wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

Federally Qualified Health Centers
HealthCheck Providers
Nurse Practitioners
Physician Assistants
Physician Clinics
Physicians
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HMOs and Other Managed Care Programs

Changes to local codes and paper claims for HealthCheck and HealthCheck outreach and case management services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for HealthCheck and HealthCheck outreach and case management 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.
- Requiring HealthCheck nursing agencies to submit claims for dental sealants using the ADA 2000 Claim Form.

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 HealthCheck and HealthCheck outreach and case management 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

ATTENTION: Physicians, Physician Clinics, Physician Assistants, and Nurse Practitioners

This *Update* is primarily for HealthCheck nursing agencies. Physicians, physician clinics, physician assistants, and nurse practitioners who perform HealthCheck screens should pay particular attention to the information in this box.

With the implementation of HIPAA, HealthCheck providers will no longer have to indicate Wisconsin Medicaid local modifiers "MR," "NO," or "VH" when billing for a comprehensive HealthCheck screen.

The only modifier that will be applicable to HealthCheck services that physicians, physician clinics, physician assistants, and nurse practitioners provide is **"UA"** to indicate that a comprehensive HealthCheck screen (procedure codes 99381-99385 and 99391-99395) resulted in a referral for further evaluation or treatment. (Modifier "UA" is a national modifier that is locally defined by Wisconsin Medicaid for providers to indicate that a comprehensive HealthCheck screen resulted in a referral for further evaluation or treatment.) If a comprehensive HealthCheck screen does *not* result in a referral for further evaluation or treatment, providers should *only* indicate the procedure code, not the modifier. Use of procedure codes 99381-99385 or 99391-99395, with or without a modifier, should only be used to indicate a comprehensive HealthCheck screen. All other visits should be billed using office visit procedure codes.

Refer to Attachment 6 of this *Update* for a sample CMS 1500 claim that reflects the changes to billing these procedures.

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 and returned PA requests. Specific implementation dates will be published in a future *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local codes for HealthCheck and HealthCheck outreach and case management services.

Allowable procedure codes for HealthCheck services

With the implementation of HIPAA, Wisconsin Medicaid will adopt *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace currently used local procedure codes for interperiodic screens, outreach and case management, and lead inspection services (W7013, W7015-W7018, W7083-W7084). Refer to Attachment 1 of this *Update* for a procedure code conversion chart for HealthCheck services. Providers will be required to use the appropriate procedure code that describes the service performed. HealthCheck providers will no longer be able to indicate local modifiers "HA," "HB," "HC," "MR," "NO," or "VH" when billing a comprehensive HealthCheck screen.

Wisconsin Medicaid local procedure codes W7002, W7003, W7009, and W7010, for partial screens, will no longer be valid.

Allowable procedure codes for Medicaid-certified HealthCheck outreach and case management agencies

With the implementation of HIPAA, Wisconsin Medicaid will adopt HCPCS procedure codes to replace currently used local procedure codes (W7012 and W7014) for HealthCheck outreach and case management services. Note that the billing unit has changed from a unit of service to a *unit of time*. Maximum allowable fees will be adjusted to reflect this change. Providers may submit claims with up to 4.0 units of outreach and case management services with each screen. Refer to Attachment 2 for a procedure code conversion chart for HealthCheck outreach and case management services.

Providers should continue to refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers.

HealthCheck providers will no longer be able to indicate local modifiers "HA," "HB," "HC," "MR," "NO," or "VH" when billing a comprehensive HealthCheck screen.

Modifiers

HealthCheck providers will be required to indicate the appropriate nationally recognized modifier, when appropriate, when submitting claims for HealthCheck and HealthCheck outreach and case management services. Refer to Attachment 3 for a list of modifiers that includes the circumstances in which each should be used.

