

To:

Narcotic

Treatment
Services
Providers

HMOs and Other
Managed Care
Programs

Clarification of Narcotic Treatment Coverage

This *Wisconsin Medicaid and BadgerCare Update*:

- Clarifies coverage of narcotic treatment services as described under HFS 75.15, Wis. Admin. Code, and subsequent Division of Disability and Elder Services memos.
- Describes Wisconsin Medicaid's policy on certification, covered services, claims submission, and reimbursement for narcotic treatment services effective for dates of service on and after January 1, 2004.

Narcotic Treatment Service As Described Under HFS 75.15, Wis. Admin. Code, and Subsequent Memos

A narcotic treatment service for opiate addiction provides for the management and rehabilitation of patients with certain opiate addictions. Narcotic treatment consists of the use of methadone or other Federal Drug Administration (FDA)-approved narcotics and a broad range of medical and psychological services, substance abuse counseling, and social services. A narcotic treatment service should refer to HFS 75.15, Wis. Admin. Code, and subsequent memos issued by the Division of Disability and Elder Services (DDES), dated July 24, 2003, and December 8, 2003, for additional information on narcotic treatment policy.

A Narcotic Treatment Service May Provide Only Services Directly Related to Narcotic Treatment

According to HFS 75.15, Wis. Admin. Code, and subsequent DDES memos, a narcotic treatment service may provide only services directly related to narcotic treatment which are the following:

- Assessment of the patient including current physiological or psychological dependence, length of history of addiction, medical history, and physical examination prior to administration of the first dose of methadone or an FDA-approved narcotic.
- Urine drug screens. Urine drug screens in excess of 40 per year will be allowed only if medically necessary for narcotic treatment and if the need is specifically indicated in the patient's treatment plan.
- Screening for tuberculosis, viral hepatitis, and sexually transmitted diseases upon admission and annually, assuring appropriate follow-up treatment is provided as needed.
- Prescribing and administering narcotic medication with dosage and frequency of take-home medications and ensuring that justification for reducing the frequency of service visits for observed drug ingesting is met.
- Substance abuse counseling services.

A Narcotic Treatment Service May Not Provide Any Services Not Directly Related to Narcotic Treatment

According to HFS 75.15, Wis. Admin. Code, and subsequent DDES memos, a narcotic treatment service may not provide any medical services not directly related to narcotic treatment. If a patient has medical service needs that are not directly related to narcotic treatment, the service shall refer the patient for appropriate health care.

Admission Criteria for Narcotic Treatment for Opiate Addiction

Persons admitted to a narcotic treatment service for opiate addiction must meet the following admission criteria under HFS 75.15, Wis. Admin. Code:

- The person is physiologically and psychologically dependent upon a narcotic drug that may be a synthetic narcotic.
- The person has been physiologically and psychologically dependent upon the narcotic drug not less than one year before admission.
- In instances where the presenting drug history is inadequate to substantiate such a diagnosis, the material submitted by other health care professionals indicates a high degree of probability of such a diagnosis, based on further evaluation.
- When the person receives health care services from outside the (narcotic treatment) service, the person has provided names, addresses, and written consents for release of information from each health care provider to allow the (narcotic treatment) service to contact the providers, and agrees to update releases if changes occur.

Also, the person shall receive treatment at a (narcotic treatment) service located in the same county or at the nearest location to the person's residence, *except* that if a service is unavailable within a radius of 50 miles from the patient's residence, the patient may, in writing, request the state methadone authority to approve an

exception. In no case may a patient be allowed to attend a (narcotic treatment) service at a greater distance to obtain take-home doses.

Medicaid Coverage of Narcotic Treatment Services

Wisconsin Medicaid covers narcotic treatment services, as described in Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update*, under certification as narcotic treatment services. Substance abuse counseling provided to Medicaid recipients who are receiving narcotic treatment services is covered under the outpatient substance abuse services provider certification. Refer to Attachment 1 for a complete list of Medicaid-covered narcotic treatment services, including procedure codes, modifiers, and reimbursement rates. These are the only services that may be billed under a narcotic treatment service (NTS) provider number. Refer to Attachment 2 for a list of Medicaid-covered outpatient substance abuse services.

