuals will be available for purchase at \$20.00.**

Directions are available on page 14 of this bulletin.

**Wednesday, January 7, 1998**  
Holiday Inn  
4903 Market Street  
Wilmington, NC  
*Entourage Room*

**Friday, January 9, 1998**  
Martin Community College  
Kehakee Park Road  
Williamston, NC  
*Room 14*

**Monday, January 12, 1998**  
Ramada Inn Airport Central  
515 Clanton Road  
Charlotte, NC

**Tuesday, January 20, 1998**  
Ramada Plaza-Coliseum  
3050 University Parkway  
Winston-Salem, NC  
*Carnegie DuPont Room*

**Wednesday, January 21, 1998**  
Wake Medical Center  
MEI Conference Center  
3000 New Bern Avenue  
Raleigh, NC

**Monday, January 26, 1998**  
A-B Technical College  
340 Victoria Road  
Asheville, NC  
*Simpson Lecture Room*

(cut and return registration form only)

Home Health Provider Seminar Registration Form  
(No Fee)

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

Address \_\_\_\_\_ Contact Person \_\_\_\_\_

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ persons will attend the seminar at \_\_\_\_\_ on \_\_\_\_\_  
(location) (date)

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

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## **Attention: Carolina ACCESS and HMO Providers**

- HMO/Risk Contracting Program Expansion
- End of Direct Enrollment of ACCESS Recipients
- Dual Participation Policy

### **HMO/Risk Contracting Program Expansion**

The Division of Medical Assistance will be expanding its HMO/Risk Contracting Program to the following counties in the Triangle and contiguous area: Chatham, Durham, Harnett, Orange, Person and Wake Counties. The target date to begin HMO enrollment is January 1998. At that time, Medicaid recipients eligible to enroll with a Medicaid managed care program will have the option to choose between the HMO Program and the Carolina ACCESS Program at their respective Department of Social Services.

### **End of Direct Enrollment of ACCESS Recipients**

Effective January 1, 1998, Carolina ACCESS PCPs may no longer directly enroll patients into the Carolina ACCESS (CA) Program.

With HMOs expanding into counties currently participating in Carolina ACCESS, Medicaid recipients will be offered an additional managed care option. When HMOs establish in a CA county, DSS caseworkers will explain HMO and PCP programs to the recipient who must choose to participate in either. DSS caseworkers will share the Provider Directory with recipients and your practice will continue to be a choice if you are open for enrollment.

You will no longer be allowed to directly enroll patients into your practice after December 31, 1997.

If you have questions, please contact your local Managed Care Representative at the Department of Social Services.

### **Dual Participation Policy**

Effective October 1, 1997, primary care providers will have the option to participate simultaneously in both Carolina ACCESS, the Primary Care Case Management Program (PCCM) and the HMO/Risk Contracting Program, North Carolina's managed care programs for Medicaid recipients. This policy change allows primary care providers the greatest flexibility and choice to serve Medicaid recipients as a network member of a capitated HMO and/or as a fee-for-service Carolina Access provider.

The application process to participate in either program remains unchanged. Providers will still need to complete an application, a facility review sheet and sign a provider agreement to become a Carolina ACCESS provider. To become a member of a provider network for an HMO (or multiple HMOs), providers must contact the participating HMO(s) for their respective application procedures. To act as a primary care provider for both programs, providers must complete separate applications and meet the general terms and conditions of participation for each program.

***DMA Managed Care Unit***  
***1-800-228-8142 or 919-715-5417***

**Attention: All Providers**

**Directions to the Home Health Seminars**

The registration form for the workshop is on page 11 of this bulletin.

**HOLIDAY INN - WILMINGTON**

**Wednesday, January 7, 1998**

I-40 East into Wilmington to Highway 17 - just off of I-40. Turn right onto Market Street and Holiday Inn is located on the right.

**MARTIN COMMUNITY COLLEGE - WILLIAMSTON**

**Friday, January 9, 1998**

Take Highway 64 into Williamston College is approximately 1-2 miles west of Williamston. Room 14 is located in building 1.

**RAMADA INN AIRPORT CENTRAL - CHARLOTTE**

**Monday, January 12, 1998**

I-77 to Exit 7. Ramada Inn is located right off I-77 on Clanton Road. Signs will be posted with room locations.

**RAMADA PLAZA COLISEUM (Formerly Holiday Inn North) - WINSTON-SALEM**

**Tuesday, January 20, 1998**

I-40 Business to Cherry Street Exit. Continue on Cherry Street for 2-3 miles. Get in the left hand turn lane and make a left at IHOP Restaurant. The Holiday Inn is located behind the IHOP Restaurant.

**WAKE MEDICAL MEI CONFERENCE CENTER - RALEIGH**

**Wednesday, January 21, 1998**

Take the I-440 Raleigh beltline to New Bern Avenue, Exit 13A. Go toward Wake Medical Center on New Bern Avenue and at the stoplight at Sunnybrook Road, turn left. Turn left and park in the parking lot on the left. Parking is free. Walk back to New Bern Avenue up the sidewalk in front of the Wake County Department of Health and stay on the sidewalk until it leads you to the Medical Education Institute. Enter the building at the far left Conference Center Entrance and follow the signs to your classroom.

**A-B TECHNICAL COLLEGE - ASHEVILLE**

**Monday, January 26, 1998**

I-40 to Exit 50. Head North on Hendersonville Road to intersection with Route 25 (McDowell Street). Take a left on Route 25 to Intersection with Victoria Road. Take a left onto Victoria Road to the Administration Building.

**Attention: ICF/MR Providers**

**Individual Visits**

EDS is offering individual provider visits for all ICF/MR providers. If there are any questions regarding general Medicaid guidelines, policy changes, billing information, or claims follow-up procedures, please complete and return the form below. An EDS Provider Representative will contact you to schedule a visit.

(cut and return request form only)

ICF/MR Provider Visit Request Form  
(No Fee)

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_  
Address \_\_\_\_\_ Contact Person \_\_\_\_\_  
City, Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

List any specific concerns you would like us to address in the space below and return to:

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

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**Checkwrite Schedule**

December 9, 1997	January 6, 1998	February 3, 1998
December 16, 1997	January 13, 1998	February 10, 1998
December 30, 1997	January 22, 1998	February 19, 1998

**Electronic Cut-Off Schedule \***

December 5, 1997	January 2, 1998	January 30, 1998
December 12, 1997	January 9, 1998	February 6, 1998
December 19, 1997	January 16, 1998	February 13, 1998

\* *Electronic claims must be transmitted and completed by 5:00 p.m. EST on the cut-off date to be included in the next checkwrite as paid, denied, or pended. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite as paid, denied, or pended following the transmission date.*

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

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James R. Clayton  
Executive Director  
EDS

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<b>Bulk Rate</b>
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087

P.O. Box 30968  
Raleigh, North Carolina 27622