HealthCheck providers will be required to indicate that a comprehensive HealthCheck screen (procedure codes 99381-99385 and 99391-99395) resulted in a referral for further

evaluation or treatment by using nationally recognized modifier **"UA"** with the appropriate procedure code. Modifier "UA" is a national modifier that is state defined by Wisconsin Medicaid that providers will use to indicate that a comprehensive HealthCheck screen resulted in a referral for further evaluation or treatment. If a comprehensive HealthCheck screen does not result in a referral for further evaluation or treatment, providers should only indicate the procedure code.

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently.

HealthCheck nursing agencies will be required to use national modifier **"EP"** to indicate that interperiodic screens, outreach and case management, and lead inspection services (procedure codes 99211-99215, T1002, T1029, T1017, and T1016) were provided as part of [follow-up to] the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In addition, HealthCheck nursing agencies will be required to indicate national modifier **"TS"** for follow-up services to an environmental lead inspection (procedure code T1029).

Type of service codes

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

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently. Refer to Attachment 4 for a list of POS codes that will be allowable for HealthCheck and HealthCheck outreach and case management services.

Coverage for HealthCheck and HealthCheck outreach and case management services

Medicaid coverage and documentation requirements for HealthCheck and HealthCheck outreach and case management providers will remain unchanged. Refer to the HealthCheck Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified HealthCheck and HealthCheck outreach and case management 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 5 for the revised instructions. Attachments 6, 7, 8, 9, 10, and 11 are examples of claims for HealthCheck 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).
- Medicare disclaimer codes were revised (Element 11).
- Outside lab indicator is no longer required (Element 20).
- 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).
- HealthCheck indicators "H" and "B" are no longer required (Element 24H).

HealthCheck nursing agencies are required to use ADA 2000 claim form for dental sealants

With the implementation of HIPAA, HealthCheck nursing agencies will be required to submit claims for dental sealants using the ADA 2000 Claim Form. Previously, HealthCheck nursing agencies used the CMS 1500 claim form for dental sealants. Medicaid coverage for dental sealants will remain the same.

Claim Submission

When submitting claims for dental sealants, HealthCheck providers will be required to:

- Use the ADA 2000 Claim Form.
- Indicate American Dental Association Current Dental Terminology code D1351 (Element 59).
- Indicate the tooth numbers that received sealants on the claim form. Tooth numbers must be entered in a two-character format, such as "02," with only one tooth per line.
- Submit the claim to Medicaid fee-for-service, even if the recipient is enrolled in a Medicaid HMO, including HMOs that cover dental services.

Refer to Attachment 12 for ADA 2000 claim form completion instructions. Attachment 13 is a completed sample ADA 2000 claim form for dental sealants submitted by a HealthCheck nursing agency.

Reminder — Limitations

There is a once-per-three-year limitation on sealants for permanent first and second molars. To exceed the once-per-three-year limitation, a narrative must be attached to the claim explaining why the limitation was exceeded. The narrative must be signed by a licensed dentist.

Wisconsin Medicaid reimburses certified HealthCheck nursing agencies for providing dental sealants to Medicaid recipients under age 21 when billed as a HealthCheck service. Medicaid coverage for sealants in HealthCheck nursing agencies is limited to tooth numbers 02, 03, 14, 15, 18, 19, 30, and 31. Refer to the "Prior authorization for dental sealants" section for information on other teeth which require PA for sealants.

Reminder — Dentists or dental hygienists may provide sealants

Wisconsin Medicaid covers sealants that are provided by a dentist or a dental hygienist at a certified HealthCheck nursing agency. For a dental hygienist to apply a sealant, a prescription from a licensed dentist is required. This must be retained in the recipient's HealthCheck record. Because the HealthCheck nursing agency is Medicaid certified, Wisconsin Medicaid does not require that the dentist or dental hygienist providing the sealants be Medicaid certified.

With the implementation of HIPAA, HealthCheck nursing agencies will be required to submit claims for dental sealants using the ADA 2000 claim form.

Reminder — Submit all dental sealant claims to Wisconsin Medicaid fee-for-service

Dental sealants are covered on a fee-for-service basis for all Wisconsin Medicaid recipients, including recipients enrolled in a Medicaid HMO. This includes recipients enrolled in a Medicaid HMO that provides dental coverage.

