wisconsin Medicaid update
and BadgerCare

February • No. 2007-16

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Nursing Homes

HMOs and Other Managed Care Programs

New UB-04 (CMS 1450) Claim Instructions for Nursing Homes Services

Wisconsin Medicaid will begin accepting the new UB-04 (CMS 1450) claim form for UB claims received on and after March 1, 2007. Wisconsin Medicaid will continue to accept the UB-92.

Wisconsin Medicaid will begin accepting the new UB-04 (CMS 1450) claim form for UB claims received on and after March 1, 2007. Wisconsin Medicaid will continue to accept the UB-92; however, the National Uniform Billing Committee will supply only the new UB-04 claim form as of May 23, 2007.

New UB-04 Claim Form Completion Instructions

Providers should use the instructions in Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* when submitting UB-04 claim forms to Wisconsin Medicaid. Use these claim form completion instructions, not the form locator descriptions on the claim form, to avoid claim denial or inaccurate claim payment. Attachments 2 and 3 include sample UB-04 claim forms.

Providers who are using the UB-92 claim form should continue to use their most recently published claim form instructions.

Important Changes with the UB-04

Providers should note the following changes to the claim form completion instructions for the UB-04:

- Covered days, indicated on the UB-92 in Form Locator 7, are now indicated on the UB-04 in Form Locators 39-41 a-d using value code "80." The number of covered days is indicated in the corresponding amount field.
- Noncovered days, indicated on the UB-92 in Form Locator 8, are now indicated on the UB-04 in Form Locators 39-41 a-d using value code "81." The number of noncovered days is indicated in the corresponding amount field.
- Service dates, indicated on the UB-92 in Form Locator 43, are now to be indicated using Form Locators 45 and 49. Indicate the first date or a single date of service (DOS) in Form Locator 45 in MMDDYY format. Indicate the last DOS in Form Locator 49 in DD format.
- Signature and date, indicated on the UB-92 in Form Locator 85, is not on the UB-04. Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to Medicaid.
- The sum of all the charges on a claim is now indicated on Detail Line 23 in the

field following the word "*TOTALS*." Providers no longer indicate a claim's total charge with revenue code "0001" in Form Locator 42 and the sum in Form Locator 47.

- For Form Locator 76 on the UB-04, the biller is required to indicate a provider identification qualifier (refer to Attachment 1) before indicating the provider's identification number. The qualifier identifies the type of identification number being indicated (e.g., a Medicaid provider number, a license number).

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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
UB-04 (CMS 1450) Claim Form Instructions for Nursing Home Services

(Effective for UB-04 Claims Received Beginning March 1, 2007)

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

These instructions are for the completion of the UB-04 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card when initially 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 Recipient Eligibility section of the All-Provider Handbook or the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for more information about the EVS.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to Medicaid.

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state and ZIP code. The name in Form Locator 1 should correspond with the provider number in Form Locator 57.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl. # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will be included in Medicaid remittance information.

Form Locator 3b — Med. Rec. # (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will be included in Medicaid remittance information.

Form Locator 4 — Type of Bill

Enter the three-digit type of bill code. Type of bill codes for nursing homes include the following:

- 211 = Inpatient Nursing Home — Admit through discharge claim.
- 212 = Inpatient Nursing Home — Interim, first claim.
- 213 = Inpatient Nursing Home — Interim, continuing claim.
- 214 = Inpatient Nursing Home — Interim, last claim.

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 1, 2006, would be 11/01/06). Include the date of discharge or death. Do *not* include Medicare coinsurance days.

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8a-b — Patient Name

Enter the recipient's last name and first name, separated by a space or comma, in Form Locator 8b. 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.

Form Locator 9a-b — Patient Address (not required)

Form Locator 10 — Birthdate

Enter the recipient's birth date in MMDDCCYY format (e.g., September 25, 1975 would be 09251975).

Form Locator 11 — Sex (not required)

Form Locator 12 — Admission Date

Enter the admission date in the MM/DD/YY format (e.g., November 1, 2001, would be 11/01/01). The date of admission to the nursing home is the first date the recipient enters the facility as an inpatient for the current residency. (Current residency is not interrupted by bedhold days or changes in level of care or payer status.)

