ForwardHealth
Wisconsin serving you

**Update**
**July 2008**

**No. 2008-111**

**Affected Programs:** BadgerCare Plus, Medicaid
**To:** Federally Qualified Health Centers, HealthCheck Providers, HealthCheck "Other Service" Providers, Nurse Practitioners, Physician Assistants. Physician Clinics, Physicians, Rural Health Clinics, HMOs and Other Managed Care Programs

# ForwardHealth Announces Changes to Paper and Electronic Claims Submission for HealthCheck Providers

This *ForwardHealth Update* announces changes to paper and electronic claim submission for HealthCheck providers, effective October 2008, with the implementation of the ForwardHealth interChange system and the adoption of National Provider Identifiers.

This *Update* includes sample 1500 Health Insurance Claim Forms (dated 08/05) and revised completion instructions and the revised Adjustment/Reconsideration Request, F-13046 (10/08), with completion instructions.

A separate *Update* will give providers a calendar of important dates related to implementation.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

## Implementation of ForwardHealth interChange

In October 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to paper and electronic claims submission procedures that are detailed in this *Update*. These changes are not policy or coverage related.

Providers may use any of the following methods to submit claims after the October 2008, implementation of ForwardHealth interChange:

- Electronic, using one of the following:
  - ✓ Online claim submission through the ForwardHealth Portal. This is a **new** claim submission option available with the implementation of ForwardHealth interChange.
  - ✓ Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant

claim transaction submissions through Electronic Data Interchange.

- ✓ Provider Electronic Solutions (PES) software.

- Paper, using the 1500 Health Insurance Claim Form (dated 08/05).

The PES software will be updated to accommodate changes due to ForwardHealth interChange and National Provider Identifier (NPI) implementation; a revision to the PES Manual will be furnished for PES users.

## General Changes for Claims Submission

Unless otherwise indicated, the following information applies to both paper and electronic claims submission for providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

*Note:* Providers should only use these instructions for claims received following implementation of ForwardHealth interChange. Following these procedures prior to implementation will result in the claim being denied.

### *Elimination of Prior Authorization Number on Claims*

Providers will no longer be required to indicate a PA number on claims. ForwardHealth's paper Remittance Advice and the 835 Health Care Claim Payment/Advice will report to the provider the PA number used to process the claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

### *Elimination of M-5 Medicare Disclaimer Code*

The ForwardHealth interChange system will be able to determine whether a provider is Medicare certified on the date of service (DOS). Therefore, Medicare disclaimer code "M-5" (Provider is not Medicare certified) has been eliminated. The only allowable Medicare disclaimer codes in the ForwardHealth interChange system will consist of "M-7" (Medicare disallowed or denied payment) and "M-8" (Noncovered Medicare service). Providers should note that if the "M-5" disclaimer code is indicated on the claim, the claim will be denied.

### *Revision of Good Faith Claims Process*

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment file and the member's actual enrollment. If a member presents a temporary card or an Express Enrollment (EE) card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's Enrollment Verification System (EVS) indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to BadgerCare Plus. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related Explanation of Benefits code, providers should contact Provider Services at (800) 947-9627 for assistance.

### *Elimination of Series Billing*

ForwardHealth will accept multi-page claims with as many as 50 details on a 1500 Health Insurance Claim Form; therefore, series billing (i.e., allowing providers to indicate up to four DOS per detail line) is no longer necessary and will no longer be accepted. Claims submitted with series billing will be denied. Single and range dates on claims will be accepted.

### *Performing Provider Changing to Rendering Provider*

ForwardHealth has adopted the HIPAA term "rendering provider" in place of "performing provider" to align with HIPAA terminology.

## 1500 Health Insurance Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the 1500 Health Insurance Claim Form (dated 08/05) with the

instructions included in this *Update*. Claims received on the CMS 1500 claim form (dated 12/90) after implementation will be returned to the provider unprocessed.

Refer to Attachments 1-7 of this *Update* for completion instructions and sample 1500 Health Insurance Claim Forms for HealthCheck services.

*Note:* Providers should only use these instructions for claims received following ForwardHealth interChange implementation. Following these procedures prior to implementation will result in the claim being denied.

### *Tooth Number or Area of Oral Cavity Requirement*

Procedures that require a tooth number or an area of oral cavity cannot be submitted on the 1500 Health Insurance Claim Form. Providers are required to use the ADA 2006 Claim Form when submitting claims for procedures that require a tooth number or an area of oral cavity. Refer to Attachments 8 and 9 for the ADA 2006 claim form instructions and a sample claim form. Attachment 10 provides other insurance indicators and billing instructions for dental providers.

### *Valid Diagnosis Codes Required*

ForwardHealth will monitor claims submitted on the 1500 Health Insurance Claim Form for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

### *Diagnosis Code Pointer Changes*

ForwardHealth requires at least one valid diagnosis code but will accept up to eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To add additional diagnosis codes in this element, providers should indicate the fifth diagnosis code between the first and third diagnosis code blanks, the sixth diagnosis code between the second and fourth diagnosis code blanks, the seventh diagnosis code to the right of the third diagnosis code blank, and the eighth diagnosis code to the right of the fourth diagnosis code blank. Providers should not number any additional diagnosis codes.

