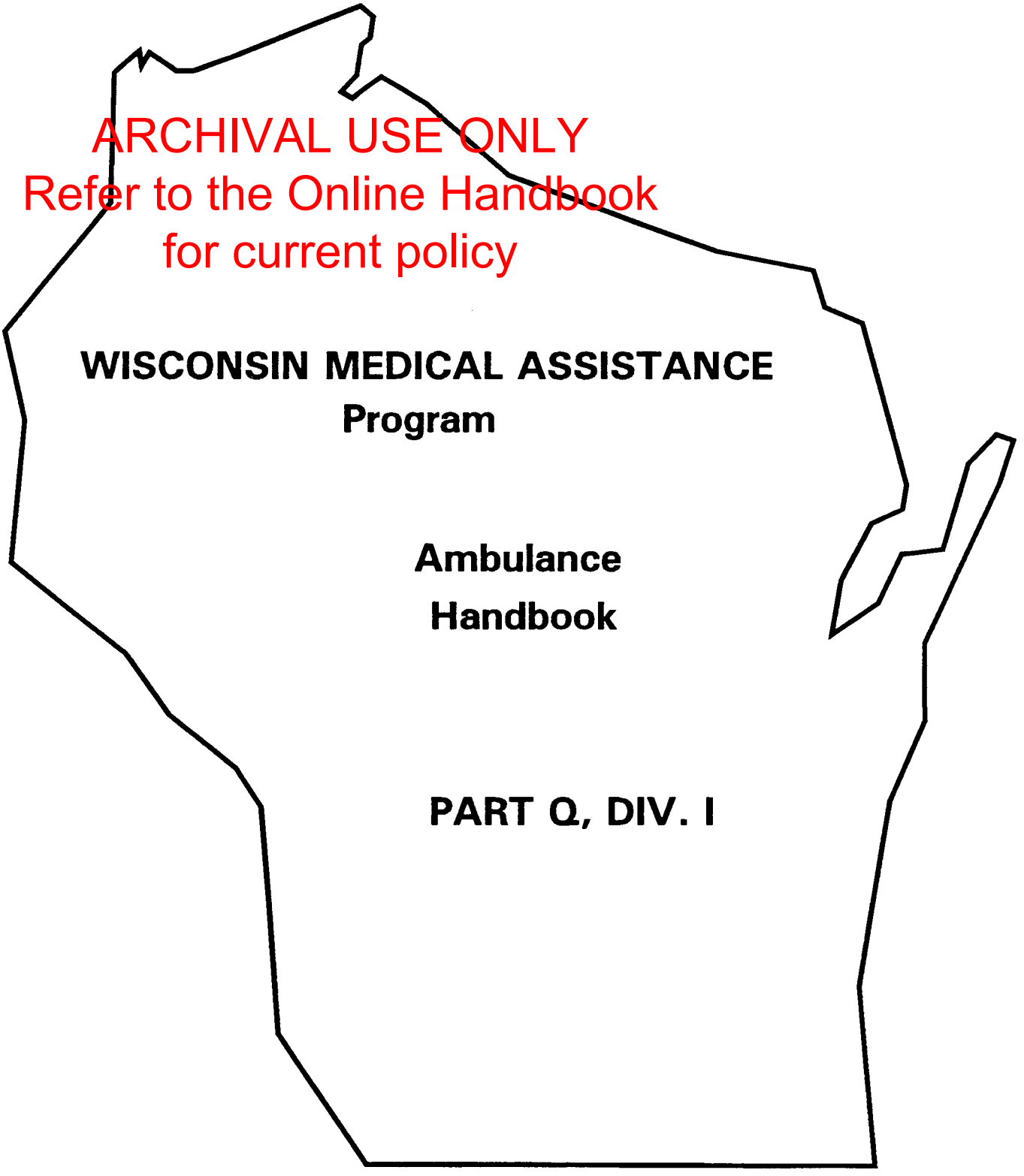

WISCONSIN MEDICAL ASSISTANCE
Program

Ambulance
Handbook

PART Q, DIV. I

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Health and Social Services, Chapters HSS 101-108, and by state and federal law. These regulations are interpreted for provider use in two WMAP provider handbooks. The two handbooks are designed to be used with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased by completing the order form found in Appendix 36 of the WMAP Part A Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental).