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src

For bill type 211 and 212, enter the code indicating the source of this admission.

Code Structure for Source of Admission		
Code	**Title**	**Description**
1	Physician referral	The recipient was admitted to this facility by the recommendation of his or her personal physician.
2	Clinic referral	The recipient was admitted to this facility by the recommendation of this facility's clinic physician.
3	HMO referral	The recipient was admitted to this facility by the recommendation of an HMO physician.
4	Transfer from a hospital	The recipient was admitted to this facility as a hospital transfer from an acute care facility where the recipient was an inpatient.
5	Transfer from a skilled nursing facility	The recipient was admitted to this facility as a transfer from a skilled nursing facility where the recipient was an inpatient.
6	Transfer from another health facility	The recipient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities, and skilled nursing facility recipients that are at a nonskilled level of care.
7	Emergency room	The recipient was admitted to this facility by the recommendation of this facility's emergency room physician.
8	Court/law enforcement	The recipient was admitted to this facility by the direction of a court of law or by the request of a law enforcement agency representative.
9	Information not available	The means by which this recipient was admitted to this facility is not known.
A	Transfer from a Critical Access Hospital	The patient was admitted to this facility as a transfer from a Critical Access Hospital where he or she was an inpatient.
D	Transfer	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer.

Form Locator 16 — DHr (not required)

Form Locator 17 — Stat

Enter the code indicating patient status as of the "Statement Covers Period" through date from Form Locator 6.

Code Structure for Patient Status	
Code	**Description**
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
20	Expired
30	Still patient
43	Discharged/transferred to a federal health care facility.
61	Discharged/transferred to hospital-based Medicare approved swing bed.
62*	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital.
63*	Discharged/transferred to a Medicare long term care hospital (LTCH).
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to Critical Access Hospital.

***** Patient status code valid for Medicare crossover (coinsurance) claims, but not for Medicaid-only claims.

Form Locators 18-28 — Condition Codes (required, if applicable)

Enter the code identifying a condition related to this claim.

Condition Code Structure for Insurance Codes		
Code	**Title**	**Description**
01	Military service related	Medical condition incurred during military service.
02	Condition is employment related	Recipient alleges that medical condition is due to environment/events resulting from employment.
03	Patient covered by insurance not reflected here	Indicates that recipient/recipient's representative has stated that coverage may exist beyond that reflected on this bill.
05	Lien has been filed	Provider has filed legal claim for recovery of funds potentially due to a recipient as a result of legal action initiated by or on behalf of the recipient.
A5	Disability	Developmentally disabled.

Form Locator 29 — Accident State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in MM/DD/YY format.

Code Structure for Occurrence Codes and Dates		
Code	**Title**	**Description**
01	Auto accident	Code indicating the date of an auto accident.
02	No fault insurance involved — including auto accident/other	Code indicating the date of an accident including auto or other where state has applicable no-fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/tort liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/employ ment related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other accident	Code indicating the date of an accident not described by the above codes.
06	Crime victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

Form Locator 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (required, if applicable)

To indicate covered days, enter value code "80" in the code field. Enter the number of covered days in the corresponding amount field, right-justified to the left of the dollars/cents delimiter.

To indicate noncovered days, enter value code "81" in the code field. Enter the number of noncovered days in the corresponding amount field, right-justified to the left of the dollars/cents delimiter.

Form Locator 42 — Rev. Cd.

Enter the four-digit revenue code as defined by the NUBC that identifies a specific accommodation, ancillary service, or billing calculation. Refer to nursing home publications for Medicaid-allowable revenue codes. Do not include Medicare coinsurance days.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rates/HIPPS Code (not required)

Form Locator 45 — Serv. Date

Enter the first date or single date of service (DOS) in MMDDYY format. The date of service must be a date on which the service was actually provided.