In Element 24E of the 1500 Health Insurance Claim Form, providers may indicate up to four diagnosis pointers per detail line. Valid diagnosis pointers are digits 1 through 8; digits should not be separated by commas or spaces. Services without at least one diagnosis pointer will be denied.

### *Indicating Quantities*

When indicating days or units in Element 24G, only use a decimal when billing fractions; for example, enter "1.50" to indicate one and a half units. For whole units, simply enter the number; for example, enter "150" to indicate 150 units.

### *Signature and Date on Medicare Crossovers*

A provider signature and date is now required on all provider-submitted claims, including all Medicare crossover claims submitted by providers on the 1500 Health Insurance Claim Form and processed after ForwardHealth interChange implementation. The words "signature on file" will no longer be acceptable. Provider-submitted crossover claims without a signature or date will be denied or be subject to recoupment.

## Adjustment/Reconsideration Request Changes

Providers will be required to use the revised Adjustment/Reconsideration Request, F-13046 (10/08). The Adjustment/Reconsideration Request was revised to be able to be used by all ForwardHealth providers to request an adjustment of an allowed claim (a paid or partially paid claim). An adjustment or reconsideration request received in any other format will be returned to the provider unprocessed.

Refer to Attachments 11 and 12 for the revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

## Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhs.wisconsin.gov/forwardhealth/*.

P-1250

# ATTACHMENT 1
# 1500 Health Insurance Claim Form Completion Instructions for HealthCheck Services

Effective for claims received on and after implementation of ForwardHealth interChange.

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

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about verifying enrollment.

*When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.*

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

### Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other

Enter "X" in the Medicaid check box.

### Element 1a — Insured's ID Number

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct member ID.

### Element 2 — Patient's Name

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

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

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

### Element 4 — Insured's Name

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

### Element 5 — Patient's Address
Enter the complete address of the member'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 ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

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

If the EVS indicates that the member 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, one of the following three other insurance (OI) explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the first page of the claim.

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 member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following:<br>• The member denied coverage or will not cooperate.<br>• The provider knows the service in question is not covered by the carrier.<br>• The member's commercial health insurance failed to respond to initial and follow-up claims.<br>• Benefits are not assignable or cannot get assignment.<br>• Benefits are exhausted. |

*Note:* The provider may not use OI-D or OI-Y if the member 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 ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

### Element 9a — Other Insured's Policy or Group Number (not required)

### Element 9b — Other Insured's Date of Birth, Sex (not required)

### Element 9c — Employer's Name or School Name (not required)

### Element 9d — Insurance Plan Name or Program Name (not required)

### Element 10a-10c — Is Patient's Condition Related to: (not required)

### Element 10d — Reserved for Local Use (not required)

### Element 11 — Insured's Policy Group or FECA Number

Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member 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 member does not have Medicare Part A.
- ForwardHealth 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. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

| Code | Description |
|---|---|
| **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 member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.<br>*For Medicare Part A, use M-7 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part A.<br>• The member is eligible for Medicare Part A.<br>• The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits.<br>*For Medicare Part B, use M-7 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part B.<br>• The member is eligible for Medicare Part B.<br>• The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits. |
| **M-8** | **Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance.<br>*For Medicare Part A, use M-8 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part A.<br>• The member is eligible for Medicare Part A.<br>• The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).<br>*For Medicare Part B, use M-8 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part B.<br>• The member is eligible for Medicare Part B.<br>• The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis). |

### Element 11a — Insured's Date of Birth, Sex (not required)

### Element 11b — Employer's Name or School Name (not required)

### Element 11c — Insurance Plan Name or Program Name (not required)

### Element 11d — Is there another Health Benefit Plan? (not required)

### Element 12 — Patient's or Authorized Person's Signature (not required)

### Element 13 — Insured's or 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)

### Element 17 — Name of Referring Provider or Other Source (not required)

### Element 17a (not required)

### Element 17b — NPI (not required)

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

### Element 19 — Reserved for Local Use

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

### Element 20 — Outside Lab? $Charges (not required)

### Element 21 — Diagnosis or Nature of Illness or Injury

Enter a valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first.

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

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

### Element 22 — Medicaid Resubmission (not required)

### Element 23 — Prior Authorization Number (not required)

### Element 24
The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

### Element 24A — Date(s) of Service
Enter to and from dates of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the place of service (POS), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

### Element 24B — Place of Service
Enter the appropriate two-digit POS code for each item used or service performed.

### Element 24C — EMG (not required)

### Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character procedure code. ForwardHealth 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.

### Element 24E — Diagnosis Pointer
Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

### Element 24F — $ Charges
Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth 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 ForwardHealth benefits.

### Element 24G — Days or Units
Enter the number of units. Only include a decimal when billing fractions (e.g., 1.50).

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

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

### Element 24I — ID Qual

If the rendering provider's NPI is different than the billing provider number in Element 33A, enter a qualifier of "ZZ," indicating provider taxonomy, in the *shaded area* of the detail line.

This element is not required for HealthCheck nursing agencies.

### Element 24J — Rendering Provider ID. #

If the rendering provider's NPI is different than the billing provider number in Element 33A, enter the rendering provider's 10-digit taxonomy code in the *shaded area* of this element and enter the rendering provider's NPI in the *white area* provided for the NPI.

This element is not required for HealthCheck nursing agencies.

### Element 25 — Federal Tax ID Number (not required)

### Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the Remittance Advice 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. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim.*

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

### Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

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. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim.*

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

### Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or 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/CCYY format.