Reminder — Prior authorization for dental sealants

Prior authorization is required for tooth numbers/letters 01, 04-13, 16, 17, 20-29, 32, A-T, and supernumerary teeth (AS-TS, 51-82). For these teeth, HealthCheck providers must refer the recipient to a Medicaid-certified dentist to request PA and provide these services. If the PA request is approved,

Wisconsin Medicaid will reimburse the dentist for the service.

Changes to STAT-PA

Although there will be some changes, Wisconsin Medicaid will continue to use Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) with the implementation of HIPAA. Changes to STAT-PA as a result of HIPAA will be addressed in a future *Update*.

Changes to STAT-PA as a result of HIPAA will be addressed in a future *Update*.

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 HealthCheck services

The following table lists the *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure codes providers will be required to use when submitting claims for HealthCheck services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Note: Refer to Attachment 3 of this *Update* for allowable modifiers that providers may use with HealthCheck services CPT and HCPCS procedure codes.

Before HIPAA implementation	**After HIPAA implementation**
Local procedure code description	**Procedure code and description**
W7013 Brief interperiodic screen (less than 15 minutes)	**99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
	99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: • a problem focused history; • a problem focused examination; • straightforward medical decision making. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
W7015 Intermediate interperiodic screen (15-30 minutes)	**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: • an expanded problem focused history; • an expanded problem focused examination; • medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
	99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: • a detailed history; • a detailed examination; and • medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Before HIPAA implementation	After HIPAA implementation
Local procedure code description	**Procedure code and description**
W7016 Long interperiodic screen (over 30 minutes)	**99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: • a comprehensive history; • a comprehensive examination; • medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
W7017 Lead education visit	**T1002** Registered nurse services, up to 15 minutes
W7083 Lead inspection (initial)	**T1029** Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling
W7084 Lead inspection (follow-up)	**T1029*** Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling
W7018 DTP and MMR and Oral polio	**90700** Diptheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use
	90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
	90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous use

*Claims for follow-up services to lead inspections should indicate procedure code T1029 *and* nationally recognized modifier **"TS"** (follow-up service).

ATTACHMENT 2
Procedure code conversion chart for HealthCheck outreach and case management services

The following table lists the Healthcare Common Procedure Coding System (HCPCS) procedure codes HealthCheck nursing agencies will be required to use when submitting claims for targeted outreach and case management services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Note: Refer to Attachment 3 of this *Update* for allowable modifiers that providers may use with HealthCheck services procedure codes.

Before HIPAA implementation	**After HIPAA implementation**
Local procedure code description	**HCPCS procedure code and description**
W7012 Targeted outreach case management	**T1017** Targeted outreach case management, each 15 minutes
W7014 Non-targeted outreach case management	**T1016** Outreach case management, each 15 minutes

Providers may bill up to 4.0 units of outreach and targeted outreach case management services with each comprehensive HealthCheck screen.

ATTACHMENT 3
Modifiers for HealthCheck and HealthCheck outreach and case management services

The following table lists national modifiers that providers will be required to use with HealthCheck services procedure codes after Wisconsin Medicaid's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Modifier	Description	Allowable procedure codes	Allowable providers
UA*	Comprehensive HealthCheck screen results in a referral or follow-up visit for diagnostic or corrective treatment	99381-99385 and 99391-99395	All HealthCheck providers, including HealthCheck nursing agencies
EP	Service provided as part of [follow-up to] Medicaid early periodic screening diagnosis and treatment (EPSDT) program	99211-99215, T1002, T1029, T1017, and T1016	HealthCheck nursing agencies only
TS	Follow-up service [for lead inspection]	T1029	HealthCheck nursing agencies only

*Modifier "UA" is a national modifier that is state defined by Wisconsin Medicaid.

