ForwardHealth
Wisconsin serving you

Update
November 2010

No. 2010-102

Affected Programs: BadgerCare Plus, Medicaid
To: Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) Agencies, HMOs and Other Managed Care Programs

WIC Agencies May Now Be Medicaid-Certified to Be Reimbursed for Blood Lead Testing Services

This *ForwardHealth Update* informs Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) agencies that beginning December 1, 2010, they may apply to become Medicaid-certified providers. Medicaid-certified WIC agencies may provide and submit claims for reimbursement for blood lead testing services for dates of service on and after January 1, 2011.

ForwardHealth is including Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) agencies for Medicaid certification because approximately 82 percent of all children seen in WIC clinics in Wisconsin are Medicaid and BadgerCare Plus members. The Centers for Medicare and Medicaid Services (CMS) requires that all children on Medicaid and BadgerCare Plus have their blood tested for lead levels at age 1 and again at age 2.

Beginning December 1, 2010, WIC agencies contracted with the Wisconsin Division of Public Health (DPH) may apply to become Medicaid certified. By being certified with Wisconsin Medicaid, WIC agencies may be reimbursed for blood lead testing services performed on children age 4 and younger who are enrolled in Wisconsin Medicaid, the BadgerCare Plus Standard Plan, and the BadgerCare Plus Benchmark Plan. Medicaid-certified WIC agencies may submit claims for reimbursement for blood lead testing services for dates of service (DOS) on and after January 1, 2011.

Applying for Certification

To apply for Wisconsin Medicaid certification online, providers can choose the Become a Provider link under the Providers quick links area on the ForwardHealth Portal home page at *www.forwardhealth.wi.gov/*. Contracted DPH WIC agencies will be certified by Wisconsin Medicaid as a HealthCheck "Other Service" provider. For a sample "HealthCheck Other" certification packet, choose the Certification Packets link in the Providers quick links area on the Portal.

Providers may also call Provider Services at (800) 947-9627 to request a paper application.

Contracted DPH WIC agencies will be certified as billing/rendering providers. Certification as a billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

ForwardHealth will notify providers when the certification is approved and what the effective date of Medicaid certification is. Certifying agencies may refer to the HealthCheck "Other Service" Online Handbook for more information on certification.

Special Supplemental Nutrition Program for Women, Infants, and Children agencies are reminded that this certification is solely for submitting claims for reimbursement for blood lead testing services. Providers are responsible for all relevant Medicaid policy and program information.

Blood Lead Testing Services

Providers may be reimbursed for providing blood lead testing services to children age 4 and younger who are enrolled in Wisconsin Medicaid, the Standard Plan or the Benchmark Plan.

Allowable Procedure Codes

The following are the allowable *Current Procedural Terminology* procedure codes for providers when submitting claims for blood lead testing services:

- 36416 (Collection of capillary blood specimen [eg, finger, heel, ear stick]).
- 83655 (Lead).
- 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory).
- 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services).

Note: Providers will not be reimbursed for both procedure codes 83655 or 99000 if rendered for the same member on the same DOS.

Guidelines for On-Site Blood Lead Testing

Providers may be reimbursed for on-site blood lead testing using LeadCare II or similar Clinical Laboratory Improvement Amendment (CLIA)-waived instruments if the following guidelines are met:

- Providers are successfully participating in the proficiency testing (PT) program as administered by the Wisconsin State Laboratory of Hygiene (WSLH) or another CMS-approved proficiency testing program.
- Providers must report all lead testing results, regardless of the lead level, to the Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP).

Proficiency Testing

Reimbursement for on-site blood lead testing of Medicaid and BadgerCare Plus members is conditional on successful participation in the WSLH or other approved PT program. The WSLH program is currently available at no cost to participants. Performance must be consistent with 1988 CLIA regulatory requirements, regardless of the test method employed.

The CLIA regulations require three test events each year, each consisting of five test samples. Labs must obtain an 80 percent or better score for satisfactory performance in an individual event and are required to attain satisfactory event performance in two of every three consecutive events. For additional information about PT, contact the WSLH at (608) 224-6252.

Reporting of Results

Providers are required to report all on-site blood lead test results to the WCLPPP, regardless of the lead level. For reporting requirements, refer to DHS 181, Wis. Admin. Code. Providers may use the Blood Lead Lab Reporting form, DPH 7142 (01/07). To establish a mechanism for reporting results, providers may call the WCLPPP at (608) 266-5817 and ask for the data manager.