IT IS IMPORTANT THAT BOTH THE PROVIDER OF SERVICE AND THE PROVIDER'S BILLING PERSONNEL READ ALL MATERIALS PRIOR TO INITIATING SERVICES TO ENSURE A THOROUGH UNDERSTANDING OF WMAP POLICY AND BILLING PROCEDURES.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address indicated in Appendix 3 of the WMAP Part A Provider Handbook.

Providers should also be aware of other documents, including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 - 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations appears in Appendix 30 of the WMAP Part A Provider Handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

PART Q, DIVISION I
AMBULANCE SERVICES
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part Q, Divison I, of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

If a provider is missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 1Q-3 and you receive 1Q-5, you are missing 1Q-4. If a provider is missing a transmittal, copies of complete provider handbooks may be purchased by writing to the address listed in Appendix 3 of the WMAP Part A Provider Handbook.

Transmittal Number	Initials	Issue Date

Transmittal Number	Initials	Issue Date

AMBULANCE SERVICES
TABLE OF CONTENTS

AMBULANCE SERVICES
TABLE OF CONTENTS
(continued)

A. TYPE OF HANDBOOK

Part Q, Division I, is the Ambulance Handbook of the Wisconsin Medical Assistance Program (WMAP), to be used with the Part A handbook.

Part Q, Division I, contains:	Part A contains:
- provider eligibility criteria; - recipient eligibility criteria; - covered services; - reimbursement information; and - billing instructions.	- general policy guidelines; - regulations; - telephone numbers and addresses; and - billing information applicable to all providers certified in the WMAP.

B. PROVIDER INFORMATION

Provider Eligibility and Certification

Ambulance
Per section HSS 105.38, Wis. Admin. Code:

> "For Medical Assistance certification, ambulance service providers shall be licensed pursuant to s. 146.50, Stats., and ch H 20 (HSS 110), and shall meet ambulance inspection standards adopted by the Wisconsin Department of Transportation under s. 341.085, Stats., and found in ch. Trans 157."

Ambulance providers who are granted border status and who do not provide services in Wisconsin are exempt from the Wisconsin licensure requirement, but must be licensed by the appropriate agency in the state in which they provide services. Section 105.48, Wis. Admin. Code, explains which provider may be granted border status.

Separate Certification
All ambulance providers who operate either air ambulance or specialized medical vehicles (SMV) must obtain separate certification for each service, in order to bill for these services.

Air Ambulance
An air ambulance service must be licensed by the Division of Health pursuant to s. 146.50 Wis. Stats.

Scope of Service
The policies in Part Q, Division I, govern services provided within the scope of the practice of the profession as defined in ss. 49.46, Wis. Stats. and Chapter HSS 107.23, Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

Reimbursement
Providers can bill the WMAP for covered services only if the services are also billed to non-Medical Assistance recipients.

Ambulance providers are reimbursed by maximum allowable fees for all covered ambulance services provided to WMAP recipients eligible on the date of service. The maximum allowable fees are based on three geographic reimbursement areas:

B. PROVIDER INFORMATION (continued)

- statewide/out-of-state;
- metropolitan professional; and
- Milwaukee county.

Ambulance providers must bill their usual and customary charges for the services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medical Assistance recipients.

Available Transportation Services
The following types of transportation are available to WMAP recipients:

Public Common Carrier/Private Motor Vehicle Program
The WMAP does not reimburse providers for this type of transportation. The local tribal or county social and human service agencies reimburse the recipient. For more information on this program, contact the local county department of social or human services.

This type of transportation includes:

- car;
- airplane;
- train;
- bus; or
- taxi.

This form of transportation is used when:

- the recipient is physically and mentally able to take this form of travel without the assistance of another person;
- a child of any age is able to take a bus, airplane, train, taxi, or car with an adult; and
- the local county department of social and human service agency approves the service.

Specialized Motor Vehicle (SMV)
SMV transportation is a WMAP-covered benefit to be used when the recipient is disabled and is unable to take public common carrier or private motor vehicle transportation and the purpose of the trip is to receive WMAP-covered medical services.

If the recipient is enrolled in an HMO, contact the HMO for coverage information. Refer to Section I-C of this handbook for additional WMAP eligibility information.