ATTACHMENT 4
Place of service codes for HealthCheck services

The following table lists the place of service (POS) codes that HealthCheck providers will be required to use after Wisconsin Medicaid's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

POS Code	Description
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
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 5
CMS 1500 claim form instructions for HealthCheck and HealthCheck outreach and case management 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 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, 1996, would be 02/03/96) or in MM/DD/YYYY format (e.g., February 3, 1996, would be 02/03/1996). 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") insurance only 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 in part or in full 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

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage, including Medicare Cost ("MCC") or Medicare + Choice ("MPC"), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** *(M-5 is not applicable to physicians.)* This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

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

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

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.

When a specific medical diagnosis has not been determined, indicate diagnosis code V20.2 — Routine infant or child health check.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

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, 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.

POS Code	Description
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
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of 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 (up to four per procedure code) 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. Always use a decimal (e.g., 2.0 units).

HealthCheck nursing agencies may bill up to 4.0 units of outreach and targeted outreach case management services with each screening.

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

Element 24I — EMG (not required)

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 that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial. This element is *not* required for HealthCheck nursing agencies.

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

ATTACHMENT 6

Sample CMS 1500 claim form for HealthCheck services

(Physician, physician clinic, physician assistant, or nurse practitioner performed a comprehensive HealthCheck screen with referral and follow-up visit)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐
(Medicare #) P (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (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: 02 10 02 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. V20.2 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 12 17 03		11		99381	UA	1	XX XX	1.0				
2 12 28 03		11		99211		1	XX XX	1.0				
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.)

J.M. Oathkeeper 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. 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 7

Sample CMS 1500 claim form for HealthCheck services

(Comprehensive screen with referral and vaccines)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

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

3. PATIENT'S BIRTH DATE MM DD YY: 06 10 03 | SEX M ☐ F ☒

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): OI-P

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. V20.2 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 12 17 03		11		99391	UA	1	XX XX	1.0				12345678
2 12 17 03		11		90713		1	XX XX	1.0				12345678
3 12 17 03		11		90700		1	XX XX	1.0				12345678
4 12 17 03		11		90648		1	XX XX	1.0				12345678
5 12 17 03		11		90669			XX XX	1.0				12345678
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 $ XX XX

30. BALANCE DUE $ XX 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. Onthisfyd 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. 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 8
Sample CMS 1500 claim form for HealthCheck nursing agency

(Follow-up visit and lab handling fee)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 10 03 | SEX M ☐ F ☒

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 ☐ | 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)

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.

PATIENT AND INSURED INFORMATION

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. V20.2
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 17 03		11		99211	EP	1	XX XX	1.0				
2 12 17 03		11		99000			X XX	1.0				
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.)

J.M. Oathaday 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. 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)

ATTACHMENT 9
Sample CMS 1500 claim form for HealthCheck environmental lead inspection with educational visit

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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: 05 21 01 SEX M [X] F ☐

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. V20.2 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

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 01 05 04		12		T1029	EP	1	XX XX	1.0				
2 01 05 04		12		T1002	EP	1	XX XX	1.0				
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.)

J.M. Onthatsigned 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. Billing
1 W. Williams
Anytown, WI 55555 87654321

