wisconsin Medicaid update and BadgerCare

June 2003 ● No. 2003-35
PHC 1967

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Prenatal Care Coordination Providers

HMOs and Other Managed Care Programs

Changes to local codes and paper claims for prenatal care coordination services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for prenatal care coordination (PNCC) services effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for prenatal care coordination (PNCC) services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are *not* policy or coverage related (e.g., documentation requirements). These changes include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

Note: Use of the newly adopted national codes or revised paper claim instructions prior to implementation dates may result in claim denials. Specific implementation dates will be published in a future *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for PNCC services.

Allowable procedure codes

Wisconsin Medicaid will adopt Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W7090-W7094) for PNCC services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart and revised PNCC maximum allowable fees. Keep in mind that the maximum allowable fees are the proposed fees and may be subject to change. Wisconsin

Medicaid will notify providers if the fees change from those printed in this *Update*. Providers will be required to use the appropriate HCPCS procedure code that describes the service performed.

The following specific changes will be made regarding procedure codes:

- For follow-up visits provided in the home, use procedure code H1004. The only valid POS for H1004 is "12" (home). For all other ongoing care coordination, use procedure code H1002.
- When billing the initial assessment, use procedure code H1000 and always bill a quantity of one.
- Updates to the assessment or care plan may be billed using procedure code H1002 or, if provided in the home, procedure code H1004.

Modifiers

Modifiers "00"-"30", currently used to indicate the recipient's total risk-assessment score, will no longer be valid for PNCC services. Wisconsin Medicaid will recognize two locally defined HCPCS modifiers ("U1" and "U2") and one nationally defined HCPCS modifier ("TT") for PNCC services. Modifier descriptions are as follows:

- Modifier "U1" — For Wisconsin Medicaid providers, "U1" in the PNCC service area is defined as "subsequent pregnancy." This will replace local modifier "SP." Modifier "U1" must be used with all procedure codes when submitting claims for PNCC services provided within 185 days of a previous pregnancy.
- Modifier "U2" — For Wisconsin Medicaid providers, "U2" in the PNCC service area is defined as "initial care plan development." This modifier must be used with procedure code H1002 when billing for initial care plan development. The procedure code-modifier combination replaces procedure code W7091.
- Modifier "TT" — Nationally defined as an "individualized service provided to more than one patient in same setting." This modifier is valid with procedure code H1003 only. It will be used to indicate health or nutrition education services provided in a group setting.

Diagnosis codes

Providers will continue to use diagnosis code V23.9 (unspecified high-risk pregnancy), when submitting claims for recipients who score 40 points or more on the Pregnancy Questionnaire, or V22.2 (pregnant state, incidental), for recipients who score fewer than 40 points.

Providers will continue to use diagnosis code V23.9 (unspecified high-risk pregnancy), when submitting claims for recipients who score 40 points or more on the Pregnancy Questionnaire, or V22.2 (pregnant state, incidental), for recipients who score fewer than 40 points.

Type of service codes

Type of service codes will no longer be required on Medicaid claims.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit POS codes used currently by Wisconsin Medicaid. Refer to Attachment 2 for a list of allowable POS codes for PNCC services.

Time units

When billing for a risk assessment (procedure code H1000), a quantity of one will always be used, which indicates a complete service. For all of the other procedure codes, one unit of service will be equal to 15 minutes. Maximum allowable fees have been adjusted for the new time units. Refer to Attachment 3 for new rounding guidelines for PNCC services.

Coverage for prenatal care coordination services

Medicaid coverage and documentation requirements for PNCC services will remain

unchanged. Refer to the Prenatal Care Coordination Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified PNCC providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 4 for the revised instructions. Attachments 5 and 6 are samples of claims for PNCC services that reflect the changes to the billing instructions.

With the implementation of HIPAA, Medicaid-certified PNCC providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time.

Note: In some instances, paper claim instructions are different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the CMS 1500 claim form instructions

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT 1
Procedure code conversion chart for prenatal care coordination services

The following table lists the nationally recognized procedure codes that providers will be required to use when submitting claims for prenatal care coordination (PNCC) services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Maximum allowable fees listed in this attachment are the proposed fees and may be subject to change. Wisconsin Medicaid will notify providers if the fees change from those printed in this *Update*.

