ForwardHealth
Wisconsin serving you

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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Blood Banks, Dentists, Dispensing Physicians, Federally Qualified Health Centers, Hospital Providers, Nurse Practitioners, Nursing Homes, Optometrists, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Information and Policy Clarifications for the Medication Therapy Management Benefit

This *ForwardHealth Update* provides additional information and clarifies certain policies for the Medication Therapy Management benefit.

This *ForwardHealth Update* provides additional information and clarifies certain policies for the Medication Therapy Management (MTM) benefit, which ForwardHealth first introduced in the August 2012 *Update* (2012-39), "Medication Therapy Management Benefit." Comprehensive information about the MTM benefit can be found in the Medication Therapy Management chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

As a reminder, the MTM benefit consists of the following types of services:

- **Intervention-based services**. These are focused interventions between a pharmacist and a member. All Medicaid-enrolled pharmacies are eligible to provide these services to members. Certification by the Wisconsin Pharmacy Quality Collaborative (WPQC) is *not* required to perform and receive reimbursement for intervention-based services.
- **Comprehensive Medication Review and Assessment (CMR/A) services.** These are private consultations between a pharmacist and a member to review the member's drug regimen. The member must be approved by ForwardHealth as a patient who is at high risk of experiencing medical complications due to his or her drug regimen to receive the CMR/A. (For more information on the criteria for determining high-risk patients, refer to the Comprehensive Medication Review and Assessments topic [topic #14677] in the Medication Therapy Management chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook.) The pharmacy requests approval to perform the CMR/A by calling the Drug Authorization and Policy Override (DAPO) Center. In addition to Medicaid enrollment, WPQC certification is required to perform and receive reimbursement for CMR/A services.

Providers Can Access a One-Time List of Eligible Members

For a limited time, pharmacy providers with secure Provider Portal accounts can access a one-time customized list of current members who visit their pharmacy and may be eligible to receive CMR/A services. This customized list of CMR/A-eligible members is based on historical drug data that ForwardHealth has on file for the pharmacy. The MTM Eligible Member List is accessible from the secure Providers area of the Portal.

As a reminder, providers are required to receive DAPO approval before scheduling a CMR/A with a member.

How to Access the Medication Therapy Management Eligible Member List

The following are steps for accessing the MTM Eligible Member List for the pharmacy:

1. Log in to the pharmacy's secure Provider Portal account.
2. In the Quick Links box on the right side of the Providers home page, click the MTM Eligible Member List link, which will display the new landing page for the MTM Eligible Member List.
3. On the MTM Eligible Member List page, click the MTM Eligible Member List link. Pharmacy providers will have the option of viewing the list in either a text (TXT) report format or a comma-separated value (CSV) report format. (*Note:* Information provided in a CSV file can be easily imported into a spreadsheet or database, which allows for sorting by various fields.)

Pharmacy providers may contact the ForwardHealth Portal Helpdesk at (866) 908-1363 with questions on accessing or downloading their MTM Eligible Member List on the Portal.

Information Included on Medication Therapy Management Eligible Member List

The following information about each CMR/A eligible member is included on the MTM Eligible Member List:

- Member name.
- Medicare indicator (i.e., whether the member has Medicare, including Part A, Part B, or Part D).
- Drug count (i.e., the number of drugs the member is currently taking).
- Chronic condition indicator (i.e., whether the member takes medication to treat hypertension, diabetes, asthma/chronic obstructive pulmonary disease, depression, or dyslipidemia).
- Poly-pharmacy indicator (i.e., the number of pharmacies from which the member receives prescriptions).
- Other indicators (e.g. date of birth, the number of emergency room visits).

Establishing a Provider Portal Account

Providers who do not have a Provider Portal account will need to establish one to access the MTM Eligible Member List. Having a secure Provider Portal account allows providers to conduct business online with ForwardHealth via a secure connection. Some of the functions that can be performed via a secure Provider Portal account include the following:

- Submitting, adjusting, and correcting claims.
- Verifying member enrollment.
- Viewing Remittance Advices.
- Updating and maintaining provider information on file with ForwardHealth.
- Receiving electronic notifications and provider publications from ForwardHealth.
- Enrolling in electronic funds transfer.

For detailed instructions on establishing a Provider Portal account, providers may refer to the Account User Guide on the Portal User Guides page of the Portal at *www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/userguides.htm.spage*.

Clarifications for Both Intervention-Based and Comprehensive Medication Review and Assessment Services

The information in this section applies to both intervention-based services and CMR/A services.

