wisconsin Medicaid update
and BadgerCare

July 2003 ● No. 2003-61
PHC 1993

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Federally Qualified Health Centers

Nurse Practitioners

Physician Assistants

Physician Clinics

Physicians

Rural Health Clinics

HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for physician services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces changes to local codes, paper claims, and prior authorization (PA) for physician 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.
- Revising Medicaid PA request forms and 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 billing and prior authorization (PA) changes for physician services 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., PA requirements, documentation), 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.
- Revising PA request forms and instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes, revised paper claim instructions, or revised PA forms and instructions prior to HIPAA 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 medical codes to replace currently used local Wisconsin Medicaid codes for physician services.

Allowable procedure codes

Wisconsin Medicaid will adopt *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System procedure codes to replace currently used local "W" procedure codes for physician services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Attachment 2 is a conversion chart for injection procedure

codes. This includes codes that will be discontinued. Providers will be required to use the appropriate procedure code that describes the service performed.

Type of service codes

Type of service (TOS) codes will no longer be required on Medicaid claims and PA requests. As a result, selected national modifiers have been adopted to replace the use of TOS codes. Refer to Attachment 3 for a conversion chart of TOS codes to modifiers.

Anesthesiologists will be required to use CPT anesthesia codes 00100-01999 and applicable modifier(s) when submitting claims for anesthesia services. Wisconsin Medicaid will no longer reimburse claims for anesthesia services with CPT surgery procedure codes and TOS "7."

Modifiers

Wisconsin Medicaid will adopt nationally recognized modifiers to replace the local modifiers used currently by Wisconsin Medicaid. Refer to Attachment 4 for a modifier conversion chart for physician services.

Diagnosis code for second opinions

Wisconsin Medicaid will no longer accept local diagnosis code V67.S to indicate that a second surgical opinion was obtained. Instead providers will use modifier **SM** in Element 24D on the claim if a second opinion was obtained for a surgery procedure.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 5 for a list of allowable POS codes for physician services.

Coverage for physician services

Medicaid coverage and documentation requirements for most physician services will remain unchanged. Refer to the Physician Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified providers of physician services will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 is not being revised at this time. Refer to Attachment 6 for the revised instructions. Attachments 7, 8, 9, 10, 11, 12, and 13 are samples of claims for physician 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.

Anesthesiologists will be required to use CPT anesthesia codes 00100-01999 and applicable modifier(s) when submitting claims for anesthesia services.

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 are no longer required (Element 24H).

Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it.

- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the amount of the recipient's spenddown amount.
- Wisconsin Medicaid will no longer accept mother/baby claims. Refer to the June 2003 *Update* (2003-29), titled "Wisconsin Medicaid no longer reimburses claims for newborns under the mother's identification number," for more information.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, physician services providers will be required to use the new Prior Authorization Request Form (PA/RF), HCF 11018, 06/03. Instructions for completion of this new PA/RF are located in Attachment 14. A sample PA/RF is in Attachment 15.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Requested start date field added (Element 14).
- Space for performing provider number added for each service/procedure (Element 15).
- Space added for additional modifiers (Element 17).
- Place of service codes were revised (Element 18).
- Type of service codes are no longer required.

Revised prior authorization attachments

The Prior Authorization "J" Code Attachment (PA/JCA), HCF 11034, dated 06/03, and Prior Authorization Physician Otological Report (PA/POR), HCF 11019, dated 06/03, have also been revised. The basic information requested on the forms has not changed; only the format of the forms has changed. Refer to Attachment 16 for a copy of the PA/JCA Completion Instructions and Attachment 17 for a copy of the PA/JCA. Refer to Attachment 18 for a copy of the PA/POR Completion Instructions and Attachment 19 for a copy of the PA/POR.

The Prior Authorization Physician Attachment (PA/PA), HCF 11016, dated 01/03, was revised in the January 2003 *Update* (2003-01), titled "Wisconsin Medicaid revises the Prior Authorization Physician Attachment."

