wisconsin Medicaid update and BadgerCare

July 2003 ● No. 2003-49
PHC 1981

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Community Support Programs
HMOs and Other Managed Care Programs

Changes to local codes and paper claims for community support program services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for community support program (CSP) 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 community support program (CSP) 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), but 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 national codes that will replace Wisconsin Medicaid local 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 CSP services.

Allowable procedure codes and modifiers

Wisconsin Medicaid will adopt the Healthcare Common Procedure Coding System (HCPCS) code H0039 combined with various nationally recognized HCPCS modifiers to replace the

currently used Wisconsin Medicaid local procedure codes for CSP services. Providers will be required to submit claims with the new procedure code/modifier combination to avoid claim denials. Refer to Attachment 1 of this *Update* for a procedure code/modifier conversion chart. Providers will be required to use the appropriate procedure code/modifier combination that describes the service performed.

Modifiers

All providers of CSP services will be required to indicate at least one modifier in Element 24D of the CMS 1500 claim form for each procedure performed.

For CSP services, modifiers are needed to identify the professional level of the provider performing each procedure for reimbursement purposes. For example, for CSP services, modifier "UA" would indicate that a psychiatrist performed the service.

For services provided by registered nurses, modifier "TD" for "registered nurse" must be used along with either modifier "HN" for Bachelor's degree level or "HO" for Master's degree level.

In addition to the professional level modifier, modifier "U5" must be used when CSP clients are inpatients in a hospital or nursing home and they are transitioning to community living.

Modifiers and corresponding descriptions for CSP services are included in Attachment 1. The national modifier descriptions that begin with the letter "U" are defined by Wisconsin Medicaid. These modifiers may have different descriptions when used for other Wisconsin Medicaid-covered services.

Time units

HCPCS code H0039 represents only 15 minutes of service. The currently used local procedure codes represent an hour of service. The maximum fees for the new code have been adjusted to represent 15 minutes (one-fourth of the hourly rate).

Providers should use the following rounding guidelines:

Minutes Billed	Quantity
0-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0

Type of service codes

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

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 Wisconsin Medicaid POS codes. Refer to Attachment 2 for a list of allowable POS codes for CSP services.

Coverage for community support program services

Medicaid coverage and documentation requirements for CSPs remain unchanged. Use this *Update* along with the Community Support Program Handbook and *Updates* for complete policy guidelines. Refer to the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified CSPs 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 3 for the revised instructions. Attachments 4 and 5 are samples of claims for CSP services that reflect the changes to the billing instructions.

Note: In some instances, paper claim instructions will be 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:

- Other insurance indicators were revised (Element 9).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

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 community support program services

The following table lists the nationally recognized procedure codes and modifiers that providers will be required to use when submitting claims for community support program 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).

Note that for services provided by registered nurses, modifier "TD" for "registered nurse" must be used along with either modifier "HN" for Bachelor's degree level or "HO" for Master's degree level.

Procedure code modifier descriptions	
Modifier	**Description**
HM	Less than bachelor degree level
HN	Bachelors degree level
HO	Masters degree level
HP	Doctoral level
TD	Registered nurse
UA	Psychiatrist
UB	Advanced practice nurse prescriber with mental health specialty
U1	Group professional
U2	Group, Masters
U3	Group, Ph.D.
U4	Group M.D./Advanced practice nurse prescriber with mental health specialty
U5	Transition to community living

Before HIPAA implementation	**After HIPAA implementation**	
Local procedure code description	**Replaced by HCPCS* procedure code**	**Allowable modifier(s)**
W8200 CSP-assessment and treatment planning; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB
W8201 CSP assessment and treatment planning; Ph.D.		HP
W8202 CSP-assessment and treatment planning; Masters		HO, TD
W8203 CSP-assessment and treatment planning; Professional		HN, TD

*HCPCS = Healthcare Common Procedure Coding System.

Before HIPAA implementation	After HIPAA implementation	
Local procedure code description	**Replaced by HCPCS* procedure code**	**Allowable modifier(s)**
W8210 CSP-transition to community living; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB, U5 (modifer U5 is required)
W8211 CSP-transition to community living; Ph.D.		HP, U5 (modifier U5 is required)
W8212 CSP-transition to community living; Masters		HO, TD, U5 (modifier U5 is required)
W8213 CSP-transition to community living; Professional		HN, TD, U5 (modifier U5 is required)
W8220 CSP-Routine psychiatric treatment; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB
W8221 CSP-routine psychiatric treatment; Ph.D.		HP
W8222 CSP-routine psychiatric treatment; Masters		HO, TD
W8230 CSP-medication, prescription and administration; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB
W8232 CSP-medication, prescription and administration; Masters (R.N. only)		HO, TD
W8233 CSP-medication, prescription and administration; Professional		HN, TD

*HCPCS = Healthcare Common Procedure Coding System.