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

### Element 32 — Service Facility Location Information (not required)

### Element 32a — NPI (not required)

### Element 32b (not required)

### Element 33 — Billing Provider Info & Ph #
Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code.

### Element 33a — NPI
Enter the NPI of the billing provider.

### Element 33b
Enter qualifier "ZZ" followed by the 10-digit provider taxonomy code.

Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

# ATTACHMENT 2

## Sample 1500 Health Insurance Claim Form for HealthCheck Services (Physician, Physician Assistant, Physician Clinic, or Nurse Practitioner Performed a Comprehensive HealthCheck Screen with Referral and Follow-up Visit)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): MEMBER, 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): SAME |
| 5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST | | | 6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other | | | | 7. INSURED'S ADDRESS (No., Street) |
| CITY: ANYTOWN | STATE: WI | | 8. PATIENT STATUS: Single Married Other | | | | CITY / STATE |
| ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX | | Employed Full-Time Student Part-Time Student | | | | ZIP CODE / TELEPHONE (Include Area Code) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | a. EMPLOYMENT? (Current or Previous) YES NO | | | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | | | b. AUTO ACCIDENT? YES NO PLACE (State) | | | | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | c. OTHER ACCIDENT? YES NO | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | 10d. RESERVED FOR LOCAL USE | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d. |

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

| | | |
|---|---|---|
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. V20 2 2. 3. 4. | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER |

| | 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11 03 08 | 11 | | 99381 | HO | 1 | XXX XX | 1 | | NPI | |
| 2 | 11 17 08 | 11 | | 99211 | | 1 | XXX XX | 1 | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

| | | | |
|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO.: 1234JED | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE: $ XXX XX / 29. AMOUNT PAID: $ / 30. BALANCE DUE: $ 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.): I.M. PROVIDER MM/DD/YY SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b. | 33. BILLING PROVIDER INFO & PH #: I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 | a. 0222222220 b. ZZ123456789X |

CARRIER

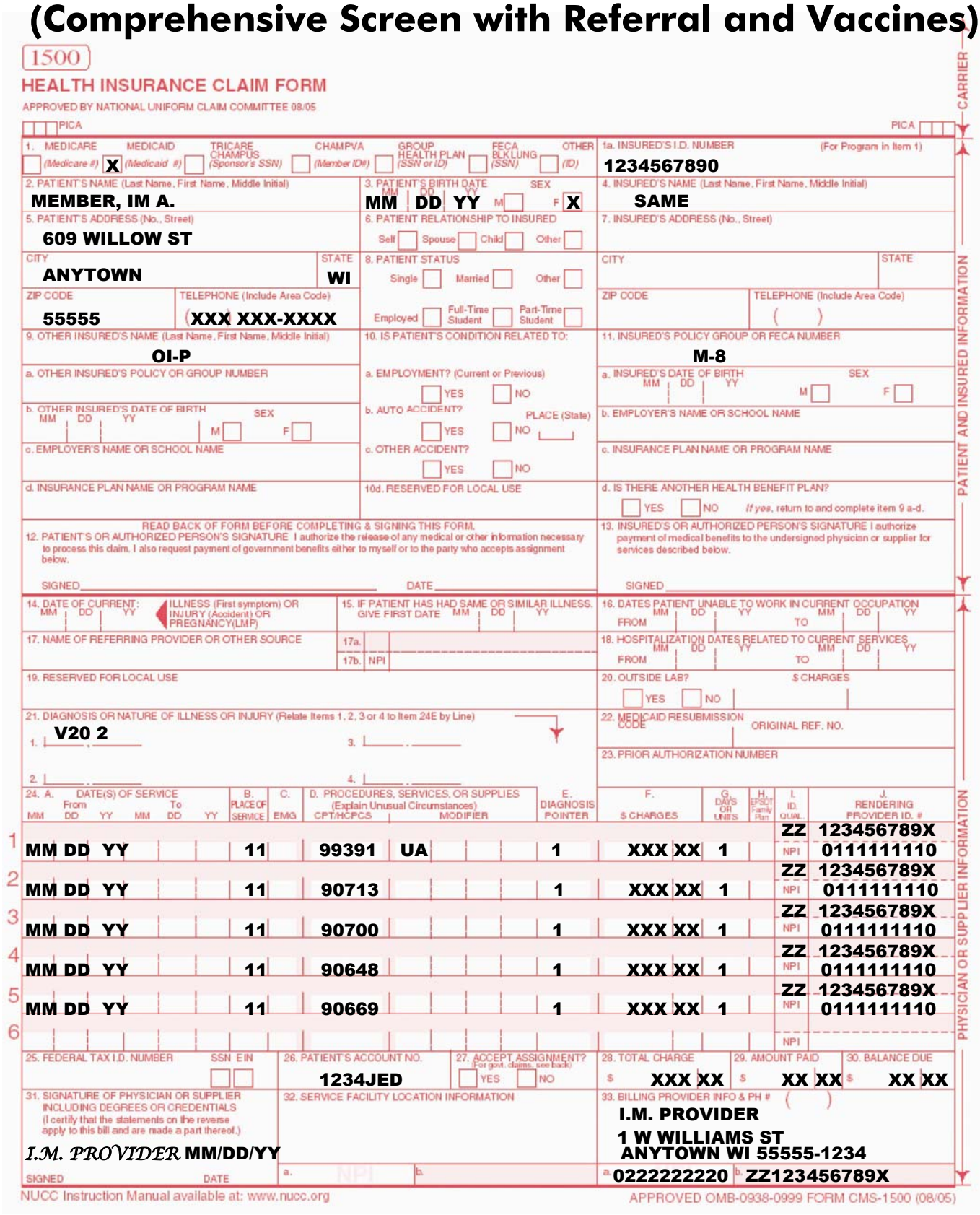
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