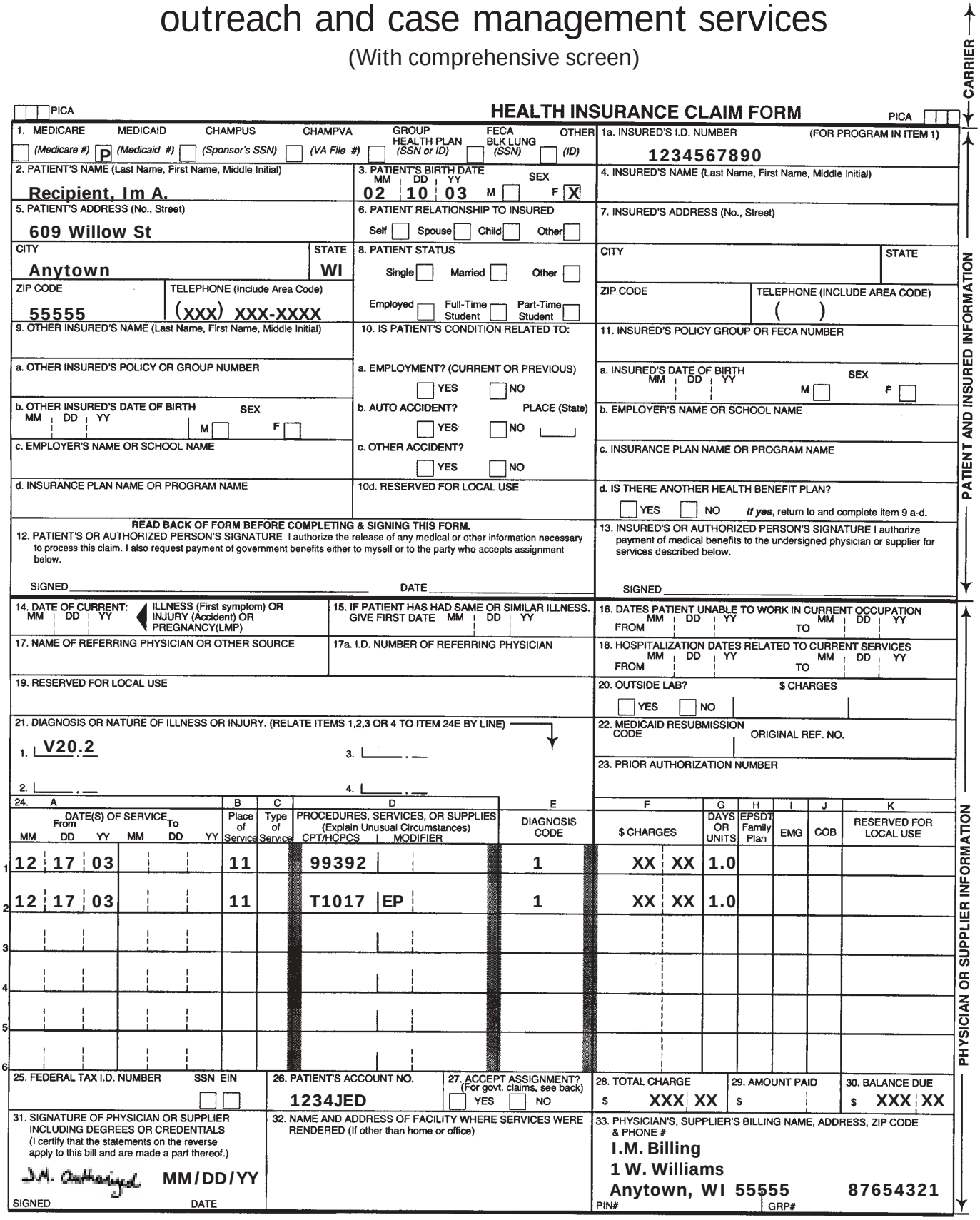
PIN# GRP#

(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)

ATTACHMENT 10
Sample CMS 1500 claim form for HealthCheck outreach and case management services

(With comprehensive screen)



PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐
(Medicare #) P (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (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: 02 10 03 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 _____

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. V20.2 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 12 17 03		11		99392		1	XX XX	1.0				
2 12 17 03		11		T1017	EP	1	XX XX	1.0				
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.)

J.M. Oathkeeper 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. 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)

ATTACHMENT 11
Sample CMS 1500 claim form for HealthCheck outreach and case management services

(Screen performed by another provider)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
(Medicare #) / (Medicaid #) P / (Sponsor's SSN) / (VA File #) / (SSN or ID) / (SSN) / (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: 02 10 03 SEX M [X] F [ ]

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? PLACE (State) YES [ ] NO [ ]

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. V20.2 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 12 17 03		11		T1017	EP	1	XX XX	2.0				
2												
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 $ XX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XX 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. Onthisfyd 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. 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)

ATTACHMENT 12
ADA 2000 Claim Form instructions

(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 in the Wisconsin Medicaid Dental Services Handbook.