Maintaining an Existing Partner Account and Establishing a Provider Portal Account

Many WIC agencies currently have a partner Portal account used to verify member enrollment and access med stat code information for income eligibility purposes. Partner Portal accounts should be maintained to continue to access med stat code information. Once Medicaid certified, WIC agencies are encouraged to

establish a provider Portal account to accomplish the following:

- Submit claims and adjustments via the Portal.
- View Remittance Advices (RAs).
- Verify member enrollment for all ForwardHealth programs, including the HMO in which the child is enrolled.
- Update and maintain provider file information.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in Electronic Funds Transfer.

Note: Providers will receive paper RAs for the first four weeks after certification. After that, a provider Portal account is the only way providers can access their remittance information.

For more information about provider Portal accounts, refer to the Account Users Portal User Guide on the References and Tools page on the Providers area of the Portal.

Claims Submission

Providers are encouraged to submit claims using the following electronic submission options:

- ForwardHealth Portal Direct Data Entry (DDE).
- Provider Electronic Solutions (PES) software.
- 837 Health Care Claims for Electronic Data Interchange (EDI).

There are several resources available on the Portal at *www.forwardhealth.wi.gov/* for more information on submitting claims electronically, such as the "Claims" Portal User Guide.

Providers may also submit claims on the paper 1500 Health Insurance Claim Form (10/05). Providers should note that claims submitted on paper will be subject to a $1.10 reimbursement reduction. Refer to Attachments 1-3 of this *Update* for claim form instructions and claim form samples for blood lead testing services.

For more information on claims submission, refer to the HealthCheck Online Handbook on the Portal under the Submission chapter of the Claims section.

Diagnosis Codes

All claims for reimbursement must contain one valid diagnosis code. Diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. ForwardHealth recommends using the diagnosis code V70.0 (Routine general medical examination at a health care facility).

Place of Service Codes

The allowable place of service (POS) codes for blood lead testing services are:

- 11 (Office).
- 99 (Other Place of Service).

Reimbursement

Providers should refer to the interactive maximum allowable fee schedule on the Portal for reimbursement rates. There are no copayments for blood lead testing services.

Documentation Requirements

By documenting on the Real-time Online Statewide Information Environment (ROSIE) Web site, providers are fulfilling the documentation requirements. Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment.

For more information on documentation requirements, refer to the HealthCheck Online Handbook on the Portal under the Documentation chapter of the Certification and Ongoing Responsibilities section.

Coordination of Benefits

Medicaid-certified WIC agencies are not required to bill commercial health insurance or Medicare before

submitting claims to ForwardHealth for blood lead testing services.

Enrollment Verification

It is imperative that providers verify a member's enrollment and determine the plan under which they are covered. Providers are reminded to *always* verify a member's enrollment *before* providing services to determine enrollment at the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage.

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

Providers may verify member enrollment through one of the following methods:

- ForwardHealth Portal provider or partner accounts.
- WiCall. Providers may obtain enrollment information from WiCall by calling (800) 947-3544.
- Commercial Enrollment Vendors.
- 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions.
- Provider Services. Providers may request enrollment verification by calling Provider Services at (800) 947-9627.

For more information on enrollment verification, refer to the August 2008 *ForwardHealth Update* (2008-151), titled "Enrollment Verification for Members Enrolled in ForwardHealth Programs."

Resources

There are a number of resources available for all providers to obtain more information on ForwardHealth program and policy information. Refer to the following resources for more information:

- HealthCheck Online Handbook.
- Provider Services at (800) 947-9627.
- Provider Relations representatives. For more information on Provider Relations representatives, refer to the Resources section of the HealthCheck Online Handbook.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations 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). The 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 *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
1500 Health Insurance Claim Form Completion Instructions for Blood Lead Testing Services

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.

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. 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's 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 is 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 (not required)

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 (not required)

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 (not required)

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

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).

Family Planning Services (not required)

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-24G (shaded area) (not required)

Element 24A — Date(s) of Service (service specific)

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 BadgerCare Plus 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 BadgerCare Plus benefits.