# ATTACHMENT 3
## Sample 1500 Health Insurance Claim Form for HealthCheck Services (Comprehensive Screen with Referral and Vaccines)



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) 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): MEMBER, 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): SAME

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: M-8

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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V20 2 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 MM DD YY | | 11 | | 99391 | UA | 1 | XXX XX | 1 | | ZZ<br>NPI | 123456789X<br>0111111110 |
| 2 MM DD YY | | 11 | | 90713 | | 1 | XXX XX | 1 | | ZZ<br>NPI | 123456789X<br>0111111110 |
| 3 MM DD YY | | 11 | | 90700 | | 1 | XXX XX | 1 | | ZZ<br>NPI | 123456789X<br>0111111110 |
| 4 MM DD YY | | 11 | | 90648 | | 1 | XXX XX | 1 | | ZZ<br>NPI | 123456789X<br>0111111110 |
| 5 MM DD YY | | 11 | | 90669 | | 1 | XXX XX | 1 | | ZZ<br>NPI | 123456789X<br>0111111110 |
| 6 | | | | | | | | | | NPI | |

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.)

I.M. PROVIDER MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# ATTACHMENT 4
# Sample 1500 Health Insurance Claim Form for HealthCheck Environmental Lead Inspection and Educational Visit

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): MEMBER, IM A.

3. PATIENT'S BIRTH DATE MM DD YY | SEX M | F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY: ANYTOWN | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V20 2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | MM DD YY | 12 | | T1029 | EP | 1 | XXX XX | 1 | | NPI | |
| 2 | MM DD YY | 12 | | T1002 | EP | 1 | XXX XX | 1 | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ 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.)

*I.M. PROVIDER* MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# ATTACHMENT 5
# Sample 1500 Health Insurance Claim Form for HealthCheck Nursing Agency Services (Follow-up Visit and Lab Handling Fees)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): MEMBER, 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): SAME

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

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

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

CITY: ANYTOWN | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] | Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | FROM | TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V20.2

2.

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EFSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | MM DD YY | 11 | | 99211 | EP | 1 | XXX XX | 1 | | NPI | |
| 2 | MM DD YY | 11 | | 99000 | | | XXX XX | 1 | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ 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.)

*I.M. PROVIDER* MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

# ATTACHMENT 6
# Sample 1500 Health Insurance Claim Form for HealthCheck Outreach and Case Management Services (Screen Performed by Another Provider)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): MEMBER, 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): SAME

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY: ANYTOWN | STATE: WI

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V20 2

2.

3.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | MM DD YY | 11 | | T1017 | EP | 1 | XXX XX | 2 | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ 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.)

I.M. PROVIDER MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# ATTACHMENT 7
# Sample 1500 Health Insurance Claim Form for HealthCheck Outreach and Case Management Services (with Comprehensive Screen)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): MEMBER, 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): SAME

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY: ANYTOWN | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | FROM | TO | MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V20 2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | MM DD YY | 11 | | 99392 | | 1 | XXX XX | 1 | | NPI | |
| 2 | MM DD YY | 11 | | T1017 | EP | 1 | XXX XX | 1 | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ 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.)

*I.M. PROVIDER* MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

# ATTACHMENT 8
# American Dental Association 2006 Claim Form Completion Instructions

Effective for claims received on and after the implementation of ForwardHealth interChange.

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

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about verifying enrollment.

*When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.*

Submit completed single-page paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Submit completed multiple-page paper claims to the following address:

ForwardHealth
Multiple-Page Dental Claims
Ste 22
6406 Bridge Rd
Madison WI 53784-0022

## HEADER INFORMATION

### Element 1 — Type of Transaction (required, if applicable)

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

### Element 2 — Predetermination/Preauthorization Number (not required)

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

### Element 3 — Company/Plan Name, Address, City, State, Zip Code (not required)

## OTHER COVERAGE

### Element 4 — Other Dental or Medical Coverage? (not required)

### Element 5 — Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) (not required)

### Element 6 — Date of Birth (MM/DD/CCYY) (not required)

### Element 7 — Gender (not required)

### Element 8 — Policyholder/Subscriber ID (SSN or ID#) (not required)

### Element 9 — Plan/Group Number (not required)

### Element 10 — Patient's Relationship to Person Named in #5 (not required)

### Element 11 — Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Except for a few instances, ForwardHealth is the payer of last resort for any services covered by ForwardHealth. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing ForwardHealth unless the service is not covered by commercial health insurance. Element 11 identifies Medicare and commercial health insurance and whether the member has commercial health insurance coverage, Medicare coverage, or both.

There are specific instructions for each coverage type. Providers should use the following guidelines for this element depending on the member's coverage:

- Members with commercial health or dental insurance coverage.
- Members with Medicare coverage.
- Members with both Medicare and commercial health or dental insurance coverage.