Medicaid Provider Certification

Narcotic treatment service providers are required to have separate Medicaid certification to submit claims for narcotic treatment to Wisconsin Medicaid. Narcotic treatment service providers are required to complete the Mental Health and Substance Abuse *Agency Certification Packet* to receive a group billing number. All individuals providing services in an NTS agency are required to be individually Medicaid certified and have performing provider numbers. If an individual is not certified, the individual must complete the Mental Health and Substance Abuse *Individual Certification Packet* to receive an individual provider number.

Narcotic treatment service providers are required to have separate Medicaid certification to submit claims for narcotic treatment to Wisconsin Medicaid.

Medicaid certification packets may be obtained from the Medicaid Web site at dhfs.wisconsin.gov/medicaid/ or from Provider Services at (800) 947-9627 or (608) 221-9883.

Certified AODA counselors and Certified AODA counselors with Master's degrees and 3,000 hours of psychotherapy, certified by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors, Ph.D. psychologists, physicians, and physician assistants are *not* required to obtain additional Medicaid certification for narcotic treatment if they are currently Medicaid certified.

Alcohol and Other Drug Abuse Counselors

Registered Alcohol and Other Drug Abuse (AODA) counselors, registered by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors, may obtain Medicaid certification for narcotic treatment only. (Wisconsin Medicaid will not reimburse registered AODA counselors for any other Medicaid-covered service except for those services indicated in Attachment 1 [drug assessments only].) These providers are required to complete the Mental Health and Substance Abuse *Individual Certification Packet* to receive a performing provider number.

Registered Nurses and Licensed Practical Nurses

Registered nurses and licensed practical nurses are also required to obtain a separate Medicaid certification for narcotic treatment only. These providers are required to complete the Mental Health and Substance Abuse *Individual Certification Packet* to receive a performing provider number.

Other Providers

Certified AODA counselors and Certified AODA counselors with Master's degrees and 3,000 hours of psychotherapy, certified by the Wisconsin Certification Board on Alcohol and Other Drug Abuse counselors, Ph.D. psychologists, physicians, and physician assistants are *not* required to obtain additional Medicaid certification for narcotic treatment if they are currently Medicaid certified.

Submitting Claims to Wisconsin Medicaid for Narcotic Treatment Services

Providers are required to submit separate claims for the following components of narcotic treatment:

- Methadone or other FDA-approved drugs, using the NTS billing provider number.

- Other narcotic treatment services, using the NTS billing provider number.
- Substance abuse counseling services, using the outpatient substance abuse clinic billing provider number.

Claims for Methadone or Other Food and Drug Administration-Approved Narcotics

Narcotic treatment service providers may submit claims for methadone or other FDA-approved narcotics using either the National Council for Prescription Drug Programs (NCPDP) 5.1 Telecommunication Standard for Retail Pharmacy Claims or the Noncompound Drug Claim form, HCF 13072 (Rev. 06/03). Refer to the Wisconsin Medicaid Companion Document to HIPAA Implementation Guide: NCPDP 5.1 for real-time claims for more information. Refer to Attachments 3 and 4 for the paper Noncompound Drug Claim form and instructions.

Wisconsin Medicaid covers only one dispensing fee per month per recipient for methadone or other FDA-approved narcotics, regardless of the provider. When submitting claims to Wisconsin Medicaid for methadone or other FDA-approved narcotics, an NTS provider is required to indicate the appropriate National Drug Code of the drug product being dispensed on the real-time or paper claim. Refer to the Claims Submission section of the Pharmacy Handbook for more information on claims submission.

Claims for All Other Narcotic Treatment Services

When submitting claims to Wisconsin Medicaid for all other narcotic treatment services, an NTS provider is required to indicate the appropriate procedure code and modifiers on either the electronic 837 Health Care Claim: Professional (837P) or the CMS 1500 paper

claim form. Refer to the Wisconsin Medicaid Companion Document for the 837P transactions for more information. Providers should refer to Attachment 5 for CMS 1500 claim form instructions. Attachment 6 is a sample claim for billing narcotic treatment services. Refer to Attachment 1 for a list of NTS procedure codes and modifiers.

Note: Providers are not allowed to submit claims for narcotic treatment services across separate calendar weeks on a single detail. Wisconsin Medicaid considers a calendar week to span from Sunday through Saturday. In addition, providers should indicate only the dates on which a service was actually performed.