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

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

Element 24I — ID Qual (not required)

Element 24J — Rendering Provider ID. # (not required)

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 (not required)

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

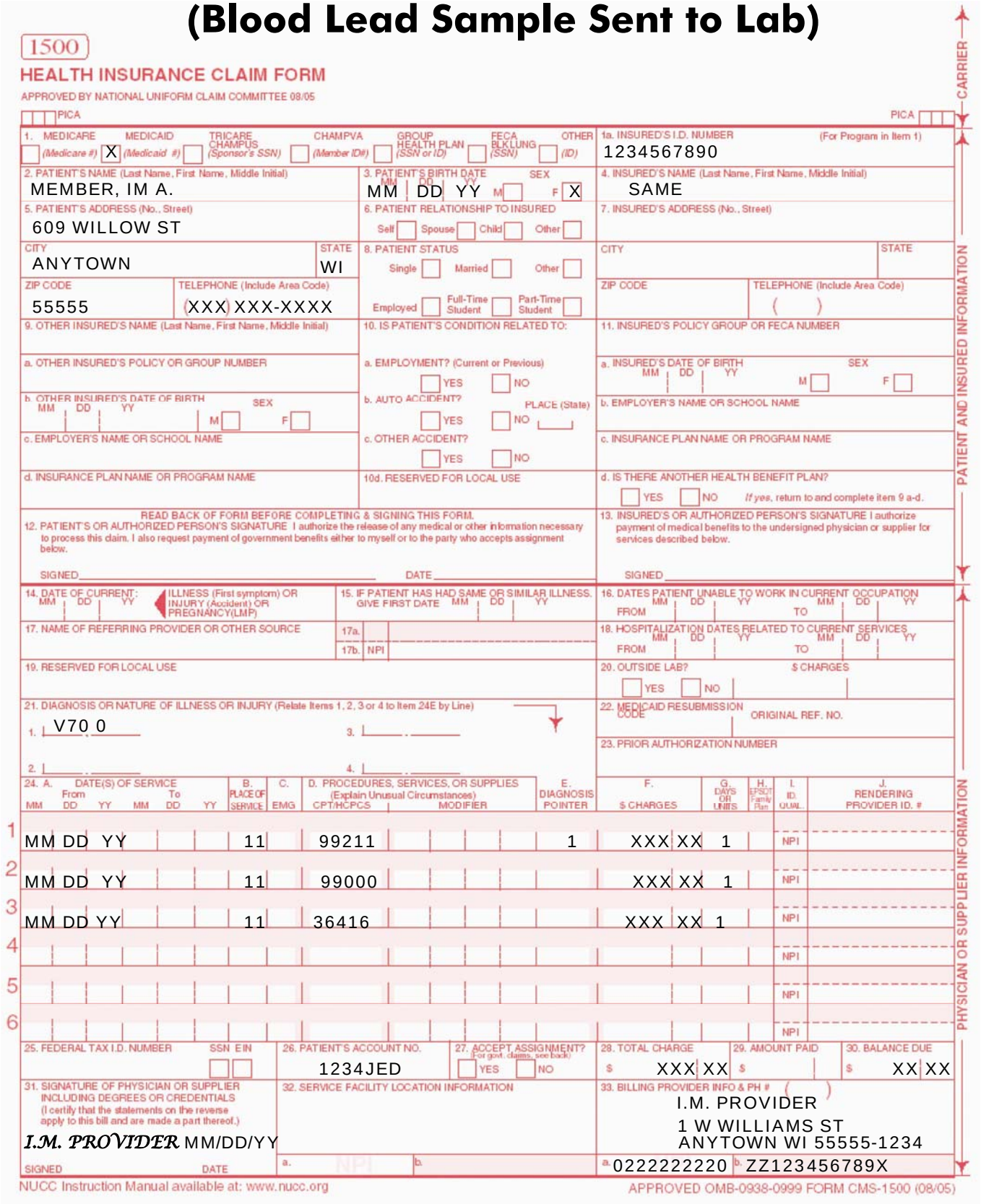
Enter the NPI of the billing provider.