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 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 — Dentist's Pre-Treatment Estimate, Dentist's Statement of Actual Services, Specialty (not required)

Element 2 — Medicaid Claim, EPSDT, Prior Authorization # (required, if applicable)

EPSDT (HealthCheck): HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). If the services were performed as a result of a HealthCheck/EPSDT exam, check the EPSDT box.

Prior authorization #: Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Elements 3-7 — Carrier Name, Carrier Address, City, State, ZIP Code (not required)

Element 8 — Patient Name (Last, First, Middle)

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (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.

Elements 9-11 — Patient's Address, City, State (not required)

Element 12 — Date of Birth (MM/DD/YYYY)

Enter the recipient's birth date in MM/DD/YYYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 13 — Patient ID

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Elements 14-16 — Patient's Sex, Phone Number, Zip Code (not required)

Element 17 — Relationship to Subscriber/Employer (not required)

Element 18 — Employer/School (not required)

Element 19 — Subs/Emp. ID#/SSN# (not required)

Element 20 — Employer Name (not required)

Element 21 — Group# (not required)

Element 22-30 — Subscriber/Employer Name (Last, First, Middle), Address, Phone Number, City, State, ZIP Code, Date of Birth (MM/DD/YYYY), Marital Status, Sex (not required)

Element 31 — Is Patient Covered by Another Plan (not required)

Element 32 — Policy # (not required)

Element 33 — Other Subscriber's Name (required, if applicable)

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by insurance. Wisconsin Medicaid uses Element 33 to identify commercial health insurance information.

Recipients with commercial health or dental insurance coverage
Commercial health or dental insurance coverage 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. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services
When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

When the EVS indicates the code "DEN" for "Other Coverage," commercial dental insurance must be billed prior to billing Wisconsin Medicaid for dental sealants and one of the following insurance codes must be indicated in this element:

Code	When to use code
OI–P (other insurance paid)	PAID in part or in full by commercial health insurance or commercial HMO. In Element 59, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI–D (other insurance denied)	Use OI-D for dental claims in either of the following situations: • 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. • 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.
None. Providers may leave this element blank.	N/a.
Note: The provider may not use OI-D 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.	

The following table lists appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid:

Situation	Appropriate response
No insurance indicator is indicated by Medicaid's EVS.	• Leave Element 33 blank.
Provider: • Is aware of other commercial health or dental insurance not indicated on the EVS. • Bills the insurance. • Receives reimbursement from the insurer.	• Place "OI–P" in Element 33. • Place the amount paid by commercial health or dental insurance in the "Payment by other plan" box in Element 59. • Complete the Other Coverage Discrepancy Report (HCF 1159) Rev. 10/02, located on the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* . Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.
Provider: • Is aware of other commercial health or dental insurance not indicated on the EVS. • Bills the insurance. • Does not receive reimbursement from that insurer.	• Leave Element 33 and the "Payment by other plan" box in Element 59 blank. • Complete the Other Coverage Discrepancy Report to update Medicaid files.

Element 34 — Date of Birth (MM/DD/YYYY) (not required)

Element 35 — Sex (not required)

Element 36 — Plan/Program Name (not required)

Element 37 — Employer/School (not required)

Element 38 — Subscriber/Employer Status (not required)

Element 39 — Subscriber/Employee Signature (not required)

Element 40 — Employer/School (not required)

Element 41 — Employee/Subscriber Signature Authorizing Payment (not required)

Element 42 — Name of Billing Dentist or Dental Entity

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 42 must match the provider identification number in Element 44.

Element 43 — Phone Number (not required)

Element 44 — Provider ID

Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must match the provider name indicated in Element 42.