Before HIPAA implementation	After HIPAA implementation	
Local procedure code description	**Replaced by HCPCS* procedure code**	**Allowable modifier(s)**
W8240 CSP-symptom management; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB
W8241 CSP-symptom management; Ph.D.		HP
W8242 CSP-symptom management; Masters		HO, TD
W8243 CSP-symptom management; Professional		HN, TD
W8250 CSP-case management; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB
W8251 CSP-case management; Ph.D.		HP
W8252 CSP-case management; Masters		HO, TD
W8253 CSP-case management; Professional		HN, TD
W8262 CSP-employment-related behavioral training; Masters	**H0039** Assertive community treatment, face-to-face, per 15 minutes	HO, TD
W8263 CSP-employment-related behavioral training; Professional		HN, TD

*HCPCS = Healthcare Common Procedure Coding System.

Before HIPAA implementation	After HIPAA implementation	
Local procedure code description	**Replaced by HCPCS* procedure code**	**Allowable modifier(s)**
W8271 CSP-psychosocial rehabilitation; Ph.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	HP
W8272 CSP-psychosocial rehabilitation; Masters		HO, TD
W8273 CSP-psychosocial rehabilitation; Professional		HN, TD
W8274 CSP-psychosocial rehabilitation; Mental health technician		HM
W8280 CSP-group therapy; M.D.	**H0039** Assertive community treatment, face-to-face, per 15 minutes	U4
W8281 CSP-group therapy; Ph.D.		U3
W8282 CSP-group therapy; Masters level		U2
W8283 CSP-group therapy; Professional		U1

*HCPCS = Healthcare Common Procedure Coding System.

Before HIPAA implementation	After HIPAA implementation	
Local procedure code description	**Replaced by HCPCS* procedure code**	**Allowable modifier(s)**
W8290 Non-psychiatric medication and physical healthcare services; psychiatrist	**H0039** Assertive community treatment, face-to-face, per 15 minutes	UA, UB
W8292 Non-psychiatric medication and treatment services; Masters (RN Only)		HO, TD
W8293 Non-psychiatric medication and treatment services; (RN Only)		HN, TD
W8294 Non-psychiatric treatment services; Mental health technician (LPN only)		HM

*HCPCS = Healthcare Common Procedure Coding System.

ATTACHMENT 2
Place of service codes for community support program services

The following tables list the allowable place of service (POS) codes that providers will be required to use when submitting claims for community support program 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).

The following POS codes are allowable for all procedure codes:

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
15	Mobile Unit
20	Urgent Care Facility
22	Outpatient Hospital
23	Emergency Room – Hospital
34	Hospice
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

The following additional POS codes are allowable when procedure code H0039 is used with modifier "U5"(Transition to community living):

Code	Description
21	Inpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
51	Inpatient Psychiatric (only for persons below age 21 or age 65 and older)
54	Intermediate Care Facility/Mentally Retarded

ATTACHMENT 3
CMS 1500 claim form instructions for community support program services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate Medicaid 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 obtain the correct spelling of the recipient's name and correct Medicaid identification number. 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, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). 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

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO") or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

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 *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Allowable diagnosis codes for CSP services are:

295.10-295.15		295.20-295.25		295.30-395.35		295.60-295.65		295.70-295.75		295.90-295.95		296.1	
296.20-296.26		296.30-296.36		296.40-296.46		296.50-296.56		296.60-296.66		296.7	296.80-296.82		296.89
296.90-296.99		297.1	298.9	299.00-299.01		300.01	300.11	300.14	300.16	300.19	300.21	300.3	300.4
300.81	301.0	301.22	301.50	301.51	301.6	301.81-301.84		301.9	307.1	307.23	311	312.34	

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

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

- When billing for one date of service (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 first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing **only** the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier(s), if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service.

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 ICD-9-CM 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 billed for each line item. Always use a decimal (e.g., 30 minutes equals 2.0 units).

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

Element 24I — EMG

Enter an "E" for **each** procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider *for each procedure* if it is different than the billing provider number indicated in Element 33.

In counties where the county contracts with a qualified CSP, enter the eight-digit nonbilling/performing provider number of the contracted CSP.

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

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

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 provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 4
Sample CMS 1500 claim form for county-owned community support program services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) P 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 [X] F ☐

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

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

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): OI-D

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. L 295.60 3. L ____.__

2. L ____.__ 4. L ____.__

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 11 03		05		H0039	UB	1	XX XX	4.0				
2 11 14 03	21 28	12		H0039	HM	1	XXX XX	12.0				
3												
4												
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.)

I.M. Provider SIGNED MMDDYY 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. Billing
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 5
Sample CMS 1500 claim form for county-contracted community support program services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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 [X] F [ ]

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

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

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

CITY: STATE:

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

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

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

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 _____

PHYSICIAN OR SUPPLIER 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 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. 295.60
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 11 03		05		H0039	UB	1	XX XX	4.0				11223344
2 11 14 03	21 28	12		H0039	HM	1	XXX XX	12.0				11223344
3												
4												
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.)

I.M. Provider MMDDYY

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. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)