Obtaining prior authorization request forms

The PA/PA and PA/JCA are available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it. Providers cannot obtain copies of the PA/POR from the Medicaid Web site since it is a three-part form.) To access the PA/PA and PA/JCA and other Medicaid forms, follow these instructions:

1. Go to *www.dhfs.state.wi.us/medicaid/*.
2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader®* and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/PA, PA/JCA, PA/POR, or the PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883.

Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the HCF number of the form (if applicable) and send the request to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

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 Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

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 physician services

The following table lists the national procedure codes providers will be required to use in lieu of Wisconsin Medicaid local codes when submitting claims for physician 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). Providers should refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers for physician services.

Before HIPAA implementation	**After HIPAA implementation**	
Local procedure code and description	**Replaced by procedure code and description**	**Modifier and description**
W6000 Antepartum care; initial visit	**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: • a comprehensive history; • a comprehensive examination; • medical decision making of moderate complexity. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.	**TH*** (obstetrical treatment/ services, prenatal)
W6001 Antepartum care; two or three visits	**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key 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.	**TH*** (obstetrical treatment/ services, prenatal)
W6020 Infant Head Molding Bands	**L0100**** Cranial orthosis (helmet), with or without soft interface, molded to patient model	

*Providers are required to use modifier "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both modifiers "TH" and the appropriate Health Professional Shortage Area (HPSA) modifier when these prenatal services are HPSA eligible.

**Medicaid reimbursement for L0100 covers all services necessary to fit and adjust the head molds, including the cost of the molds and headbands.

Providers should use this as a guide for submitting claims for a specific number of antepartum care visits.

Antepartum care claims submission guide for use after HIPAA implementation			
Total visit(s)	**Procedure code and modifier (if applicable)**	**Description**	**Quantity**
One	**99204 + TH**	See previous chart.	1.0
Two	**99204 + TH**	See previous chart.	1.0
	99213 + TH	See previous chart.	1.0
Three	**99204 + TH**	See previous chart.	1.0
	99213 + TH	See previous chart.	2.0
Four to six	**59425**	Antepartum care only; 4-6 visits	1.0
Seven +	**59426**	7 or more visits	1.0

ATTACHMENT 2
Injection codes conversion chart

The following table lists the local procedure codes that will no longer be valid for injections after Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers will be required to use *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting claims for injections. The table indicates procedure code conversions for many of the local codes. In instances where no conversion is indicated, the provider must determine the appropriate nationally recognized CPT or HPCPS code. A future *Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA. Providers should refer to the Physician Services Handbook for other Medicaid-covered national injection codes.

Before HIPAA implementation	**After HIPAA implementation**
Local procedure code and description	**National procedure code and description**
W6100 Injection, ACTH Gel, 80 units	No longer an allowable procedure code
W6102 Injection, Ampicillin (1 g)	**J0295** Injection, ampicillin sodium/sulbactam sodium, per 1.5 g
W6104 Injection, Bicillin CR (900/300)	**J0560** Injection, penicillin G benzathine; up to 600,000 units
W6105 Injection, bicillin C-R, up to 300,000 units	No longer an allowable procedure code
W6106 Injection, calcimar, 100 units	No longer an allowable procedure code
W6107 Injection, calcimar, 200 units	No longer an allowable procedure code
W6109 Injection, calcium chloride, 10 ml	No longer an allowable procedure code
W6110 Injection, Cleocin, up to 600 mg	**S0077** Injection, clindamycin phosphate, 300 mg
W6112 Injection, cortrosyn, 0.25 mg	No longer an allowable procedure code
W6114 Injection, Depo-Medrol, 60 mg	**J2930** Injection, methylprednisolone sodium sucinate, up to 125 mg
W6115 Injection, Depo-Medrol, 120 mg	**J2930** Injection, methylprednisolone sodium succinate, up to 125 mg
W6116 Injection, Depo-Provera, 250 mg	**J1051** Injection, medroxyprogesterone acetate, 50 mg
	J1055 Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
W6117 Depo-Medroxyprogesterone, 150 mg	**J1055** Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
W6118 Injection, depo-testosterone, 300 mg	No longer an allowable procedure code
W6119 Injection, depo-testosterone, 400 mg	No longer an allowable procedure code
W6120 Injection, Dexamethasone, LA 8 mg/ml	**J1094** Injection, dexamethasone acetate, 1 mg