#### *Members with commercial health or dental insurance coverage*

Commercial health or dental insurance coverage must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by Wisconsin's Enrollment Verification System (EVS) under "Other Commercial Health Insurance." Refer to Attachment 10 of this *ForwardHealth Update* for a list of "other insurance" indicators. Attachment 10 also lists *Current Dental Terminology* (CDT) codes that must be billed to other insurance sources prior to being billed to ForwardHealth.

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

The following table indicates appropriate other insurance codes for use in Element 11.

| Code | Description |
|---|---|
| **OI-P** | PAID in part or in full by commercial health or dental insurance or commercial HMO. In Element 32 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured. |
| **OI-D** | Use OI-D for dental claims in either of the following situations:<br>• DENIED by commercial health or dental insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible.<br>• YES, the member has commercial health or dental insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following:<br>✓ The member denied coverage or will not cooperate.<br>✓ The provider knows the service in question is not covered by the carrier.<br>✓ The member's commercial health or dental insurance failed to respond to initial and follow-up claims.<br>✓ Benefits are not assignable or cannot get assignment.<br>✓ Benefits are exhausted. |
| **None** | Providers may leave this element blank if none of the CDT procedure codes on the claim are listed in the tables in Attachment 10 or if the other insurance is vision only. |

*Note:* The provider may not use OI-D if the member 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 ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

### *Members with Medicare coverage*

Submit claims to Medicare before submitting claims to ForwardHealth.

Do not enter a Medicare disclaimer code in Element 11 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member 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 member does not have Medicare Part A.
- ForwardHealth 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 is true, a Medicare disclaimer code is necessary. The following table indicates appropriate Medicare disclaimer codes for use in Element 11 when billing Medicare prior to billing ForwardHealth.

| Code | Description |
|---|---|
| **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 member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.<br><br>*For Medicare Part A, use M-7 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part A.<br>• The member is eligible for Medicare Part A.<br>• The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits.<br><br>*For Medicare Part B, use M-7 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part B.<br>• The member is eligible for Medicare Part B.<br>• The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits. |
| **M-8** | **Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance.<br><br>*For Medicare Part A, use M-8 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part A.<br>• The member is eligible for Medicare Part A.<br>• The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).<br><br>*For Medicare Part B, use M-8 in the following instances (all three criteria must be met):*<br>• The provider is identified in ForwardHealth files as certified for Medicare Part B.<br>• The member is eligible for Medicare Part B.<br>• The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis). |

### *Members with both Medicare and commercial health or dental insurance coverage*

Use both a Medicare disclaimer code ("M-7" or "M-8") and an other insurance explanation code (e.g., "OI-P") when applicable.

## POLICYHOLDER/SUBSCRIBER INFORMATION

### Element 12 — Policyholder/Subscriber Name (First, Last, Middle Initial, Suffix), Address, City, State, Zip Code

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS. The member's address, city, state, and ZIP code are not required.

### Element 13 — Date of Birth

Enter the member's birth date in MM/DD/CCYY format.

### Element 14 — Gender (not required)

### Element 15 — Policyholder/Subscriber ID (SSN or ID#)
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

### Element 16 — Plan/Group Number (not required)

### Element 17 — Employer Name (not required)

### PATIENT INFORMATION

### Element 18 — Relationship to Policyholder/Subscriber in #12 Above (not required)

### Element 19 — Student Status (not required)

### Element 20 — Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code (not required)

### Element 21 — Date of Birth (MM/DD/CCYY) (not required)

### Element 22 — Gender (not required)

### Element 23 — Patient ID/Account # (Assigned by Dentist) (not required)

### RECORD OF SERVICES PROVIDED

### Element 24 — Procedure Date (MM/DD/CCYY)
Enter the dates of service in MM/DD/CCYY format for each detail.

### Element 25 — Area of Oral Cavity
If the procedure applies to gingivectomy, perio scaling, repair of dentures or partials, or alveoplasty, the area of the oral cavity is entered here.

### Element 26 — Tooth System (not required)

### Element 27 — Tooth Number(s) or Letter(s)
If the procedure applies to only one tooth, the tooth number or tooth letter is entered here.

### Element 28 — Tooth Surface
Enter the tooth surface(s) restored for each restoration.

### Element 29 — Procedure Code
Enter the appropriate procedure code for each dental service provided.

### Element 30 — Description
Write a brief description of each procedure.

### Element 31 — Fee
Enter the usual and customary charge for each detail line of service.

### Element 32 — Other Fee(s) (required for other insurance information, if applicable)
Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 32 is greater than zero, "OI-P" must be indicated in Element 11.) Do not include the copayment amount. If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement. This allows ForwardHealth to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.

### Element 33 — Total Fee
Enter the total of all detail charges. Do not subtract other insurance payments.

## MISSING TEETH INFORMATION

### Element 34 — Permanent and Primary (Place an 'X' on each missing tooth) (not required)

### Element 35 — Remarks (required, if applicable)
List any unusual services, including reasons why limitations were exceeded. Providers should enter the word "Emergency" in this element for an emergency service.