Claims for Substance Abuse Counseling

Claims for substance abuse counseling must be submitted separately from claims for narcotic treatment services. When submitting claims to Wisconsin Medicaid for substance abuse counseling, indicate the appropriate outpatient substance abuse clinic billing provider number, procedure codes, and modifiers on the electronic 837P transaction or the CMS 1500 paper claim form. Refer to Attachment 2 for a list of substance abuse counseling procedure codes and appropriate modifiers. Refer to the Medicaid Web site for more information on substance abuse counseling coverage policy, prior authorization, and claims submission requirements.

Medicaid Documentation Requirements

All narcotic treatment services shall be documented in accordance with HFS 75.15 and 106.02(9), Wis. Admin. Code. For more information about documentation, refer to the April 2004 *Update* (2004-34), titled "Medical Record Documentation Requirements for Mental Health and Substance Abuse Services." Also, refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for more information.

Medicaid Reimbursement

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, Wisconsin Medicaid shall pay the *lesser* of a provider's usual and customary charge or the maximum allowable fee established by Wisconsin Medicaid. Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered payment in full.

Refer to Attachment 1 for reimbursement rates for narcotic treatment services. Attachment 2 includes reimbursement rates for substance abuse counseling services.

Managed Care Coverage

Medicaid recipients in state-contracted managed care organizations (MCOs) receive Medicaid identification cards indicating their status as managed care enrollees. Recipients in state-contracted MCOs may request exemptions from HMO enrollment to receive narcotic treatment. Recipients may call (800) 760-0001 for more information about requesting an HMO exemption.

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 dhfs.wisconsin.gov/medicaid/.

PHC 1250

ATTACHMENT 1

Medicaid-Covered Narcotic Treatment Services

When submitting claims to Wisconsin Medicaid for providing narcotic treatment services, providers are required to indicate the appropriate procedure code and modifiers on the 837 Health Care Claim: Professional transaction or the CMS 1500 paper claim form.

The following reimbursement rates are in effect as of January 1, 2004. Wisconsin Medicaid-certified providers are reimbursed for services provided to recipients at the lower of their usual and customary charge or the Medicaid reimbursement rate.

Procedure Code and Description	Program Modifier ¹	Phase Modifier ²	Service Modifier	Limitations	Allowable Performing Providers	Rate	Copay
H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	U1 = Methadone administration (dosing)	One dosing per day, up to six per calendar week. Includes supplies/equipment related to dosing. Daily dosing limited to two years.	Registered nurse Licensed practical nurse	\$12.07	N/A
H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	U2 = Methadone dosage determination by physician	One per day, up to six units per calendar year. ⁴	Physician	\$31.68	N/A
			AM ³ = Physician, team member service		Physician assistant	\$28.51	N/A
H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	U3 = Narcotic treatment service (NTS) physical examination by physician	One NTS physical per calendar year, up to one hour (1 unit = 1 hour).	Physician	\$89.74	N/A
			U4 = Narcotic treatment service physical examination by registered nurse or physician assistant		Registered nurse Physician assistant	\$80.76	N/A

Procedure Code and Description	Program Modifier ¹	Phase Modifier ²	Service Modifier	Limitations	Allowable Performing Providers	Rate	Copay
H0001 Alcohol and/or drug assessment	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	U5 = Narcotic treatment service initial assessment utilizing an instrument such as the addiction screening instrument (ASI)	One NTS initial assessment per recipient, up to two hours. May be billed on only one date of service (DOS) (1 unit = 1 hour).	Ph.D. psychologist	\$65.00	\$1.00
					Certified Alcohol and Other Drug Abuse (AODA) counselor with Master's and 3,000 hours of psychotherapy	\$55.00	
					Certified AODA counselor	\$31.96	
					Registered AODA counselor	\$22.51	
H0001 Alcohol and/or drug assessment	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	U6 = Narcotic treatment service annual reassessment utilizing an instrument such as the ASI	One NTS reassessment per calendar year, up to one hour. May be billed on only one DOS (1 unit = 1 hour).	Ph.D. psychologist	\$65.00	\$1.00
					Certified AODA counselor with Master's and 3,000 hours of psychotherapy	\$55.00	
					Certified AODA counselor	\$31.96	
					Registered AODA counselor	\$22.51	
H0003 ⁵ Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	59 = Distinct procedural service (ONLY use modifier "59" to indicate a screen for five to eight drugs for assessment purposes. Only one use of modifier "59" allowed per calendar year. No modifier is required when testing for the presence of four or less drugs.)	Quantity up to 39 separate DOS per calendar year and up to four drugs screened per DOS, as indicated in the treatment plan, plus one DOS per calendar year at which up to eight drugs may be screened. ³	Licensed practical nurse Registered nurse	\$19.03 per drug screened	\$1.00