Ambulance
Ambulance transportation is:

- licensed by the Department of Health and Social Services;
- a covered emergency transport, usually to the hospital; or
- a covered non-emergency transport when the recipient has a significant medical condition or a need for medical monitoring that does not allow common carrier, private motor vehicle, or specialized motor vehicle transportation.

Ambulance transportation providers are separately certified.

B. PROVIDER INFORMATION (continued)

Provider Responsibilities

Specific WMAP provider responsibilities are stated in Section IV of the WMAP Part A Provider Handbook. Reference Section IV of Part A for detailed information regarding:

- fair treatment of the recipient;
- maintenance of records;
- recipient requests for noncovered services;
- services rendered to a recipient during periods of retroactive eligibility;
- grounds for provider sanctions; and
- additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance

The identification cards include:

- the recipient's name;
- date of birth;
- 10-digit Medical Assistance identification number; and
- when applicable, indicator of private health insurance coverage, HMO coverage, Medicare coverage, and Medicare QMB-Only coverage.

The Medical Assistance identification cards are:

- sent to recipients monthly; and
- valid only through the end of the month for which they are issued.

It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine the recipient's eligibility and if there are any limitations to the recipient's coverage.

Section V-C of the WMAP Part A Handbook provides detailed information on:

- Medical Assistance eligibility;
- identification cards, temporary cards, and restricted cards; and
- how to verify eligibility.

A sample Medical Assistance identification card is in Appendix 7 of the WMAP Part A Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V of the WMAP Part A Provider Handbook for additional medical status information.

Medicare/Medical Assistance Dual Entitlement

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Providers can identify Medicare recipients by an "A" or "B" on the Medical Assistance identification card. See Appendix 7 of the WMAP Part A Handbook for an example.

Medicare QMB-Only Coverage

Providers can identify Qualified Medicare Beneficiary Only (QMB-Only) recipients by the presence of "QMB-Only", or "QMB-Only NH" (nursing home residents) on the Medical Assistance identification card. QMB-Only recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare covered services.

C. RECIPIENT INFORMATION (continued)

Health Maintenance Organization (HMO) Coverage

WMAP recipients enrolled in WMAP-contracted HMOs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's HMO. The codes are defined in Appendices 20, 21, and 22 of the WMAP Part A Provider Handbook.

Providers must check the recipient's current Medical Assistance identification card for HMO coverage before providing services. A sample Medical Assistance identification card can be found in Appendix 7 of the WMAP Part A Handbook. Claims submitted to EDS for services covered by WMAP-contracted HMOs are denied.

For recipients enrolled in a WMAP-contracted HMO, all conditions of reimbursement and prior authorization for ambulance services are established by the contract between the HMOs and certified providers. Ambulance providers, serving WMAP-contracted HMO recipients, should contact the recipient's HMO for further information regarding specific HMO prior authorization and billing information.

Additional information regarding HMO noncovered services, emergency services, and hospitalizations is included in Section IX-E of the WMAP Part A Provider Handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining non-emergency ambulance services. The procedure codes and their applicable copayment amounts are in Appendix 3 of this handbook.

Providers are reminded of the following copayment exemptions:

- emergency services;
- services provided to nursing home residents;
- services provided to recipients under 18 years of age;
- services provided to a pregnant woman if the services are related to the pregnancy;
- services covered by a WMAP-contracted Health Maintenance Organization (HMO) to HMO enrollees; and
- family planning services and related supplies.

The provider collects the recipient copayment. Applicable copayment amounts are automatically deducted from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of recipient copayment.

A. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) covers ambulance transportation when the recipient has an illness or an injury that makes it impossible to use other types of transportation.