## AUTHORIZATIONS

### Element 36 — Patient/Guardian Signature and Date (not required)

### Element 37 — Subscriber Signature and Date (not required)

## ANCILLARY CLAIM/TREATMENT INFORMATION

### Element 38 — Place of Treatment (Check applicable box)
Check the appropriate box.

### Element 39 — Number of Enclosures (00 to 99) (not required)

### Element 40 — Is Treatment for Orthodontics? (not required)

### Element 41 — Date Appliance Placed (MM/DD/CCYY) (not required)

### Element 42 — Months of Treatment Remaining (not required)

### Element 43 — Replacement of Prosthesis? (not required)

### Element 44 — Date Prior Placement (MM/DD/CCYY) (not required)

### Element 45 — Treatment Resulting from (Check applicable box) (required, if applicable)
Check the appropriate box if the dental services were the result of an occupational illness/injury, auto accident, or other accident.

### Element 46 — Date of Accident (MM/DD/CCYY) (required, if applicable)
If a box was checked in Element 45, enter the date the accident happened.

### Element 47 — Auto Accident State (required, if applicable)
Enter the state where the auto accident occurred.

## BILLING DENTIST OR DENTAL ENTITY

### Element 48 — Name, Address, City, State, Zip Code

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+4 code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 48 must correspond with the National Provider Identifier (NPI) in Element 49.

### Element 49 — NPI (National Provider Identifier)

Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name indicated in Element 48.

### Element 50 — License Number (not required)

### Element 51 — SSN or TIN (not required)

### Element 52 — Phone Number (not required)

### Element 52A — Additional Provider ID

Enter the billing provider's 10-digit taxonomy code. The taxonomy code in this element must correspond with the NPI indicated in Element 49.

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

### Element 53 — Dentist's Signature and Date

The provider or the authorized representative must sign in Element 53. The month, day, and year the form is signed must also be entered in MM/DD/CCYY format.

*Note:* The signature may be a computer-printed or typed name and date or a signature stamp with a date. However, claims with "signature on file" stamps are denied.

### Element 54 — NPI (required, if applicable)

If the treating provider's NPI is different than the billing provider NPI in Element 49, enter the treating provider's NPI in this element.

### Element 55 — License Number (not required)

### Element 56 — Address, City, State, Zip Code (not required)

### Element 56A — Provider Specialty Code (required, if applicable)

Enter the treating provider's 10-digit taxonomy code. The taxonomy code in this element must correspond with the NPI indicated in Element 54.

### Element 57 — Phone Number (not required)

### Element 58 — Additional Provider ID (not required)

# ATTACHMENT 9
# Sample American Dental Association (ADA) 2006 Claim Form for HealthCheck Nursing Agencies Billing for Dental Sealants

(A copy of the sample "ADA 2006 Claim Form" for HealthCheck nursing agencies billing for dental sealants is located on the following page.)

# ADA Dental Claim Form

## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

## OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

| 6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#) |
|---|---|---|
| | | |

| 9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other |
|---|---|
| | |

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

**MEMBER, IM A.**

| 13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#) |
|---|---|---|
| **MM/DD/CCYY** | | **1234567890** |

| 16. Plan/Group Number | 17. Employer Name |
|---|---|
| | |

## PATIENT INFORMATION

| 18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS |
|---|---|
| | |

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

| 21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist) |
|---|---|---|
| | | |

## RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|
| 1 | **MM/DD/CCYY** | | | **02** | | **D1351** | **SEALANTS** | **XX XX** |
| 2 | **MM/DD/CCYY** | | | **03** | | **D1351** | **SEALANTS** | **XX XX** |
| 3 | **MM/DD/CCYY** | | | **18** | | **D1351** | **SEALANTS** | **XX XX** |
| 4 | **MM/DD/CCYY** | | | **19** | | **D1351** | **SEALANTS** | **XX XX** |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |



## MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

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

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

32. Other Fee(s) **XX XX**

33. Total Fee **XX XX**

35. Remarks

## AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

## BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

**I.M. HEALTHCHECK NURSING AGENCY**
**1 W. WILLIAMS ST.**
**ANYTOWN, WI 55555-1234**

| 49. NPI | 50. License Number | 51. SSN or TIN |
|---|---|---|
| **0111111110** | | |

| 52. Phone Number ( ) – | 52A. Additional Provider ID **123456789X** |
|---|---|
| | |

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X *I.M. PROVIDER* **MM/DD/CCYY**
Signed (Treating Dentist) Date

| 54. NPI **0222222220** | 55. License Number |
|---|---|
| 56. Address, City, State, Zip Code | 56A. Provider Specialty Code **123456789X** |

| 57. Phone Number ( ) – | 58. Additional Provider ID |
|---|---|
| | |



J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

# ATTACHMENT 10
# Other Insurance Indicators and Billing Instructions for Dental Providers Using the American Dental Association 2006 Claim Form

This attachment lists the insurance indicators used by Wisconsin's Enrollment Verification System (EVS) to identify a member's other insurance coverage. Subsequent tables list *Current Dental Terminology* (CDT) codes that dental providers must bill to other insurance sources before submitting a claim to ForwardHealth. Providers should use this attachment when filling out an American Dental Association (ADA) 2006 Claim Form.

### Other Insurance Indicators

When a member's enrollment is confirmed in the EVS, one of seven "other insurance" indicators may be indicated. The following is a list of the indicators and descriptions:

- DEN — Commercial Dental Insurance.
- HMO — Health Maintenance Organization (non-Medicaid).
- SUP — Medicare Supplement.
- BLU — BlueCross and BlueShield.
- WPS — Wisconsin Physicians Service.
- CHA — TriCare.
- HPP — Wausau Health Protection Plan.
- OTH — All other commercial health or dental insurance plans.