Element 33b

If an NPI was entered in Element 33a, 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 Blood Lead Testing Services (Blood Lead Sample Sent to Lab)



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 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. V70 0
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		99211		1	XXX XX	1		NPI	
2 MM DD YY		11		99000			XXX XX	1		NPI	
3 MM DD YY		11		36416			XXX XX	1		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

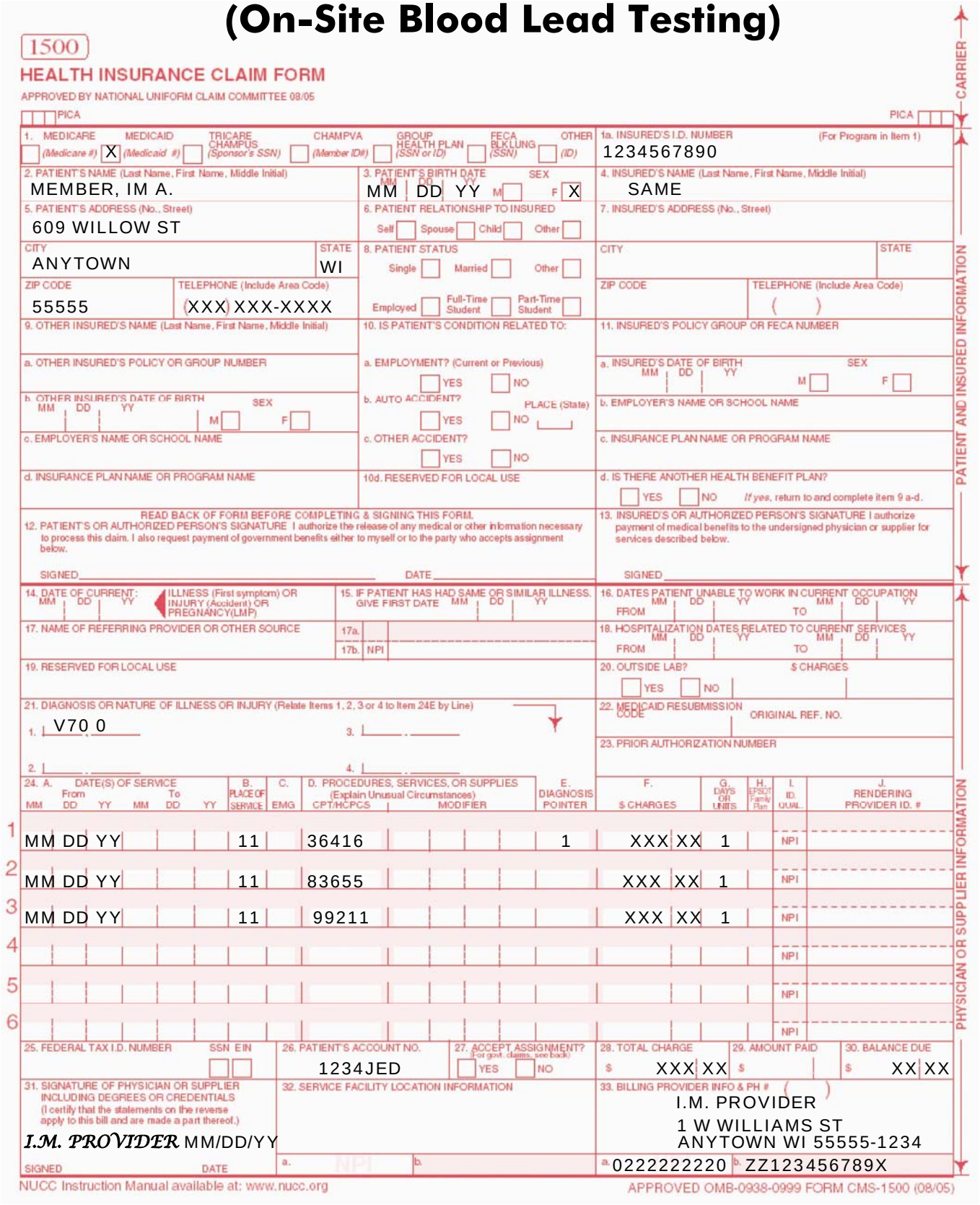
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 3
Sample 1500 Health Insurance Claim Form for HealthCheck Blood Lead Testing Services (On-Site Blood Lead Testing)



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 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. V70 0

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		36416		1	XXX XX	1		NPI	
2 MM DD YY		11		83655			XXX XX	1		NPI	
3 MM DD YY		11		99211			XXX XX	1		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

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