Before HIPAA implementation	After HIPAA implementation
Local procedure code and description	**National procedure code and description**
W6121 Injection, dexamethasone, LA 16 mg	No longer an allowable procedure code
W6122 Injection, dextrose, 50 ml	No longer an allowable procedure code
W6124 Injection, ephedrine	No longer an allowable procedure code
W6126 Injection, furosemide, 20 mg	No longer an allowable procedure code
W6127 Injection, furosemide, 40 mg	No longer an allowable procedure code
W6128 Injection, furosemide, 80 mg	No longer an allowable procedure code
W6130 Injection, glucagon, 1 mg	No longer an allowable procedure code
W6134 Injection, heparin, 10,000 units	No longer an allowable procedure code
W6136 Injection, heparin, 20,000 units	No longer an allowable procedure code
W6137 Injection, heparin, 5,000 units	No longer an allowable procedure code
W6138 Injection, hydrocortisone, 250 mg	No longer an allowable procedure code
W6140 Injection, imferon, 1 ml	No longer an allowable procedure code
W6141 Injection, imferon, 3 ml	No longer an allowable procedure code
W6142 Injection, isoproterenol	No longer an allowable procedure code
W6144 Injection, kantrex, 1 g	No longer an allowable procedure code
W6146 Injection, kefzol, 1 g	No longer an allowable procedure code
W6148 Injection, Magnesium Sulfate	**J3475** Injection, magnesium sulfate, per 500 mg
W6150 Injection, Marcaine	**S0020** Injection, bupivicaine HCl, 30 ml
W6152 Injection, Nubain	**J2300** Injection, nalbuphine HCl, per 10 mg
W6156 Injection, penicillin G procaine, 900,000 units	No longer an allowable procedure code
W6157 Injection, Penicillin G Procaine, 1.2 ml units	**J0540** Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units
W6158 Injection, Pencillin G Procaine, 2.4 ml units	**J0550** Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units
W6159 Injection, penicillin G procaine, 4.8 mil units	No longer an allowable procedure code

Before HIPAA implementation	After HIPAA implementation
Local procedure code and description	**National procedure code and description**
W6160 Injection, penicillin G procaine, 2.4 mil units/probe	No longer an allowable procedure code
W6161 Injection, Pencillin G Procaine, 4.8 ml units/probe	**J0550** Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units
W6162 Injection, Procaine	**J0550** Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units
W6164 Injection Prolixin decanoate, 50 mg	**J2680** Injection, fluphenazine deconoate, up to 25 mg
W6166 Injection Prolixin decanoate, 25 mg	**J2680** Injection, fluphenazine deconoate, up to 25 mg
W6167 Injection, prolixin enanthate, 50 mg	No longer an allowable procedure code
W6168 Injection Stadol	**J3490*** Unclassified drugs
W6170 Injection Susphrine	**J0170** Injection, adrenalin, epinephrine, up to 1 ml ampul
W6172 Injection, tensilon, 5 mg	No longer an allowable procedure code
W6173 Injection, terramycin, 100 mg	No longer an allowable procedure code
W6175 Tine/Mantoux/PPD	**86580** Skin test; tuberculosis/intradermal (for testing portion)
	90585 Bacillus calmette-guerin vaccine (BCG) for tuberculosis, live, for percutaneous (for the vaccination portion)
W6177 Injection Velban, 2 mg	**J9360** Vinblastine sulfate, 1 mg
W6178 Injection, velban, 5 mg	No longer an allowable procedure code
W6179 Injection, velosef, 250 mg	No longer an allowable procedure code
W6180 Injection, velosef, 500 mg	No longer an allowable procedure code
W6181 Vistaril, 100 mg	**J3410** Injection, hydroxyzine HCl, up to 25 mg
W6200 Intrauterine device — progesterone	No longer an allowable procedure code

* Refer to the Medicine and Surgery section of the Physician Services Handbook for more information on submitting claims for unclassified injectable drugs.