Procedure Code and Description	Program Modifier ¹	Phase Modifier ²	Service Modifier	Limitations	Allowable Performing Providers	Rate	Copay
86580 Skin test; tuberculosis, intradermal	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	No service modifier needed. Tuberculosis skin test (TST) for negative TST reactors.	One unit per calendar year.	Licensed practical nurse Registered nurse	\$9.20	\$0.50
99001 Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory	HG	UA = Phase 1 UB = Phase 2 UC = Phase 3 UD = Phase 4	U7 = Specimen handling for viral hepatitis screen	One unit per calendar year for viral hepatitis screen.	Licensed practical nurse Registered nurse	\$3.74	N/A
			U8 = Specimen handling for sexually transmitted disease (STD) screen	One unit per calendar year for STD screen.			
			U9 = Specimen handling for peak and trough	Up to four units per calendar year for peak and trough.			

¹ Always required. "HG" = Opioid addiction treatment program.

² A phase represents a patient's level of dosing frequency, as defined in HFS 75.15, Wis. Admin. Code, that is determined by the NTS provider. A phase modifier is always required; only one phase modifier can be billed per DOS. Different phase modifiers cannot be billed for the same DOS.

³ Indicate modifier "AM" when methadone dosage determination is done by a physician assistant.

⁴ If limitations are exceeded, submit additional documentation with the claim, including the current treatment plan and recent urinalysis, justifying medical necessity for exceeding limitations.

⁵ The Clinical Laboratory Improvement Amendment (CLIA) requires **all** laboratories and providers performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. Wisconsin Medicaid complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service CLIA.
- 42 CFR Part 493, Laboratory Requirements.

ATTACHMENT 2

Medicaid-Covered Outpatient Substance Abuse Services

The procedure codes listed in this attachment will be allowable to those providers who provide substance abuse services in outpatient settings. This includes psychiatrists and Ph.D. psychologists in private practice and all outpatient mental health or substance abuse clinics (for services provided by psychiatrists, Ph.D. psychologists, Master's-level psychotherapists, and alcohol and other drug abuse [AODA] counselors). Not all providers may be reimbursed for all outpatient mental health or substance abuse services.

Maximum allowable fees listed in this attachment are the proposed fees effective July 1, 2002, and may be subject to change. Wisconsin Medicaid will notify providers if the fees change from those printed in this *Wisconsin Medicaid and BadgerCare Update*.

Professional Level Modifiers		
Modifier	Description	Providers
HN	Bachelor's degree level	Alcohol and other drug abuse counselor (counselors that have less credentials than a Master's level psychotherapist)
HO	Master's degree level	Master's level psychotherapist (Master's-level psychotherapists are Master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. This includes registered nurses with a master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.)
HP	Doctoral level	Psychologist, Ph.D.
UA	MD, Psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing substance abuse services

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee	Copayment
H0005	Alcohol and/or drug services; group counseling by a clinician (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN	\$8.45	\$0.50
		Master's degree level	HO	\$11.26	\$1.00
		Doctoral level	HP	\$13.82	\$1.00
		MD, Psychiatrist	UA	\$20.23	\$1.00
H0022	Alcohol and/or drug intervention service (planned facilitation) (quantity of 1.0 = per person in group per 60 minutes)	Bachelor's degree level	HN	\$31.96	\$2.00
		Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD, Psychiatrist	UA	\$80.13	\$3.00

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee	Copayment
H0047	Alcohol and/or other drug abuse services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Substance abuse diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD, Psychiatrist	UA	\$80.13	\$3.00
T1006	Alcohol and/or substance abuse services, family/couple counseling (quantity of 1.0 = 60 minutes)	Bachelor's degree level	HN	\$31.96	\$2.00
		Master's degree level	HO	\$55.00	\$3.00
		Doctoral level	HP	\$65.00	\$3.00
		MD, Psychiatrist	UA	\$80.13	\$3.00

ATTACHMENT 3

Noncompound Drug Claim Completion Instructions

(A copy of the "Noncompound Drug Claim Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID NONCOMPOUND DRUG CLAIM COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these claim instructions refer to Medicaid recipients, these instructions also apply to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should 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 Noncompound Drug Claim form is used by Wisconsin Medicaid and is mandatory when submitting paper claims for noncompound drugs. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

To avoid denial or inaccurate claim payment, use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is indicated.