B. COVERED AMBULANCE SERVICES

Emergency Ambulance Services

Emergency ambulance services are covered when:

- the recipient is transported in an emergency condition resulting from an accident, serious injury, or acute illness (for example, automobile accident, possible hip fracture, severe facial lacerations);
- recipient is in shock;
- recipient is unconscious;
- recipient has difficulty breathing;
- recipient has neck pain, back pain, or a head injury subsequent to significant trauma;
- recipient has chest pains and is over 30 years old, regardless of vital signs;
- recipient is suspected of sustaining an acute stroke or myocardial infarction;
- recipient is experiencing severe hemorrhaging;
- recipient has severe bleeding or bleeding with blood pressure less than 100 systolic (adult);
- recipient has blood pressure of over 100 diastolic with other relevant signs or symptoms;
- recipient has a temperature of greater than 104 orally, 103 axillary, or 105 rectally, with other relevant signs or symptoms;
- recipient has severe burns;
- recipient has severe pain and associated abnormal physiologic changes;
- recipient has suspected poisoning;
- recipient has prolonged or repetitive seizure activity which is observed by ambulance personnel;
- recipient has a bee or other insect sting with significant swelling locally, or any sting in the head area;
- recipient has had a previous or planned cesarean section and is in active labor;
- recipient's delivery has already occurred or the baby's head is presenting;
- recipient is in labor with contractions confirmed as less than four minutes apart, with a history of three or more deliveries, and the bag of waters has broken;
- a prolapsed cord is visible;
- recipient has to remain immobile because of a large bone fracture, or possible fracture, that has not been set.

B. COVERED AMBULANCE SERVICES (continued)

Air and Water Transportation
Emergency and prior authorized non-emergency helicopter, fixed-wing air, and water ambulance services are covered by the WMAP.

Refer to Section III of this handbook for prior authorization information.

Nonemergency Ambulance Services
Nonemergency services are covered if:

- the recipient is confined to bed before and after the ambulance trip (for example, bed-ridden cancer patient going for radiation therapy); or
- the recipient must be moved only by stretcher in order to receive necessary medical services.

A physician's prescription is required indicating that an ambulance transfer is necessary.

The prescription must:

- be obtained prior to transportation;
- be reduced to writing;
- be maintained on file;
- give the reason why the discharging facility was inappropriate for the recipient's condition (for example, the inappropriate facility may not have the equipment, staff, or services needed for the recipient's care).

Transports from a hospital to a nursing home, from one nursing home to another nursing home, or from a recipient's residence to a doctor's or dentist's office are nonemergency transfers. Hospital to hospital transfers are considered nonemergency transfers since the recipient should be in stable condition.

Waiting Time
"Waiting time" is when the ambulance provider is waiting for the recipient to receive medical services and return to the vehicle. It is:

- covered only when a "to" and "from" trip is being billed (round trip);
- limited to a maximum of six hours per date of service;
- may be charged only once when waiting for more than one recipient.

Life Support Services
An ambulance must be used to transport a recipient on life-support systems. The reimbursement is included in the base rate.

The WMAP defines life-support systems as:

- the administration of any prescription medication or IV solution (portable oxygen used by the recipient without the assistance of medical personnel is not considered prescription medication);
- the need for medically-trained personnel (nurse, paramedic, EMT) to monitor and treat the recipient;
- the use of medical equipment (ECG monitor) beyond that specified in HSS 105.39 Wis. Admin. Code.

B. COVERED AMBULANCE SERVICES (continued)

Additional Attendant Services
Services provided by a third ambulance attendant are covered if the recipient's condition requires a third attendant for restraint or lifting.

Isolettes
Transportation of an isolette (incubator) is covered as a nonemergency service when the recipient is under one year of age.

First Aid at the Scene
First aid at the scene is covered when providers make a good-faith response, but the recipient is not transported. Disposable supplies and oxygen may be billed with first aid at the scene. First aid at the scene is not covered when billed with a base rate and mileage charge.

C. NONCOVERED SERVICES OR RELATED LIMITATIONS

Noncovered Ambulance Services
The WMAP does not cover:

- additional charges to pick up the recipient's personal belongings;
- vehicle sterilization;
- charges for a recipient's failure to cancel a scheduled transport;
- sales tax;
- transportation of lab specimens;
- extra charges for nights, weekends, or holiday services;
- reusable devices and equipment such as backboards, neckboards, and inflatable splints;
- ambulance trips to obtain physical, occupational or speech therapy, audiology, chiropractic, or psychotherapy services;
- medical personnel who care for the recipient in transit (other than those employed by the ambulance provider);
- excessive mileage;
- trips to facilities where no medical services are received (e.g., day-care center, sheltered workshop);
- no recipient conveyance;
- processes, treatments, or services which are an integral part of care while in transit (complex bandaging procedures, EKG monitoring, drugs used in transit or for starting intravenous solutions);
- trips for the purpose of locating a recipient closer to their family or home;
- trips to relocate a recipient for the sole purpose of improving the recipient's mental, psychological, or emotional health.