ATTACHMENT 3
Physician services type of service code to modifier conversion chart

The following table lists the nationally recognized *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) modifiers that providers will be required to use in lieu of local type of service codes when submitting claims for physician services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of specific effective dates of Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation	After HIPAA implementation
Local type of service (TOS) code and description	**CPT/HCPCS modifier and description**
7	**AA*** Anesthesia services performed personally by anesthesiologist
U	**TC** Technical component
Q, **S**, **T**, **W**, or **X**	**26** Professional component
8	**80** Assistant surgeon
1, **2**, **3**, **4**, **5**, **6**, **9**, **B**, **K**, or **M**	No modifier assigned to replace these type of service codes.

*Anesthesiologists will be required to use CPT anesthesia procedure codes 00100-01999 for all anesthesia services. Modifier "AA" is *only* to be used when an anesthesiologist is personally performing anesthesia services. Refer to Attachment 4 for modifiers that will be required for medically directing certified registered nurse anesthetists or anesthesiologist assistants.

ATTACHMENT 4
Modifier and diagnosis code conversion chart for physician services

The following table lists nationally recognized modifiers that providers will be required to use in lieu of Wisconsin local modifiers or diagnosis codes when submitting claims for physician 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).

Before HIPAA implementation	**After HIPAA implementation**
Local modifier or diagnosis code and description	**National modifier and description**
No modifier exists	**TH*** Obstetrical treatment/services, prenatal
PD Pediatric recipient (less than age 19)	**TJ** Program group, child and/or adolescent
HP Health Professional Shortage Area (HPSA)/ Adult (over 18 years of age) **HK** HPSA/Child (18 years of age and under)	*Choose one:* **QB**** Physician providing service in a rural HPSA **QU**** Physician providing service in an urban HPSA
W1 Medically Directing one certified registered nurse anesthetist (CRNA)/ anesthesiologist assistant (AA)	**QY***** Medical direction of one CRNA (or AA) by an anesthesiologist
W2 Medically directing two CRNAs/AAs	**QK***** Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
W3 Medically directing three CRNAs/AAs	
W4 Medically directing four CRNAs/AAs	
Physician services billed with diagnosis code **V67.S** (second opinion obtained)	**SM** Second opinion obtained

*Providers are required to use modifier "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both modifiers "TH" and the appropriate HPSA modifier when these prenatal services are HPSA eligible.

**Wisconsin Medicaid reimburses providers the same enhanced reimbursement for either HPSA modifier. Providers may use Medicare guidelines to define rural and urban HPSAs.

***Anesthesiologists will be required to use *Current Procedural Terminology* anesthesia procedure codes 00100-01999 for all anesthesia services.

ATTACHMENT 5
Place of service codes for physician services

The following tables list the allowable place of service (POS) codes that providers will be required to use when submitting claims after Wisconsin Medicaid's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for the various changes.

Evaluation and management, medicine, and surgery services	
POS 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
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance — Land
42	Ambulance — Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric
54	Intermediate Care Facility/Mentally Disabled
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

Laboratory services	
POS 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
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Disabled
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

Radiology services	
POS 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
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Disabled
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

Anesthesia services	
POS 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
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric
54	Intermediate Care Facility/Mentally Disabled
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

ATTACHMENT 6
CMS 1500 claim form instructions for physician 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 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, 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") 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.

Physicians must be Medicare enrolled to provide Medicare-covered services for dual entitlees. Dual entitlees are those recipients covered under both Medicare and 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.** *(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 (required for Evaluation and management consultations and laboratory and radiology services only

Enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

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. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Family planning services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are contraceptive management-related only.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (required for selected surgeries and injection codes)

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. Refer to the Medicine and Surgery section of the Physician Services Handbook for procedures that require PA.