### Insurance Indicator "DEN"

When the EVS indicates the code "DEN" for "other coverage," submit claims for the following CDT procedure codes to commercial dental insurance prior to billing these procedures to ForwardHealth.

| Service Type | Service | Codes |
|---|---|---|
| Diagnostic | Exams | D0120-D0170 |
| | X-rays | D0270-D0274 |
| Preventive | Prophylaxis, Fluoride | D1110-D1202 |
| | Sealants | D1351 |
| | Space maintainers | D1510-D1515, D1550 |
| Restorative | Fillings | D2140-D2394 |
| | Crowns | D2390, D2920-D2933 |
| Endodontic | Root canals | D3310-D3330 |
| Periodontic | Gingivectomy | D4210-D4211 |
| | Scaling | D4341-D4342 |
| | Full-mouth debridement | D4355 |
| Prosthodontic | Dentures | D5110-D5212, D5510-D5761 |
| | Bridges | D6930-D6940, D6980-D6985 |

| Service Type (Cont.) | Service | Codes |
|---|---|---|
| Extractions | Extractions | D7111-D7250 |
| Surgical | Surgeries | D7260-D7780, D7840-D7850, D7910-D7991 |
| Orthodontic | Orthodontia | D8010-D8680, D8692 |

### Insurance Indicator "HMO"

When the EVS indicates the code "HMO" for "other coverage," submit claims for the following CDT procedure codes to the commercial HMO prior to billing these procedures to ForwardHealth. The provider must be a member of the commercial HMO to receive reimbursement.

| Service Type | Service | Codes |
|---|---|---|
| Diagnostic | Exams | D0120-D0170 |
| Preventive | Cleanings | D1110-D1120 |
| Restorative | Fillings | D2140-D2394 |
| Oral and Maxillofacial Surgery | Extractions | D7111-D7250 |
| Surgical | Surgeries | D7260-D7780, D7840-D7850, D7910-D7991 |

### Insurance Indicator "SUP"

When the EVS indicates the code "SUP" for "other coverage," submit claims for the following CDT procedure codes to the member's commercial health or dental insurance prior to billing these procedures to ForwardHealth.

| Service Type | Service | Codes |
|---|---|---|
| Adjunctive/General Services | Anesthesia | D9220, D9241 |

### Insurance Indicators "BLU," "WPS," "CHA," "HPP," or "OTH"

When the EVS indicates either "BLU," "WPS," "CHA," "HPP," or "OTH" codes for "other coverage," submit claims for the following procedure codes to the member's commercial health or dental insurance prior to billing these procedures to ForwardHealth.

| Service Type | Service | Codes |
|---|---|---|
| Adjunctive/General Services | Anesthesia | D9220, D9241 |

# ATTACHMENT 11
# Adjustment/Reconsideration Request Completion Instructions

(A copy of the "Adjustment/Reconsideration Request Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

# FORWARDHEALTH
# ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth 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 payment for the service.

The Adjustment/Reconsideration Request, F-13046, is used by ForwardHealth to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627.

The Adjustment/Reconsideration Request is reviewed by ForwardHealth based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Providers should be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

The provider is required to maintain a copy of this form for his or her records.

The provider should mail the Adjustment/Reconsideration Request to the appropriate mailing address:

BadgerCare Plus
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

WCDP
PO Box 6410
Madison WI 53716-0410

WWWP
PO Box 6645
Madison WI 53716-0645

**INSTRUCTIONS**
Type or print clearly. Enter the following information from the provider's Remittance Advice or the 835 Health Care Claim Payment/Advice (835) transaction.

**SECTION I — BILLING PROVIDER AND MEMBER INFORMATION**

Check the appropriate box to indicate the applicable program to which the adjustment request is being submitted.

**Element 1 — Name — Billing Provider**
Enter the billing provider's name.

**Element 2 — Billing Provider's Provider ID**
Enter the Provider ID of the billing provider.

**Element 3 — Name — Member**
Enter the complete name of the member for whom payment was received.

**Element 4 — Member Identification Number**
Enter the member ID.

**SECTION II — CLAIM INFORMATION (Non-Pharmacy)**

**Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date**
Enter the date of the remittance advice or the payment date or check issue date from the 835.

**Element 6 — Internal Control Number / Payer Claim Control Number**
Enter the internal control number (ICN) from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

**Add a new service line(s).**
Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

**Correct detail on previously paid/allowed claim.**
Check if correcting details on a previously paid or allowed claim.

**Element 7 — Date(s) of Service**
Enter to and from date(s) of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under “From.” Leave “To” blank or re-enter the “From” date. If grouping services, the place of service, procedure code, charges, and rendering provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive dates. The number of days must correspond to the number of units in Element 24G of the 1500 Health Insurance Claim Form.

**Element 8 — POS**
Enter the appropriate two-digit POS code for each service.

**Element 9 — Procedure / NDC / Revenue Code**
Enter the single most appropriate procedure code. ForwardHealth will deny claims received without an appropriate procedure code, National Drug Code (NDC), or revenue code. When adjusting a detail that includes an NDC and a “J” code, providers are required to attach a paper claim form to the adjustment request and follow the claim form instructions for submitting the NDC.