Form Locator 46 — Serv. Units

Enter the number of covered accommodations days or ancillary units of service for each line item. Do not count or include the day of discharge/death for accommodation codes. Do not include Medicare coinsurance days. The sum of the accommodation days must equal the billing period in Form Locator 43 and must equal the total days indicated in the amount field with value code "80" in Form Locators 39-41 a-d**.** For transportation services, enter the number of miles.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field

Enter the last DOS in DD format. The DOS must be a date on which the service was actually provided. Do *not* indicate the date of discharge or death. Do not include Medicare coinsurance insurance days.

DETAIL LINE 23

PAGE ___ OF ___ (not required)

Wisconsin Medicaid accepts only one-page claim forms.

CREATION DATE (not required)

TOTALS

Enter the sum of all charges for the claim in this field.

Form Locator 50 A-C — Payer Name

Enter all health insurance payers here. For Wisconsin Medicaid, enter "T-19." Enter "patient liability" to identify any patient liability.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C — Est Amount Due

Enter the dollar amount of any patient liability.

Form Locator 56 — NPI (not required)

Form Locator 57 — Other Provider ID

Enter the provider's Medicaid provider number. The provider number in Form Locator 57 should correspond with the name in Form Locator 1.

Form Locator 58 A-C — Insured's Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured's Unique ID

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

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (required, if applicable)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF), HCF 11018, for all services requiring PA (e.g., ventilator, Acquired Immune Deficiency Syndrome, head injury). 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. Do not attach the PA to the claim.

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — DX Version Qualifier (not required)

Form Locator 67 — Prin. Diag. Cd.

Enter the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible

for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" codes.

Form Locators 67A-Q — Other Diag. Codes

Enter the most specific ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx

Enter the most specific ICD-9-CM diagnosis code provided at the time of admission, as stated by the physician.

Form Locator 70 — Patient Reason Dx (not required)

Form Locator 71 — PPS Code (not required)

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending

To indicate the attending provider, enter a provider identification qualifier in the first field to the right of "Qual" and the identification number itself in the second field to the right of "Qual." In addition, include the last and first name of the attending provider. Providers may use one of the following provider identification qualifiers:

- 0B — State license number.
- 1D — Medicaid provider number.
- 1G — Universal Provider Identification Number (UPIN).

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other ID (not required)

Form Locator 80 — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information

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

When the recipient has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When 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 commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 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 following: ✓ 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 submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code 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 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 the provider is not Medicare certified.

  Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.
- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