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.

Note: Submit claims for nondrug items, such as clozapine management services, disposable medical supplies, durable medical equipment, and enteral nutrition products, on the CMS 1500 claim form or 837 Health Care Claim: Professional transaction (837P) using nationally recognized five-digit procedure codes.

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider

Enter the name of the billing provider.

Element 2 — Wisconsin Medicaid Provider Number

Enter the billing provider's eight-digit Medicaid provider number.

Element 3 — Address — Provider

Enter the address, including the street, city, state, and Zip code of the billing provider.

Element 4

Do not write in this space. This element is reserved for future Medicaid use.

SECTION II — RECIPIENT INFORMATION

Element 5 — Cardholder Identification Number — Recipient

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

Element 6 — Name — Recipient (Last, First, Middle Initial)

Enter the recipient's name from the recipient's Medicaid identification card. 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 7 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., May 21, 1980, would be 05/21/80) or in MM/DD/YYYY format (e.g., July 14, 1953, would be 07/14/1953).

Element 8 — Sex — Recipient

Enter "0" for unspecified, "1" for male, and "2" for female.

SECTION III — CLAIM INFORMATION

Providers may enter up to four sets of drug information per recipient for Elements 9-27.

Element 9 — Prescriber Number

Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These codes must *not* be used for prescriptions for controlled substances.

Element 10 — Date Prescribed

Enter the date shown on the prescription in MM/DD/YY or MM/DD/YYYY format.

Element 11 — Date Filled

Enter the date that the prescription was filled or refilled in MM/DD/YY or MM/DD/YYYY format. When billing unit dose services, the last date of service in the billing period must be entered.

Element 12 — Refill

Enter the refill indicator. The first two digits of the refill indicator is for the refill being billed. This must be "00" if the date prescribed equals the date filled. The second element is the total refills allowed (e.g., the second refill of a six-refill prescription would be "02/06.") A nonrefillable prescription would be "00/00." Enter "99" in the second element if the prescription indicates an unlimited number of refills.

Element 13 — NDC

Enter the 11-digit National Drug Code (NDC) or Medicaid-assigned 11-digit procedure code for the item being billed. (Use the NDC indicated on the product.)

Element 14 — Days' Supply

Enter the estimated days' supply of tablets, capsules, fluid cc's, etc., that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

Note: Days' supply is not the duration of treatment, but the expected number of days the drug will be used.

Element 15 — Qty

Enter the metric decimal quantity in the specified unit of measure according to the Wisconsin Medicaid Drug File. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

Element 16 — Charge

Enter the total charge for each line item. The charge should represent the provider's usual and customary fee.

Element 17 — UD

Enter one of the following National Council for Prescription Drug Programs (NCPDP) single-numeric indicators when billing for unit dose (UD) drugs and nonunit dose drugs. (This field is required for *all* pharmacy claims.)

Indicator	Description
0	Not Specified
1	Not Unit Dose
2	Manufacturer Unit Dose
3	Pharmacy Unit Dose

Element 18 — Prescription Number

Enter the prescription number. Each legend and over-the-counter drug billed must have a unique prescription number.

Element 19 — DAW

Enter the appropriate one-digit NCPDP dispense as written (DAW) code:

Code	Description
0	No Product Selection Indicated
1	Substitution Not Allowed by Prescriber
8	Substitution Allowed — Generic Drug Not Available in Marketplace

Element 20 — Drug Description (optional)

Enter a brief description of the drug.

Element 21 — PT LOC

Enter the appropriate two-digit NCPDP patient location code for each drug billed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 22 — Diagnosis Code

This element is required when billing for a drug in which Wisconsin Medicaid requires a diagnosis or when billing for Pharmaceutical Care (PC) services. If the diagnosis of the drug is different than that of the PC services, enter the diagnosis code of the drug from the *International Classification of Diseases, Ninth Revision, Clinical Modification* coding structure. Enter all digits of the diagnosis code, including the preceding zeros.

Element 23 — Level of Effort

This element is required when billing for PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for PC information. Enter the NCPDP code from the following list that corresponds with the time required to perform the PC service.