A. GENERAL REQUIREMENTS

Providers must have prior authorization for certain specified services before delivery of that service, unless the service is an emergency.

Payment is not made if:

- services are provided prior to the grant date on the prior authorization request form;
- services are provided after the expiration date on the prior authorization request form;
- services are provided without prior authorization. The provider is then responsible for the cost of the service.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

Prior authorization is required for:

- nonemergency air and water transportation;

Providers are advised that prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other WMAP requirements must be met prior to payment of the claim.

C. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of the WMAP Part A Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, and prior authorization for out-of-state providers.

Request prior authorization for ambulance services by submitting a Prior Authorization Request Form (PA/RF) and a Prior Authorization Physician Attachment (PA/PA). Refer to Appendices 5, 6, 7, and 8 of this handbook for sample prior authorization request forms and completion instructions.

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP):

- is the payor of last resort ; and
- reimburses the portion of the allowable cost remaining after all other third party sources have been used.

Refer to Section IX-D of the WMAP Part A Provider Handbook for more detailed information on services requiring third-party billing, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient is covered by Medicare, but Medicare denied the claim, a Medicare disclaimer code must be indicated on the claim, as explained in the claim form instructions in Appendix 2 of this handbook.

C. QMB-ONLY RECIPIENTS

Qualified Medicare Beneficiary Only (QMB-Only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. (Since Medicare covers ambulance services, claims submitted for QMB-Only recipients are reimbursed.)

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to paper claim submission, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

A sample EMC screen can be found in Appendix 1d of this handbook.

Paper Claim Submission

Ambulance services must be submitted using the HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Ambulance services submitted on any other paper form than the HCFA 1500 claim form are denied.

E. CLAIM SUBMISSION (continued)

The HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers including:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

Completed claims submitted for payment must be mailed to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims
All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX-F of the WMAP Part A Provider Handbook.

F. DIAGNOSIS CODES

Ambulance providers must use the appropriate diagnosis code for the service that is provided:

V919 - Emergency
V920 - Nonemergency Prescription on File

G. PROCEDURE CODES

All claims submitted to the WMAP must include procedure codes. HCFA Common Procedure Coding System (HCPCS) codes are required on all ambulance claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for ambulance services are listed in Appendix 3 of this handbook.

H. FOLLOW-UP TO CLAIM SUBMISSION

It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of the WMAP Part A Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.

AMBULANCE SERVICES
APPENDICES

APPENDIX 1a
AMBULANCE - EMERGENCY, ONE ROUND TRIP WITH NONEMERGENCY RETURN DESTINATION

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
[ ] (Medicare #) [A] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)		1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Ima A.	3. PATIENT'S BIRTH DATE MM DD YY / SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
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-D	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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	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 PHYSICIAN OR OTHER SOURCE I.M. Referring Provider	17a. I.D. NUMBER OF REFERRING PHYSICIAN A12345	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. V919 3. ____ 2. V920 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	2	9	A0010		1	XX XX	1		E		
2 MM DD YY	2	9	A0020		1	XX XX	9.5		E		
3 MM DD YY	2	9	A0060		2	XX XX	1				
4 MM DD YY	7	9	W9072		2	XX XX	9.5				
5											
6											spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[ ] [ ]	1234JED	[ ] YES [ ] NO	$ XXX XX	$ 0 00	$ 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.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Authorized SIGNED MM/DD/YY DATE	11223344	I.M. Billing 1 W. Wilson Anytown, WI 55555 76543218 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 1b
AMBULANCE - EMERGENCY TRIP

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [ ] (Medicaid #) [A] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.