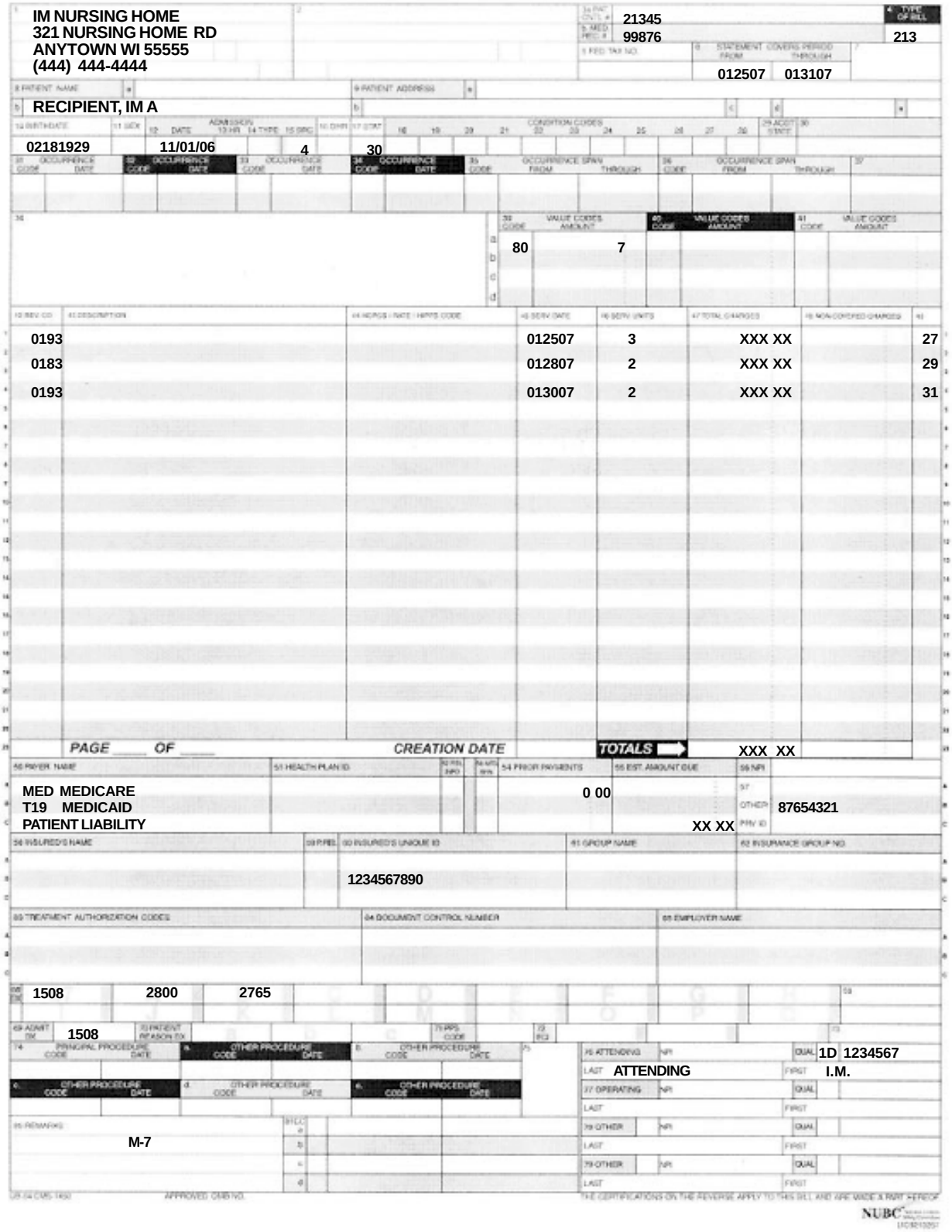
Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified but are billing for DOS before or after their Medicare certification effective dates. *For Medicare Part A, use M-5 in the following instances (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, use M-5 in the following instances (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, use M-7 in the following instances (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, use M-7 in the following instances (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, use M-8 in the following instances (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, use M-8 in the following instances (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).

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

Form Locator 81 — CC (not required)

ATTACHMENT 2
Sample UB-04 Claim for Billing the Days Denied by Medicare for a Dual Eligible



IM NURSING HOME
321 NURSING HOME RD
ANYTOWN WI 55555
(444) 444-4444

21345
99876
213
012507 013107

RECIPIENT, IM A

02181929 11/01/06 4 30

80 7

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0193			012507	3	XXX XX		27
0183			012807	2	XXX XX		29
0193			013007	2	XXX XX		31