**Element 10 — Modifiers 1-4**
Enter the appropriate modifier(s).

**Element 11 — Billed Amount**
Enter the total billed amount for each line item. Providers are to indicate 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 ForwardHealth benefits.

**Element 12 — Unit Quantity**
Enter the number of units. Only include a decimal when billing fractions (e.g., 1.50).

**Element 13 — Family Planning Indicator**
Enter a "Y" for each family planning procedure when applicable.

**Element 14 — EMG**
Emergency Indicator. Enter a "Y" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank. Dental providers should continue to enter an “E” to indicate each procedure performed as an emergency.

**Element 15 — Rendering Provider Number**
Health care providers may enter their NPI and taxonomy code. Non-healthcare providers may enter their Provider ID.

**SECTION II — CLAIM INFORMATION (Pharmacy)**

**Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date**
Enter the date of the remittance advice or the payment date or check issue date from the 835.

**Element 6 — Internal Control Number / Payer Claim Control Number**
Enter the ICN from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

**Add a new service line(s).**
Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

**Correct detail on previously paid/allowed claim.**
Check if correcting details on a previously paid or allowed claim.

**Element 7 — Date(s) of Service**
Enter the date filled in MM/DD/YY or MM/DD/CCYY format for each NDC in the "From" field.

**Element 8 — POS**
Enter the appropriate two-digit National Council for Prescription Drug Programs (NCPDP) patient location code for each NDC billed.

**Element 9 — Procedure / NDC / Revenue Code**
Enter the NDC. Claims received without an appropriate NDC will be denied.

**Element 10 — Modifiers 1-4**
Not applicable for pharmacy claims.

**Element 11 — Billed Amount**
Enter the total billed amount for each line item. Providers are to indicate 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 ForwardHealth benefits.

**Element 12 — Unit Quantity**
Enter the metric decimal quantity in the specified unit of measure according to the ForwardHealth drug file. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

**Element 13 — Family Planning Indicator**
Not applicable for pharmacy claims.

**Element 14 — EMG**
Not applicable for pharmacy claims.

**Element 15 — Rendering Provider Number**
Not applicable for pharmacy claims.

**SECTION III — ADJUSTMENT INFORMATION**

*Note:* Additional information necessary for adjustment/reconsideration of an NDC should be included in Element 16 under "Other/comments."

**Element 16 — Reason for Adjustment**
Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the member was a nursing home resident on the DOS, the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Medicare remittance information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other / comments.* Add any clarifying information not included above.*

**Element 17 — Signature — Billing Provider****
Authorized signature of the billing provider.

**Element 18 — Date Signed****
Use either the MM/DD/YY format or the MM/DD/CCYY format.

**Element 19 — Claim Form Attached**
Indicate if a corrected claim form is attached. Although this is optional, ForwardHealth encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

* This section of the Adjustment/Reconsideration Request form should be used for any pharmacy-specific fields (e.g., prescription number) pertaining to the NDC being adjusted or added to a previously processed claim. If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.

** If the date or signature is missing on the Adjustment/Reconsideration Request form, the adjustment request will be denied.

# ATTACHMENT 12
# Adjustment/Reconsideration Request
# (for photocopying)

(A copy of the "Adjustment/Reconsideration Request" is on the following pages.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-13046 (10/08)

**STATE OF WISCONSIN**

# FORWARDHEALTH
# ADJUSTMENT / RECONSIDERATION REQUEST

**Instructions:** Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

## SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate applicable program.

❑ BadgerCare Plus / SeniorCare / Wisconsin Medicaid ❑ WCDP ❑ WWWP

| 1. Name — Billing Provider | 2. Billing Provider's Provider ID |
|---|---|
| 3. Name — Member | 4. Member Identification Number |

## SECTION II — CLAIM INFORMATION

| 5. Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date | 6. Internal Control Number / Payer Claim Control Number |
|---|---|

❑ Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).

❑ Correct detail on previously paid / allowed claim (in 7-12, enter information as it appears on Remittance Advice or 835).

| 7. Date(s) of Service From | To | 8. POS | 9. Procedure / NDC / Revenue Code | 10. Modifiers 1-4 Mod 1 | Mod 2 | Mod 3 | Mod 4 | 11. Billed Amount | 12. Unit Quantity | 13. Family Planning Indicator | 14. EMG | 15. Rendering Provider Number |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

## SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment

❑ Consultant review requested.
❑ Recoup entire payment.
❑ Other insurance payment (OI-P) **$**_____.
❑ Copayment deducted in error ❑ Member in nursing home. ❑ Covered days _____. ❑ Emergency.
❑ Medicare reconsideration. (Attach the Medicare remittance information.)
❑ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
❑ Other / comments.

| 17. **SIGNATURE** — Billing Provider | 18. Date Signed |
|---|---|

Mail completed form to the applicable address:

| BadgerCare Plus | WCDP | WWWP |
|---|---|---|
| Claims and Adjustments | PO Box 6410 | PO Box 6645 |
| 6406 Bridge Rd | Madison WI 53716-0410 | Madison WI 53716-0645 |
| Madison WI 53784-0002 | | |

19. Claim Form Attached (Optional)
❑ Yes ❑ No

Maintain a copy of this form for your records.