Element 24A — Date(s) of Service

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

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the 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. Refer to Attachment 4 of this *Wisconsin Medicaid and BadgerCare Update* for allowable POS codes for physician services.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

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

Modifiers

Enter the appropriate (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 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, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Anesthesia services

Do ***not*** indicate the relative value units of the surgical, therapeutic, or diagnostic procedure performed.

Element 24H — EPSDT/Family Plan

Enter an "F" for each family planning procedure. If family planning does not apply, leave this element blank.

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 that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

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 a 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, street, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 7

Sample CMS 1500 claim form for physician medical services

(Three evaluation and management visits with pediatric modifier)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

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

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

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

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

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

CITY: Anytown STATE: WI

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

CITY: STATE:

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

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

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): 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. 480.0 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 10 03	16 23	11		99213	TJ	1	XXX XX	3.0				
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: $ 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. authorized 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. Physician
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 physician obstetrical services

(Antepartum care in a Health Professional Shortage Area)

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: MM DD YY SEX M [ ] F [X]

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

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

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

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

CITY: Anytown STATE: WI

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

CITY: STATE:

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

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

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): 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. 659.80 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 09 03		11		99204	TH QB	1	XXX XX	1.0				12345678
2 12 17 03	22	11		99213	TH QB	1	XXX XX	2.0				12345678
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 $ XXXX XX

29. AMOUNT PAID $ XXXX XX

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. Authorized 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. Physician
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 9

Sample CMS 1500 claim form for physician surgical services

(Bilateral procedure)

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 | 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; 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-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. 996.79 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 19 03		21		19370	50	1	XXX XX	1.0				
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: $ XXX XX

29. AMOUNT PAID: $ XXX XX

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. authorized 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. Physician
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 10

Sample CMS 1500 claim form for physician laboratory services

(Professional component only)

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: MM DD YY — SEX M [ ] F [X]

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

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

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

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

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] — 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-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. V79.9
2. V18.3
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 12 19 03		11		85576	26	1	XX XX	1.0				
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: $ 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. Authorized 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. Physician
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 11

Sample CMS 1500 claim form for physician radiology services

(Professional component only)

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: MM DD YY 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: I.M. Referring Physician

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

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. 959.09
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 12 18 03		11		70100	26	1	XX XX	1.0				
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 $ 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. Authorized 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. Physician
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 12

Sample CMS 1500 claim form for physician anesthesia services

(Medical direction of a single anesthetist with qualifying circumstances)

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 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): 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. 575.1
2. 284.8
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 06 03		21		00790	QY	1	XXX XX	8.0				12345678
2	11 06 03		21		99135		2	XX XX	1.0				12345678
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: $ 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. Authorized 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 13

Sample CMS 1500 claim form for physician anesthesia services

(Medical direction of two, three, or four concurrent procedures)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER 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 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. 575.1 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 03 03		21		00790	QK	1	XXX XX	4.0				12345678
2 11 03 03		21		99135		1	XX XX	8.0				12345678
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: $ 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. authorized 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 14
Prior Authorization Request Form (PA/RF) completion instructions for physician services

(For prior authorization requests submitted after HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Physician Attachment (PA/PA) or Prior Authorization/"J" Code Attachment (PA/JCA) by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the submitted claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type "117" (physician services, including family planning clinics, rural health clinics, and federally qualified health centers). The processing type is a three-digit code used to identify a category of service requested.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

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

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1996, would be 09/08/96).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

Enter the recipient's last name, followed by his or her 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 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested.

Element 15 — Performing Provider Number

Enter the eight-digit Medicaid provider number of the provider who will be providing the service, *only* if this number is different from the billing provider number listed in Element 4.

Element 16 — Procedure Code

Enter the appropriate procedure code for each service/procedure/item requested.