PAGE ____ OF ____ CREATION DATE TOTALS XXX XX

50 PAYER NAME
MED MEDICARE
T19 MEDICAID
PATIENT LIABILITY

54 PRIOR PAYMENTS: 0 00
55 EST AMOUNT DUE: XX XX
56 NPI
57 OTHER PRV ID: 87654321

60 INSURED'S UNIQUE ID: 1234567890

1508 2800 2765

66 ADMIT DX: 1508

76 ATTENDING NPI QUAL 1D 1234567
LAST ATTENDING FIRST I.M.

77 OPERATING
78 OTHER
79 OTHER

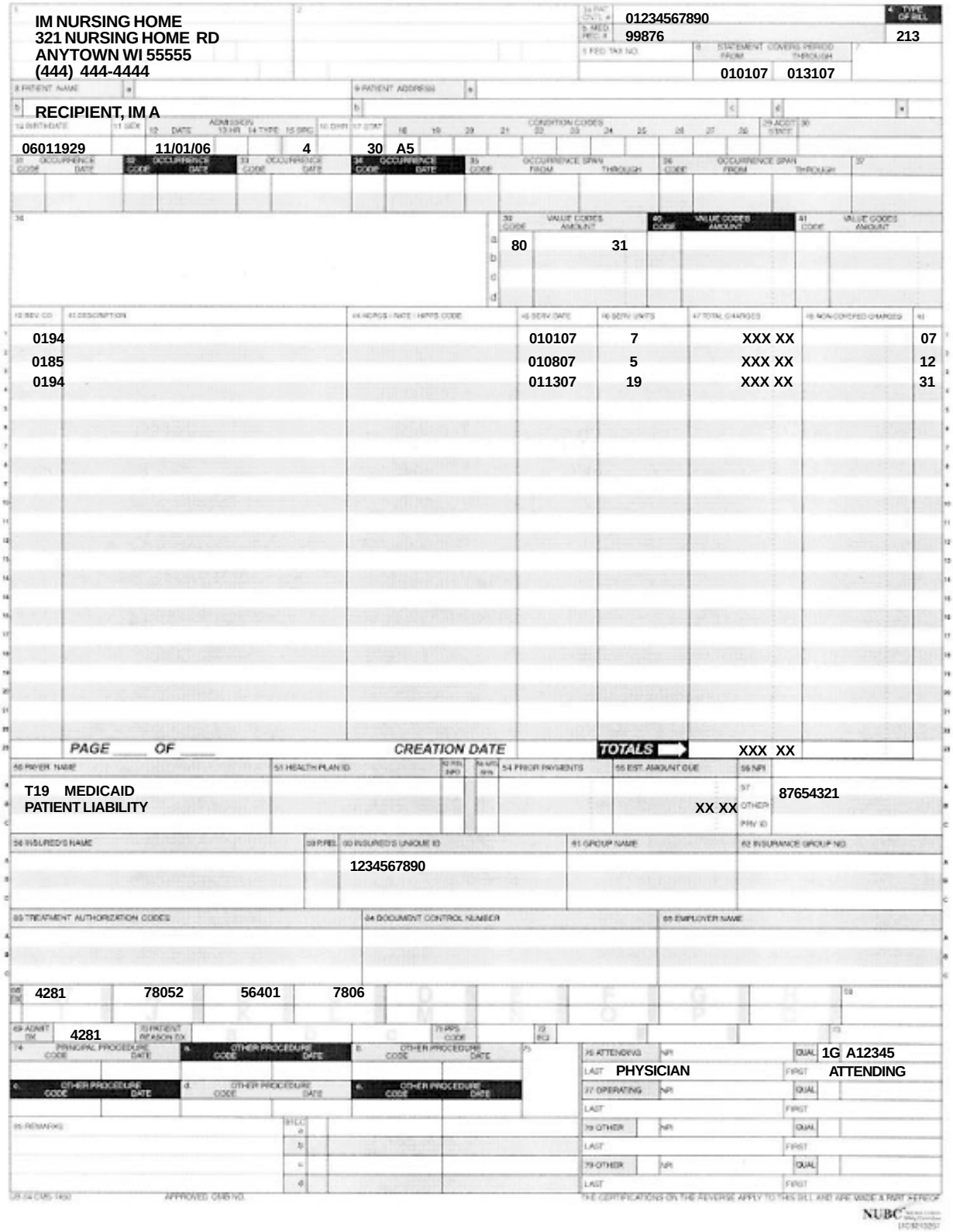
M-7

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

NUBC

ATTACHMENT 3
Sample UB-04 Claim for Billing a Standard Claim (not a Dual Eligible)



IM NURSING HOME
321 NURSING HOME RD
ANYTOWN WI 55555
(444) 444-4444

01234567890
99876
213
010107 013107

RECIPIENT, IM A

06011929 11/01/06 4 30 A5

80 31

0194		010107	7	XXX XX	07
0185		010807	5	XXX XX	12
0194		011307	19	XXX XX	31

PAGE ____ OF ____ CREATION DATE TOTALS XXX XX

T19 MEDICAID
PATIENT LIABILITY

XX XX

87654321

1234567890

4281 78052 56401 7806

4281

1G A12345

PHYSICIAN ATTENDING

NUBC