Code	Description
11	Level 1 (0-5 minutes)
12	Level 2 (6-15 minutes)
13	Level 3 (16-30 minutes)
14	Level 4 (31-60 minutes)
15	Level 5 (More than 60 minutes)

Element 24 — Reason for Service

This element is required when billing for Drug Utilization Review (DUR) or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for DUR and PC information and applicable PC values.

Element 25 — Professional Service

This element is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for DUR and PC information and applicable PC values.

Element 26 — Result of Service

This element is required when billing for DUR or PC services. Refer to the Drug Utilization Review and Pharmaceutical Care section of the Pharmacy Handbook for DUR and PC information and applicable PC values.

Element 27 — Sub Clar Code

Enter NCPDP submission clarification code "2" to indicate repackaging.

Element 28 — Prior Authorization Number

If prior authorization (PA) has been obtained, enter the seven-digit number in this element. Do not attach a copy of the PA request to the claim. Services authorized under multiple PA requests must be billed on separate claims.

Element 29 — Other Coverage Code

Wisconsin Medicaid is usually the payer of last resort for Medicaid-covered services. (Refer to the Coordination of Benefits section of the All-Provider Handbook for more information.) Prior to submitting a claim to Wisconsin Medicaid, providers must verify whether a recipient has other health insurance coverage (e.g., commercial health insurance, HMO, or Medicare).

If a recipient has Medicare and other insurance coverage, the provider is required to bill both prior to submitting a claim to Wisconsin Medicaid. Enter one of the NCPDP other coverage codes that best describes the recipient's situation.

Value	Description
0	Not specified
1	No other coverage identified
2	Other coverage exists — payment collected
3	Other coverage exists — this claim not covered
4	Other coverage exists — payment not collected
5	Managed care plan denial
6	Other coverage denied — not a participating provider
7	Other coverage exists — not in effect at time of service

Element 30 — Total Charges

Enter the total charges for this claim.

Element 31 — Other Coverage Amount

When applicable, enter the amount paid by commercial health insurance. This is required when the OC code in Element 29 indicates "2."

Note: Pharmacies may also include the Medicare-paid amount in this field for drug claims that fail to automatically crossover from Medicare to Wisconsin Medicaid within 30 days.

Element 32 — Patient Paid

When applicable for SeniorCare claims, enter the recipient's out-of-pocket expense due to other coverage, including Medicare. Do not enter a recipient's expected copayment for Wisconsin Medicaid or SeniorCare.

Element 33 — Net Billed

Enter the balance due by subtracting any other insurance amount and patient paid amount from the amount in Element 30.

Element 34 — Certification

The provider or the authorized representative must sign this element. 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 computer generated or stamped.

ATTACHMENT 4

Noncompound Drug Claim

(A copy of the "Noncompound Drug Claim" is located on the following page.)

**WISCONSIN MEDICAID
 NONCOMPOUND DRUG CLAIM**

Instructions: Type or print clearly. Before completing this form, read the Noncompound Drug Claim Completion Instructions (HCF 13072A).
 Return form to: Wisconsin Medicaid, 6406 Bridge Road, Madison, WI 53784-0002.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. Wisconsin Medicaid Provider Number
3. Address — Provider (Street, City, State, Zip Code)	4. Reserved for future Medicaid use (Do not write in this space)

SECTION II — RECIPIENT INFORMATION

5. Cardholder Identification Number — Recipient	6. Name — Recipient (Last, First, Middle Initial)	7. Date of Birth — Recipient	8. Sex — Recipient
---	---	------------------------------	--------------------

SECTION III — CLAIM INFORMATION

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge \$
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge \$
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge \$
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days' Supply	15. Qty	16. Charge \$
17. UD	18. Prescription Number	19. DAW	20. Drug Description				21. PT LOC
22. Diagnosis Code	23. Level of Effort	24. Reason for Service	25. Professional Service	26. Result of Service	27. Sub Clar Code		

28. Prior Authorization Number	29. Other Coverage Code
--------------------------------	-------------------------

30. Total Charges \$	31. Other Coverage Amount \$	32. Patient Paid \$	33. Net Billed \$
-------------------------	---------------------------------	------------------------	----------------------

34. Certification
 I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid, SeniorCare, and BadgerCare.
 I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