3. PATIENT'S BIRTH DATE MM DD YY / SEX: M [X] F [ ]

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

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): OI-D

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. V919 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	1	9	A0010		1	XX XX	1		E		
2 MM DD YY	1	9	A0020		1	XX XX	15		E		
3											
4											
5											
6											spenddown XX XX

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: $ 0 00

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized
SIGNED MM/DD/YY DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
11223344

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 76543218
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX 1c
AMBULANCE - NONMERGENCY, ONE ROUND TRIP WITH ONE MEDICAL FACILITY DESTINATION

HEALTH INSURANCE CLAIM FORM

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [A] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) 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): Recipient, Ima A.
3. PATIENT'S BIRTH DATE MM DD YY / SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):

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: 555555 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-D
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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY
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 PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider
17a. I.D. NUMBER OF REFERRING PHYSICIAN: A12345
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. V920 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	2	9	A0150		1	XX XX	1				
2 MM DD YY	2	9	W9072		1	XX XX	20				
3 MM DD YY	2	9	A0060		1	XX XX	1				
4 MM DD YY	7	9	W9072		1	XX XX	20				
5											
6											spenddown XX.XX

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 $ 0.0
30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized
SIGNED MM/DD/YY DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
11223344
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 76543218
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 1d
SAMPLE EMC SCREEN

MEDVENDR ECS SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the HCFA 1500 claim form. This screen is to be used beginning 01/04/93.

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 01/04/93
EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1a
PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23
RP NBR 17 FP NBR 32 OP NBR
DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.A	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
0													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #5 Form: MEDVENDR 01-04-1993 14:59:02

BENEFITS OF ELECTRONIC BILLING
One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data element that are not required on electronic claims include:

- claim sort indicator
- patient's date of birth
- patient's address
- patient's sex
- signature of provider
- provider's name and address

Other benefits of billing electronically include:

- free software
- improved cash flow
- lower detail denial rate
- flexible submission methods
- claim entry controlled by provider
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section 4 of the handbook, or fill out the Paperless Claims Request form located at the back of this handbook.

APPENDIX 2
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR AMBULANCE SERVICES

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

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

☑ = Elements that are required.

☑ **ELEMENT 1 - Program Block/Claim Sort Indicator**
Enter claim sort indicator "A" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

☑ **ELEMENT 1a - INSURED'S I.D. NUMBER**
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

☑ **ELEMENT 2 - PATIENT'S NAME**
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

☑ **ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX**
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

☑ **ELEMENT 5 - PATIENT'S ADDRESS**
Enter the complete address of the recipient's place of residence.

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**
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Appendix 18a of the WMAP Part A Provider Handbook.

- When the provider has billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of the WMAP Part A Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of the WMAP Part A Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by other insurance 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 in question was actually billed to and denied by the private insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: - recipient denies coverage or will not cooperate; - the provider knows the service in question is noncovered by the carrier; - insurance failed to respond to initial and follow-up claim; or - benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

☑ **ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER**
This first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes and home health agencies when Medicare had made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of the WMAP Part A Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

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 PHYSICIAN OR OTHER SOURCE**
Required for non-emergency services. Enter the referring or prescribing physician's name.

☑ **ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN**
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider. To obtain a UPIN directory, refer Appendix 3 of the WMAP Part A Handbook.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

☑ **ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
Diagnosis codes for ambulance: V919 - Emergency
V920 - Non-Emergency Prescription on File.
The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

☑ **ELEMENT 23 - PRIOR AUTHORIZATION**
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

☑ **ELEMENT 24A - DATE(S) OF SERVICE**
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same emergency indicator.

☑ **ELEMENT 24B - PLACE OF SERVICE**
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 4 of this handbook for a list of allowable place of service codes.

☑ **ELEMENT 24C - TYPE OF SERVICE CODE**
Enter the single-digit type of service code "9".

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. Refer to Appendix 3 of this handbook for a list of allowable procedure codes.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING (not required)

ELEMENT 24I - EMG
Enter an "E" for <u>each</u> procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency leave element blank.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of the WMAP Part A Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 3
HCPCS PROCEDURE CODE AND COPAYMENT TABLE FOR AMBULANCE SERVICES

The HCFA Common Procedure Code System (HCPCS) is required for all transportation claims. Please refer to the following table to determine the usage of the appropriate code.