Element 45 — Dentist Soc. Sec. or T.I.N. (not required)

Element 46 — Address

Enter the billing provider's complete street address. If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181) Rev. 09/02, to notify Wisconsin Medicaid that an address change has occurred. The form is located on the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* . Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 47 — Dentist License # (not required)

Element 48 — First Visit Date of Current Series (not required)

Element 49 — Place of Treatment

Enter the appropriate two digit place of treatment (place of service) code for each service. Check the "Office" box with an "X" and enter:

POS Code	Description
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
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Elements 50-52 — City, State, ZIP code

Enter the billing provider's complete city, state, and Zip code as they appear on the Medicaid certification letter.

Element 53 — Radiographs or Models Enclosed? (not required)

Element 54 — Is treatment for Orthodontics? (not required)

Element 55 — If Prosthesis (Crown, Bridge Dentures), Is This Initial Placement? (not required)

Element 56 — Is Treatment Result of Occupational Illness or Injury? (not required)

Element 57 — Is Treatment Result of: Auto Accident? Other Accident? Neither? (not required)

Element 58 — Diagnosis Code Index (not required)

Element 59 — Examination and Treatment Plans

Date (MM/DD/YYYY): Enter the date of service in MM/DD/YYYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Tooth: If the procedure applies to only one tooth, the tooth number or tooth letter is entered here. Enter one tooth per line.

Surface: Enter the tooth surface(s) restored for each restoration.

Diagnosis Index #: Not required by Wisconsin Medicaid.

Procedure Code: Enter procedure code D1351 — sealant - per tooth.

Qty: Enter the exact quantity billed. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.) Enter only one tooth per line.

Description: Write a brief description of each procedure.

Fee: Enter the usual and customary charge for each detail line of service.

Total Fee: Enter the total of all detail charges.

Payment by Other Plan: Enter the actual amount paid by dental insurance. (If the dollar amount indicated in Element 59 is greater than zero, "OI-P" must be indicated in Element 33.) Do not include the Wisconsin Medicaid copayment amount. If the dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Max. Allowable: Not required by Wisconsin Medicaid.

Deductible: Not required by Wisconsin Medicaid.

Carrier Pays: Not required by Wisconsin Medicaid.

Patient Pays: Not required by Wisconsin Medicaid. Do not enter recipient copayment amounts.

Admin. Use Only: Not required by Wisconsin Medicaid.

Element 60 — Identify All Missing Teeth With "X" (not required)

Element 61 — Remarks for Unusual Services (required, if applicable)

List any unusual services, including reasons why limitations were exceeded.

Element 62 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 62. The month, day, and year the form is signed must also be entered in MM/DD/YYYY format.

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

If Elements 42 and 44 indicate a clinic or group biller, indicate the Medicaid-certified performing provider's name and eight-digit Medicaid provider number in this element.

Elements 63-65 — Address Where Treatment Was Performed, City, ZIP Code (not required)

ATTACHMENT 13

Sample ADA 2000 claim form for HealthCheck nursing agencies billing for dental sealants

Dental Claim Form

©American Dental Association, 1999 version 2000

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

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Im A.
9. Address
10. City
11. State
12. Date of Birth (MM/DD/YYYY): MM/ DD / YYYY
13. Patient ID #: 1234567890
14. Sex: ☐M ☐F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

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

OTHER POLICIES

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

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: I.M. Provider
43. Phone Number ( )
44. Provider ID #: 12345678
45. Dentist Soc. Sec. or T.I.N.
46. Address: 1 W. Williams St.
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other 71
50. City: Anytown | 51. State: WI | 52. Zip Code: 55555
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☒No
If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither — Brief description and dates

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

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
MM DD YYYY	02			D1351	1	Sealants	XX.XX
MM DD YYYY	03			D1351	1	Sealants	XX.XX
MM DD YYYY	18			D1351	1	Sealants	XX.XX
MM DD YYYY	19			D1351	1	Sealants	XX.XX

Admin. Use Only

60. Identify all missing teeth with "X"

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

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

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

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X I.M. Provider 87654321 MM/DD/YYYY
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

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

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J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746