Members Eligible for Medication Therapy Management Benefit

The MTM benefit is covered for members enrolled in the following programs:

- The BadgerCare Plus Standard Plan.
- The BadgerCare Plus Benchmark Plan.
- The BadgerCare Plus Core Plan.
- The BadgerCare Plus Basic Plan.
- SeniorCare.
- Wisconsin Medicaid.

Note: MTM services are reimbursed fee-for-service for all eligible members, including those enrolled in state-contracted

managed care organizations. Pharmacy providers should submit fee-for-service claims directly to ForwardHealth for reimbursement.

Referrals for Medication Therapy Management Services

Any licensed health professional who is Medicaid-enrolled and who is authorized to prescribe drugs can be a referring provider for covered MTM services. For information on authorized prescribers, refer to the Prescriber Requirements topic (topic #2335) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook.

As a reminder, only pharmacy providers can be reimbursed for MTM services.

Face-to-Face Medication Therapy Management Services with Member or Caregiver

Medication therapy management services must be provided face-to-face with the member whenever possible. If the member is a child or has physical or cognitive impairments that preclude the member from managing his or her own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the member's behalf.

Documentation of Face-to-Face and Administrative Time

Pharmacy providers are required to document both face-to-face and administrative time for MTM services in their records; however, providers may only bill for face-to-face time on claims.

Claims for Medication Therapy Management Services

Coordination of Benefits

Commercial health insurance and Medicare Part D plans (PDPs) also have MTM programs. If a member is eligible for a commercial health insurance or Medicare Part D MTM program, the pharmacy provider is required to submit the claim to the member's commercial health insurance or PDP before submitting the claim to ForwardHealth.

As a reminder, pharmacy providers are responsible for coordination of benefits (COBs). ForwardHealth is the payer of last resort.

Refer to Attachment 2 of this *Update* for a sample 1500 Health Insurance Claim Form depicting a scenario in which other health insurance was billed.

For more information about COBs, refer to the Coordination of Benefits section of the Pharmacy service area of the Online Handbook.

Date of Service

The date of service (DOS) for an MTM service is defined as the date the medication is dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member receives the MTM service (e.g., for a medication deletion intervention).

To receive reimbursement for an MTM service, the member must be enrolled in one of the programs listed under the Members Eligible for Medication Therapy Management Benefit section of this *Update* on the DOS. Pharmacy providers are responsible for verifying the member's enrollment. The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. For more information on verifying enrollment, refer to the Enrollment Verification chapter of the Resources section of the Pharmacy service area of the Online Handbook.

Determination of New or Established Patient Status

When submitting claims for MTM services, pharmacy providers should note that a new patient is one who has *not* received any MTM services from the pharmacy within the past three years. An established patient is one who has received MTM services from the pharmacy within the past three years. The *Current Procedural Terminology* (CPT) procedure code that a provider uses to bill the first 15 minutes of an MTM service indicates whether the member is a new (procedure code 99605) or an established (procedure code 99606) patient.

Providers billing multiple MTM services for any one member on the same DOS are reminded to use the appropriate CPT procedure code for that DOS. Claims will be denied if the member is indicated as both a new patient and an established patient on the same DOS.

Multiple Medication Therapy Management Services of the Same Type on the Same Day for the Same Member

When a pharmacy provider performs the same type of MTM service more than once for the same member on the same day, the services must be listed as separate claim details. For example, if a pharmacist converts two of a member's prescriptions to a three-month supply on the same day, the pharmacist would list each three-month supply conversion as a separate claim detail, as shown on the sample 1500 Health Insurance Claim Form in Attachment 3.

Claims for Each Additional 15 Minutes

Pharmacy providers are reminded of the following policies when submitting claims for each additional 15 minutes of MTM services using CPT procedure code 99607 (Medication therapy management service[s] provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes [list separately in addition to code for primary service]):

- Procedure code 99607 must be listed on a separate detail line from the primary service code on claims for MTM services.
- Each claim detail must include the appropriate modifier.
- On the claim detail, each 15 minutes is equal to one unit (e.g., 30 minutes equals two units, 45 minutes equals three units, etc.). Providers should round up to the nearest 15 minutes when determining the number of units to bill.
- The claim detail should be submitted with a zero dollar amount. (Claim details for procedure code 99607 are paid $0 since reimbursement for intervention-based services and CMR/A services occurs with procedure code 99605 or 99606.)

Effective for dates of process on and after February 10, 2013, claim details for procedure code 99607 that are billed with a $0 amount no longer display as a denial. These details are placed in a "pay" status with an amount paid of $0.