Element 17 — Modifiers

Enter up to four modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Attachment 5 for a list of allowable POS codes for physician services.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 20 — QR

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 21 — Charge

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 15
Sample Prior Authorization Request Form (PA/RF) — Physician services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**117**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**1234 Street St.** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial) **Recipient, Ima A.**	9. Sex — Recipient ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
611.9 Unspecified breast disorder		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
724.5 Backache, unspecified	**11/01/03**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
98765432	**19318**	**50**				**21**	**Reduction mammaplasty**	**1**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized: Quantity Authorized:

❑ Approved _____ Grant Date _____ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 16
Prior Authorization / "J" Code Attachment (PA/JCA) Completion Instructions

(A copy of the "Prior Authorization/"J" Code Attachment [PA/JCA] Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / "J" CODE ATTACHMENT (PA/JCA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to your service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Physicians use this form to request PA for injectable drug ("J") codes. Attach the completed Prior Authorization/"J" Code Attachment (PA/JCA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her 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.

Element 2 — Date of Birth — Recipient
Enter the date of birth of the recipient in MM/DD/YYYY format.

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — DRUG ORDER INFORMATION

Complete all of Section II.

SECTION III — CLINICAL INFORMATION

Element 14 — Diagnosis
List the recipient's condition the prescribed drug is intended to treat. Include *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and the expected length of need.

Element 15 — Changes to previous prior authorization
If requesting a renewal or continuation of a previous prior authorization approval, indicate any changes to the clinical condition, progress, or known results to-date.

Element 16 — Use (check one)
Any of the compendium standards may be used. If an intended use is not in the drug package insert, providers may want to check the United States Pharmacopeia Drug Information (USP-DI) for the most inclusive reference for diagnosis.

Drugs not listed in compendium standards may be covered by Wisconsin Medicaid; therefore, the PA/JCA must be submitted for processing and denied before the recipient is told a particular drug is not covered by Wisconsin Medicaid.

Element 17 — Dose (check one)
Any of the compendium standards may be used. If a prescribed dosage is not in the drug package insert, you may want to check the USP-DI (the most inclusive reference for diagnosis).

Drugs not listed in compendium standards may be covered by Wisconsin Medicaid; therefore, the PA/JCA must be submitted for processing and denied before the recipient is told a particular drug is not covered by Wisconsin Medicaid.

Signature of Prescriber and Date Signed
The prescriber must review the information, verifying that the information is accurate to the best of his or her knowledge, and sign the PA/JCA.

Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Please be sure to indicate a fax or telephone number if selecting either of these options.

ATTACHMENT 17
Prior Authorization "J" Code Attachment
(for photocopying)

(A copy of the "Prior Authorization/'J' Code Attachment [PA/JCA]" [for photocopying] is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / "J" CODE ATTACHMENT (PA/JCA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/"J" Code Attachment (PA/JCA) Completion Instructions (HCF 11034A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient

3. Recipient Medicaid Identification Number

SECTION II — DRUG ORDER INFORMATION

4. Drug Name	5. Strength

6. NDC	7. HCPCS "J" Code

8. Quantity ordered	9. Date order issued	10. Daily Dose

11. Name — Prescriber

12. DEA Number	13. "Brand Medically Necessary"
	❑ Yes ❑ No

SECTION III — CLINCAL INFORMATION

14. Diagnosis

15. Changes to prior authorization

Continued

SECTION III — CLINCAL INFORMATION (Continued)

16. Use (check one)

- ❑ Compendium standards, such as the USP-DI or drug package insert, lists the intended use identified above as an accepted or as a [bracketed] indication.
- ❑ The intended use identified above is *not* listed in compendium standards. Peer reviewed clinical literature is attached.

17. Dose (check one)

- ❑ The daily dose and duration are within compendium standards of general prescribing or dosing limits for the indicated use.
- ❑ The daily dose and duration are not within compendium standards of general prescribing or dosing limits for the intended use. Attach peer reviewed literature which indicates this dose is appropriate or document the medical necessity of this dosing difference.

SIGNATURE — Prescriber	Date Signed

Please notify me of approval / denial by:

- ❑ Fax (include Fax number) _____
- ❑ Telephone (include telephone number) _____
- ❑ No special notice needed.