SIGNATURE — Pharmacist or Dispensing Physician	Date Signed
--	-------------

ATTACHMENT 5

CMS 1500 Claim Form Instructions for Narcotic Treatment Services

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

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

Element 1 — Program Block/Claim Sort Indicator

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

Element 1a — Insured's I.D. Number

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

Element 2 — Patient's Name

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

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

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

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

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

Code	Description
OI-P	PAID 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: <ul style="list-style-type: none"> ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

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

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

Element 11 — Insured’s Policy, Group, or FECA Number

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

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

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

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

Code	Description
M-5	<p>Provider is not Medicare certified. 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:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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	<p>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:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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	<p>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:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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). <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

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

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

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

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

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

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for each symptom or condition related to the services provided. The following diagnoses are the only allowable diagnoses: 304.00 through 304.03, and 304.7.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

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

- When billing for one 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 on 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 for narcotic treatment services if:

- All DOS are in the same calendar month.
- All DOS are in the same calendar week (Sunday through Saturday).
- 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 two-digit POS code “11” (office) for each service.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code as found in Attachments 1 or 2 of this *Wisconsin Medicaid and BadgerCare Update*. Wisconsin Medicaid denies claims received without an appropriate procedure code. Attachment 1 provides the allowable procedure codes and applicable modifiers for narcotic treatment services. Attachment 2 provides the allowable procedure codes and applicable modifiers for outpatient substance abuse services.

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.”

Element 24F — \$ Charges

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

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units). The defined units are listed in Attachment 1. The following table illustrates the rules of rounding and gives the appropriate billing unit for all narcotic treatment services when 1.0 unit of service is equal to one hour. Providers should follow the time specified in the procedure code description for all other codes.

Narcotic Treatment Services Rounding Guidelines	
Time (Minutes)	Unit(s) Billed
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0
Etc.	Etc.

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

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (required)

Enter the eight-digit Medicaid provider number of the performing provider for each procedure.

Element 25 — Federal Tax I.D. Number (not required)**Element 26 — Patient's Account No. (optional)**

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

Element 27 — Accept Assignment (not required)**Element 28 — Total Charge**

Enter the total charges for this claim.

Element 29 — Amount Paid

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

Element 30 — Balance Due

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

Element 31 — Signature of Physician or Supplier

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

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

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)**Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone #**

Providers are required to submit separate claims for narcotic treatment and substance abuse treatment services with the appropriate eight-digit billing provider number. Submit claims for services relating to narcotic treatment with the narcotic treatment service billing provider number. Submit claims for services relating to substance abuse treatment with the outpatient mental health/substance abuse clinic billing provider number.

Claims for Narcotic Treatment

Enter the name of the narcotic treatment service certified per HFS 75.15, Wis. Admin. Code, submitting the claim and the complete mailing address. At the bottom of Element 33, enter the narcotic treatment service eight-digit Medicaid billing provider number.

Claims for Outpatient Substance Abuse Services

Enter the name of the outpatient mental health/substance abuse clinic submitting the claim and the complete mailing address. At the bottom of Element 33, enter the outpatient mental health/substance abuse clinic eight-digit Medicaid billing provider number.

ATTACHMENT 6

Sample CMS 1500 Claim Form for Narcotic Treatment Services

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					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 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
CITY Anytown			STATE WI		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:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				
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 06 09 04 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 304.00					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
2. _____					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/HCPGS MODIFIER				
E DIAGNOSIS CODE					F \$ CHARGES				
G DAYS OR UNITS					H EPSDT Family Plan				
I EMG					J COB				
K RESERVED FOR LOCAL USE									
1 06 09 04 11 H0001 HG UA U5 1 XX XX 1.0 12345678					2 06 09 04 11 H0003 HG UA 59 1 XXX XX 8.0 12345678				
3 06 09 04 11 H0020 HG UA U2 1 XX XX 1.0 12345687					4 06 09 04 11 H0020 HG UA U4 1 XX XX 1.0 12345678				
5 06 09 04 11 H0020 HG UA U1 1 XX XX 1.0 12345678					6 06 10 04 11 H0020 HG UA U1 1 XX XX 1.0 12345678				
25. FEDERAL TAX I.D. NUMBER SSN EIN 1234JED					26. PATIENT'S ACCOUNT NO. 1234JED				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					28. TOTAL CHARGE \$ XXXX 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.) <i>J.A. Authorized</i> MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
SIGNED _____ DATE _____					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Narcotic Treatment Service 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)