Outpatient Hospital Place of Service Code Allowed

Effective for DOS on and after September 1, 2012, place of service (POS) code 22 (Outpatient Hospital) is an allowable POS code for MTM services provided in an outpatient hospital setting. As a reminder, CMR/A services must be provided by a pharmacist in a private or semi-private setting. When a pharmacist performs a CMR/A service in an outpatient hospital setting, ForwardHealth does not reimburse the facility charge.

1500 Health Insurance Claim Form Completion Instructions

When completing the 1500 Health Insurance Claim Form for MTM services, providers should note the following changes to information presented in *Update* 2012-39:

- Element 17 (Name of Referring Provider or Other Source) is a required field if the member was referred for services by a provider.
- Element 17b (NPI) is a required field if the member was referred for services by a provider.
- Element 21 (Diagnosis or Nature of Illness or Injury) is a required field. Providers are required to 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.
- Element 24A-24G (shaded area) is *not* a required field.

Refer to Attachment 1 for revised 1500 Health Insurance Claim Form completion instructions for MTM services. Refer to Attachments 3 and 4 for revised sample claim forms for intervention-based services and CMR/A services.

All diagnosis codes indicated on claims for MTM services must be the most specific ICD-9-CM diagnosis code. 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.

Providers should refer to the current ICD-9-CM code book for valid diagnosis codes. When submitting claims online via the Portal, providers may also search for diagnosis codes using the ICD-9-CM search function. For instructions on accessing and using the ICD-9-CM search function, refer to the Professional Claims User Guide on the Portal User Guides page of the Portal.

Intervention-Based Services Identified During Comprehensive Medication Review and Assessment

Intervention-based services that are identified during a CMR/A but are not completed until after the CMR/A are separately reimbursable, with the exception of focused adherence interventions and medication device instruction interventions.

Claims for SeniorCare Members with Spenddowns and Deductibles

State law limits what pharmacies may charge SeniorCare members for covered MTM services. Regardless of a member's level of participation in SeniorCare, pharmacies should always submit their usual and customary charge for MTM services, including services billed with procedure code 99607, if applicable. SeniorCare will track and maintain the member spenddown or deductible amounts for claims for MTM services. SeniorCare will inform the pharmacy of the amount to charge the member through the remittance information.

A pharmacy provider should never charge a member more than the amount indicated by SeniorCare, according to s. 49.688(5)(a), Wis. Stats. If a SeniorCare member pays an amount greater than the amount on the remittance, the provider is required to refund the difference to the member.

Until a member meets any required spenddown, pharmacies may charge the member no more than their usual and customary rate for covered MTM services. Until a member meets any required deductible, pharmacies may charge the member no more than the ForwardHealth rate for covered MTM services. (For ForwardHealth reimbursement rates for MTM services, refer to the Medication Therapy Management chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook.)

Providers may obtain deductible and spenddown information for a specific member through the following sources:

- Remittance information.
- Enrollment Verification on the ForwardHealth Portal.
- Provider Services — (800) 947-9627.

SeniorCare Members at Level 2a (Deductible) Participation

Under level 2a (deductible) participation, a member is required to pay a $500 deductible in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 2a.
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown requirement.

Until a member meets the required deductible, pharmacies may charge the member no more than the ForwardHealth rate for covered MTM services.

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible amount, the pharmacy may be reimbursed by ForwardHealth for covered MTM services.

SeniorCare Members at Level 2b (Deductible) Participation

Under level 2b (deductible) participation, a member is required to pay an $850 deductible in each of the following situations:

- Upon applying for SeniorCare, if the member meets the income limits for level 2b.
- Subsequent to applying for SeniorCare, if the member meets the SeniorCare spenddown requirement.

Until a member meets the required deductible, pharmacies may charge the member no more than the ForwardHealth rate for covered MTM services.

Dollars applied toward the deductible are not carried over into the next benefit period. After the member meets the deductible amount, the pharmacy may be reimbursed by ForwardHealth for covered MTM services.

SeniorCare Members at Level 3 (Spenddown) Participation

Under level 3 (spenddown) participation, members are required to pay a spenddown equal to the amount that their income exceeds 240 percent of the Federal Poverty Level. For households in which only one individual is eligible for SeniorCare, the member's spenddown amount is based on the individual's income. If the individual is married and living with his or her spouse, however, SeniorCare eligibility is based on the income of both spouses.

If both spouses are eligible for SeniorCare, the spenddown amount is based on the total of both members' incomes. SeniorCare-covered MTM services for either member will be applied to satisfy the spenddown amount.

Until a member meets any required spenddown, pharmacies may charge the member no more than their usual and customary rate for covered MTM services.