ATTACHMENT 18
Prior Authorization / Physician Otological Report (PA/POR) Completion Instructions

(A copy of the "Prior Authorization/Physician Otological Report [PA/POR] Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The Prior Authorization/Request Physician Otological Report (PA/POR) is required by Wisconsin Medicaid when a hearing instrument specialist requires PA for a hearing instrument. Audiologists may use the PA/POR in place of a physician prescription, which is to be kept in the recipient's medical record. Upon completion, give one copy to the recipient to take the testing center and retain a second copy for your files.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Physician
Enter the name of the requesting physician.

Element 2 — Physician's UPIN, Medicaid Provider Number, or License Number
Enter the eight-digit Medicaid provider number, six-digit Medicare Universal Provider Identification Number, or license number of the physician.

Element 3 — Address — Physician
Enter the address (street, city, state, Zip code) of the requesting physician.

Element 4 — Telephone Number — Physician
Enter the telephone number, including area code, of the requesting physician.

SECTION II — RECIPIENT INFORMATION

Element 5 — Name — Recipient
Enter the recipient's last name, followed by his or her 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.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 7 — Address — Recipient
Enter the complete address (street, city, state, and Zip code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 8 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box.

SECTION III — DOCUMENTATION

Element 10 — Medical History of Hearing Loss
Enter the recipient's medical history of hearing loss (if any).

Element 11 — Pertinent Otological Findings
Enter an "X" in the appropriate box(es) and describe all problems.

Element 12 — Additional Findings
Describe any additional findings not covered in Element 11.

Element 13 — Clinical Diagnosis of Hearing Status
Enter the diagnosis of the recipient's hearing status.

Element 14 — Medical, Cognitive, or Developmental Problems
Describe any medical, cognitive, or developmental problems of the recipient.

Element 15 — Physician's Recommendations
Enter an 'X' in the appropriate box(es) to indicate the physician's recommendations.

Signature — Physician and Date Signed
The requesting physician must sign the form and enter the date the request is made.

ATTACHMENT 19
Prior Authorization / Physician Otological Report (PA/POR) (for photocopying)

(A copy of the "Prior Authorization/Physician Otological Report [PA/POR]" [for photocopying] is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11019 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Physican Otological Report (PA/POR) Completion Instructions (HCF 11019A).

SECTION I — PROVIDER INFORMATION

1. Name — Physician	2. Physician's UPIN, Medicaid Provider Number, or License Number
3. Address — Physician (Street, City, State, Zip Code)	4. Telephone Number — Physician

SECTION II — RECIPIENT INFORMATION

5. Name — Recipient (Last, First, Middle Initial)	6. Date of Birth — Recipient
7. Address — Recipient (Street, City, State, Zip Code)	
8. Recipient Medicaid Identification Number	9. Sex — Recipient ❑ Male ❑ Female

SECTION III — DOCUMENTATION

10. Medical History of Hearing Loss

11. Pertinent Otological Findings

		Normal (check below)	Problems (describe)
Right:	Canal	❑	_____
	Ear Drum	❑	_____
	Middle Ear	❑	_____
Left:	Canal	❑	_____
	Ear Drum	❑	_____
	Middle Ear	❑	_____

12. Describe Additional Findings (e.g., results of special studies, such as caloric and postural tests)

13. Clinical Diagnosis of Hearing Status

14. Medical, Cognitive, or Developmental Problems

15. Physician's Recommendations (check all applicable)

- ❑ I have medically evaluated this patient and refer him / her for a hearing instrument evaluation as follows:
  - ❑ One or more of the situations listed below applies to this patient. Therefore, as required by Medicaid regulations, I refer this patient to an audiologist for a hearing instrument evaluation / diagnosis:
    - ❑ The patient is 21 years of age or under.
    - ❑ The patient is behaviorally or cognitively impaired.
    - ❑ The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.
  - ❑ None of the above situations applies to this patient. Either an audiologist or a hearing instrument specialist may provide the hearing instrument evaluation.
  - ❑ A home hearing test is required.

SIGNATURE — Physician	Date Signed