Before HIPAA implementation		**After HIPAA implementation**			
Local procedure code	**Local procedure code description**	**HCPCS procedure code**	**HCPCS procedure code description**	**Required modifier and description**	**Maximum allowable fee*** **
W7090	Risk assessment	**H1000**	Prenatal care, at-risk assessment	**	$48.31
W7091	Initial care plan development	**H1002***	Prenatal care, at risk enhanced service; care coordination	**U2** Initial care plan development **	$8.00 each 15 minutes
W7092	Ongoing care coordination and monitoring	**H1002***	Prenatal care, at risk enhanced service; care coordination	**	$8.00 each 15 minutes
W7093	Health education/nutritional counseling — individual	**H1003***	Prenatal care, at-risk enhanced service; education	**	$12.08 each 15 minutes
W7094	Health education/nutritional counseling — group	**H1003***	Prenatal care, at-risk enhanced service; education	**TT** Individualized service provided to more than one patient in same setting **	$1.61 each 15 minutes
N/A		**H1004***	Prenatal care, at-risk enhanced service; follow-up home visit	**	$10.70 each 15 minutes

* Procedure codes H1002 — H1004 are only allowable if diagnosis code V23.9 (unspecified high-risk pregnancy) is indicated.

** "U1" modifier — When submitting claims for services provided within 185 days of a previous pregnancy, all procedure codes require the modifier "U1" (for example, when submitting claims for an initial care plan for a subsequent pregnancy, procedure code H1002 requires the modifiers "U1" and "U2" if the date of service is within 185 days of the first initial care plan).

*** The limit for PNCC services (procedure codes H1000, H1002-H1004) is $887.46 per recipient, per pregnancy.

ATTACHMENT 2
Place of service codes for prenatal care coordination services

The table below lists the place of service (POS) codes that providers should use when submitting claims after implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA.

Place of service code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 3
Rounding guidelines for prenatal care coordination services

Time units are calculated based on rounding accumulated minutes of service for the entire month. The following chart illustrates the rules of rounding and gives the appropriate billing unit.

Accumulated time	Unit(s) billed
1-5 minutes	.3
6-10 minutes	.7
11-15 minutes	1.0
16-20 minutes	1.3
21-25 minutes	1.7
26-30 minutes	2.0

Do not use these guidelines when billing for procedure code H1000 (prenatal care, at-risk assessment). Always enter "1.0" unit for this procedure code, which indicates a complete service.

ATTACHMENT 4
CMS 1500 claim form instructions for prenatal care coordination services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1980, would be 02/03/80) or in MM/DD/YYYY format (e.g., February 3, 1980, would be 02/03/1980). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number (not required)

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the appropriate diagnosis code as follows:

- Enter V23.9 (unspecified high-risk pregnancy) if the Pregnancy Questionnaire indicates a high-risk pregnancy (a score of 40 or more points on the Pregnancy Questionnaire).
- Enter V22.2 (pregnant state, incidental) if the Pregnancy Questionnaire indicates a pregnancy that is not high risk (a score of fewer than 40 points on the Pregnancy Questionnaire).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

For services performed on more than one date of service (DOS) within the month, indicate the last date the service was performed. If billing for more than one month of activities, or more than one procedure code, use one detail line for each month's activities with the DOS determined as described below.

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the last DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field.

Element 24B — Place of Service

Enter the appropriate two-digit place of service (POS) code for each service. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for prenatal care coordination services.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item (e.g., two hours and 10 minutes would equal 8.7 units). Always use a decimal (e.g., 2.0 units). Refer to Attachment 3 for rounding guidelines. Use a quantity of one for procedure code H1000.

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. Minimum requirement is the provider's name, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 5
Sample CMS 1500 claim form for prenatal care coordination services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (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): 1234567890

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

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

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

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

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

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

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. V23.9 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 15 03		11		H1000		1	XXX XX	1.0				
2 11 15 03		11		H1002	U2	1	XX XX	4.0				
3 11 20 03		11		H1003		1	XX XX	2.7				
4 11 20 03		11		H1003	TT	1	XX XX	6.7				
5 12 28 03		11		H1002		1	XX XX	2.7				
6 12 28 03		12		H1004		1	XX XX	4.0				

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

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.)

J.M. Ostheimer MM/DD/YY

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 #

I.M. Provider
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

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)

ATTACHMENT 6

Sample CMS 1500 claim form for prenatal care coordination services provided within 185 days of a previous pregnancy

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [P] | 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): 1234567890

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

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

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

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

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

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

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

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

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

1. V23.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 20 03		11		H1000	U1	1	XX XX	4.0				
2 11 22 03		11		H1002	U1 U2	1	XX XX	4.3				
3 11 29 03		11		H1002	U1	1	XX XX	5.7				
4 12 10 03		11		H1003	U1	1	XX XX	1.3				
5												
6												

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

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.)

J.M. Onthisjob MM/DD/YY

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 #

I.M. Provider
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

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(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)