Dollars applied toward spenddown are not carried over into the next benefit period. After the member meets the spenddown amount, he or she must then meet the $850 deductible. Once the deductible is met, the pharmacy may be reimbursed by ForwardHealth for covered MTM services.

Note: For additional information on spenddowns, refer to the Special Enrollment Circumstances chapter of the Member Information section of the Pharmacy service area of the Online Handbook.

Claims for Tablet Splitting for SeniorCare Members

SeniorCare members are eligible for a reduced brand drug copayment when they have their tablets split. To ensure SeniorCare members receive the reduced copayment, pharmacy providers are required to submit claims for tablet splitting on a noncompound claim using the tablet splitting Pharmaceutical Care code. If a cost-effectiveness intervention also occurred, the provider should submit a separate professional claim for the MTM service.

The following fields are required in the Drug Use Review (DUR)/Professional Pharmacy Services (PPS) segment of noncompound claims for tablet splitting for SeniorCare members:

- The Reason for Service Code (National Council for Prescription Drug Programs [NCPDP] field 439-E4) must be SR (Suboptimal Regimen).
- The Professional Service Code (NCPDP field 440-E5) must be M0 (Prescriber Consulted).
- The Result of Service Code (NCPDP field 441-E6) should be 1D (Filled, with Different Directions) or 1F (Filled, with Different Quantity).
- The DUR/PPS Level of Effort (NCPDP field 474-8E) value must be between 11 and 15.

In addition, a diagnosis code must be included on the claim. If tablet splitting is indicated for a covered brand name drug and the member is a SeniorCare member at Level 1 (copayment) participation, the maximum copayment rate that may be deducted on the claim is $7.50.

For SeniorCare members, the following information should be indicated on professional claims for cost-effectiveness interventions for tablet splitting:

- The appropriate CPT procedure code for a new or established patient.
- Modifier U1 (cost effectiveness intervention) with a quantity of 1.

If a cost-effectiveness intervention lasts longer than 15 minutes, pharmacy providers should indicate CPT procedure code 99607 with modifier U1 for each additional 15 minutes on a separate detail.

Clarifications for Intervention-Based Services Only

The information in this section applies to intervention-based services only.

Member Consent

Only verbal consent from a member is required for intervention-based services; the member's signature is *not* required. If the member is a child or has physical or cognitive impairments that preclude the member from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide verbal consent on the member's behalf.

Claims for Intervention-Based Services

Reimbursement limits for MTM services are applied per member (not per pharmacy). Pharmacy providers are encouraged to submit claims for intervention-based services as soon as possible after provision of the service.

Three-Month Supply Interventions

Pharmacy providers will only receive reimbursement for three-month supply interventions if the intervention resulted in conversion of the prescription to a three-month supply. If the pharmacy provider contacted the prescriber to amend the prescription but the prescription was not converted to a three-month supply, the pharmacy provider is not eligible to receive reimbursement for the intervention.

Focused Adherence Intervention Follow-up Telephone Calls

Providers are encouraged to follow up with members who have received a focused adherence intervention by calling them on the telephone to ensure they understand what was discussed during the service. These telephone calls are not separately reimbursable.

Medication Addition and Deletion Interventions

If a medication addition intervention and a medication deletion intervention occur at the same time *and* one medication is replacing another, providers should submit a claim only for the medication addition.

If a medication addition intervention and a medication deletion intervention occur at the same time *but* are unrelated, providers may bill separately for the interventions, either on separate detail lines or on separate claims.

Post-intervention Prescription Numbers

When applicable, providers should include the post-intervention prescription number in documentation.

Clarifications for Comprehensive Medication Review and Assessment Services Only

The information in this section applies to CMR/A services only.

Comprehensive Medication Review and Assessment Approval Process

Pharmacy providers are required to receive DAPO approval before scheduling a CMR/A with a member. Pharmacy providers may contact the DAPO Center at (800) 947-9627 from 8:00 a.m. to 5:30 p.m. (Central Standard Time), Monday through Friday, except holidays.

When calling the DAPO Center for approval to schedule the CMR/A, the following information, similar to the documentation requirements, must be provided:

- Member information.
- Pharmacy and pharmacist information.
- Reason for CMR/A.
- Whether or not the member is enrolled in Medicare Part D.
- Member's qualifying criteria.

Member Consent

The member's verbal consent is required before calling the DAPO Center to request approval to schedule a CMR/A. The member's written consent (i.e., his or her signature) must be obtained before performing the CMR/A. If the member is a child or has physical or cognitive impairments that preclude the member from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide verbal or written consent on the member's behalf.

Claims for Comprehensive Medication Review and Assessment Services

To ensure that members receive their CMR/A services in a timely manner, pharmacy providers are encouraged to schedule, perform, and submit claims for CMR/A services as soon as possible following approval of the CMR/A request. The submission of the claim is the indication to ForwardHealth that the service has been performed. The DAPO Center may inactivate the approval for a CMR/A service if it is not billed within the 60-day approval window.

For More Information

Providers may refer to the Pharmacy service area of the Online Handbook on the Portal for more information about MTM policies and procedures.

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 AIDS/HIV Drug Assistance Program and the Wisconsin Well Woman Program are 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/*.

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ATTACHMENT 1
Revised 1500 Health Insurance Claim Form Completion Instructions for Medication Therapy Management 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. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card and members enrolled in SeniorCare receive a SeniorCare 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.

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
313 Blettner Blvd
Madison WI 53784

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 or SeniorCare 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 or SeniorCare 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 MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). 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

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, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has any other 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: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the 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

If an Explanation of Medicare Benefits (EOMB) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

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 a Medicare Advantage Plan, 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 EOMB, 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. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or 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. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). *For Medicare Part B, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Element 11 a — 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 (required if member was referred for services by a provider)

Element 17a (not required)

Element 17b — NPI (required if member was referred for services by a provider)

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

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

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

Enter the date of service (DOS) in MMDDYY or MMDDCCYY format. Enter the date under "From." Leave "To" blank or re-enter the "From" date.

The DOS is defined as the date the medication was dispensed, if applicable (e.g., for a cost-effectiveness intervention), or the date the member received the Medication Therapy Management (MTM) service (e.g., for a medication deletion intervention).

Element 24B — Place of Service

Enter the appropriate two-digit place of service (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 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)

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 MMDDYY or MMDDCCYY 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. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the National Provider Identifier (NPI) listed in Element 33a and match the practice location address on the provider's file maintained by ForwardHealth.

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

Enter qualifier "ZZ" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth. Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

Note: Providers should use qualifier "PXC" when submitting an electronic claim using the 837 Health Care Claim: Professional (837P) transaction. For further instructions, refer to the companion guide for the 837P transaction.

ATTACHMENT 2
Sample 1500 Health Insurance Claim Form for Medication Therapy Management Services, with Other Insurance

(The "Sample 1500 Health Insurance Claim Form for Medication Therapy Management Services, with Other Insurance" is located on the following page.)

Sample 1500 Health Insurance Claim Form for Medication Therapy Management Services, with Other Insurance

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (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 ☐

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 (insured):

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (444) 444-4444

ZIP CODE / TELEPHONE (Include Area Code) (insured): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)
c. OTHER ACCIDENT? YES ☐ NO ☐
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 250 . 01
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	24. A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	15	12						99605	U1	1	XX XX	1		NPI	
2	09	15	12						99607	U1	1	0 00	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: $ XX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Provider — SIGNED — DATE 09302012

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
Revised Sample 1500 Health Insurance Claim Form for Intervention-Based Services

(The revised "Sample 1500 Health Insurance Claim Form for Intervention-Based Services" is located on the following page.)

Sample 1500 Health Insurance Claim Form for Intervention-Based Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | 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 [X] F

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): (444) 444-4444

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 250 . 01
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	09 15 12				99605	U1	1	XX XX	1		NPI	
2	09 15 12				99607	U1	1	0 00	1		NPI	
3	09 15 12				99605	U2	1	XX XX	1		NPI	
4	09 15 12				99605	U2	1	XX XX	1		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: $ XX 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.)

SIGNED I. M. Provider — DATE 09302012

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

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 4
Revised Sample 1500 Health Insurance Claim Form for Comprehensive Medication Review and Assessments

(The revised "Sample 1500 Health Insurance Claim Form for Comprehensive Medication Review and Assessments" is located on the following page.)

Sample 1500 Health Insurance Claim Form for Comprehensive Medication Review and Assessments

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA

CARRIER

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 [X] F [ ]

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): (444) 444-4444

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 ____

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 250 . 00
2. ____
3. ____
4. ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	24. A. From MM	DD	YY	To MM	DD	YY	B. Place of Service	C. EMG	D. CPT/HCPCS	Modifier	E. Diagnosis Pointer	F. $ Charges	G. Days or Units	H. EPSDT Family Plan	I. ID. Qual.	J. Rendering Provider ID. #
1	09	16	12						99605	UA	1	XX XX	1		NPI	
2	09	16	12						99607	UA	1	0 00	2		NPI	
3	09	16	12						99605	U1	1	XX XX	1		NPI	
4	09	16	12						99605	U1	1	XX XX	1		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: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: I.M. Provider — DATE: 09302012

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

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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