Procedure Code	Description	TOS	POS	Copayment
Ambulance				
A0010	Emergency Base Rate	9	1,2	n/a
A0020	Emergency Mileage	9	1,2	n/a
A0150	Non-Emergency Base Rate	9	1,2,3,4,7.8.9,B	2.00[1]
W9072	Non-Emergency Mileage	9	1,2,3,4,7,8,9,B	n/a
W9081	Multiple Carry Base Rate	9	1,2,3,4,7,8	n/a
W9082	Multiple Carry Mileage, Two Recipients	9	1,2,3,4,7,8	n/a
W9083	Multiple Carry Mileage, Three or More Recipients	9	1,2,3,4,7,8	n/a
Miscellaneous Services				
A0060	Waiting Time	9	2,3,7,8,B	n/a
W9078	Third Attendant	9	0,1,2,3,4,7,8,B	n/a
W9051	Ambulance First Aid at the Scene	9	0,3,4,7,8	n/a
A0070	Oxygen	9	0,1,2,3,4,7,8,9,B	n/a
A0215	Disposable Items	9	0,1,2,3,4,7,8,9,B	n/a
W9074	Isolette, up to three hours	9	1,2	n/a
W9075	Isolette, over three hours	9	1,2	n/a
Air Ambulance				
W9060	Emergency Base Rate	9	0,1,2,9	n/a
W9061	Emergency Mileage	9	0,1,2,9	n/a
W9062	Non-Emergency Base Rate	9	0,1,2,4,9	n/a
W9063	Non-Emergency Mileage	9	0,1,2,4,9	n/a
Water Ambulance				
A0050	Emergency Rate	9	0,1,2,9	n/a
W9050	Non-Emergency Rate	9	0,1,2,9	n/a

[1] Places of service 7 and 8 are exempt from recipient copayment. Refer to Section I-C of this handbook for additional copayment exemptions.

APPENDIX 4

WMAP ALLOWABLE PLACE OF SERVICE (POS) CODES

POS	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance
B	Ambulatory Surgical Center

WMAP ALLOWABLE TYPE OF SERVICE CODE

POS	Description
9	Other

APPENDIX 5
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE
NONEMERGENCY TRANSPORTATION

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 999

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Ambulance Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: V920

11 DX: SECONDARY:

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
A0150		8	9	Non-emergency Base Rate	1	XX.XX
W9072		8	9	Non-emergency Mileage	40	XX.XX
					TOTAL CHARGE	21 XXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 J. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

APPENDIX 6
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) COMPLETION INSTRUCTIONS

ELEMENT 1 - PROCESSING TYPE
Enter processing type "999".

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the ten-digit Medical Assistance recipient identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS, AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter diagnosis code V920 - Non-Emergency Service, Prescription on File.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS (not required)

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service requested in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate single-digit place of service code designating the destination of the transport. Refer to Appendix 4 of this handbook for a list of allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter type of service code "9".

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services or number of miles) requested for each service requested.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service requested. If the quantity is greater than "1", multiply the quantity by the charge for each service requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO."

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/procedure must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 7
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA) SAMPLE

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PA

PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Ima	A	1234567890	84

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
I. M. Provider	65432187	(XXX) XXX-XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I. M. Physician, M.D.

A. Describe diagnosis and clinical condition pertinent to service or procedure requested:

Patient is an 84-year old male who suffers from fractured hip and severe arthritis. Is medically stable but unable to walk or sit upright for long periods of time. Patient requires ambulance transportation to geriatric facility in prone or semi-reclining posture.

B. Describe medical history pertinent to service or procedure requested:

Patient was released from geriatric facility for a family gathering in Upper Peninsula. At the gathering, patient fell and broke his hip. Patient was stabilized and treated at local hospital but the fracture aggravated pre-existing rheumatic discomfort. Patient requires care at the geriatric facility. Patient is receiving 10mg codeine enhanced pain reliever PRN.

C. Supply justification for service or procedure requested:

See Sections A and B for background. Patient cannot tolerate transportation in a sitting position. Cot stretcher required, but no medical treatment will be needed during the trip.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

D. 2/3/93 (Date) J. M. Provider (Requesting Provider's Signature)

APPENDIX 8
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA) COMPLETION INSTRUCTIONS

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) or the Prior Authorization Physician Attachment (PA/PA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

PROVIDER INFORMATION:

ELEMENT 6 - PRESCRIBING PHYSICIAN'S NAME
Enter the name of the provider who would perform/provide the requested service/procedure.

ELEMENT 7 - PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the physician prescribing the service.

ELEMENT 8 - PRESCRIBING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the provider prescribing the service.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the referring/prescribing physician in this element.

* *

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D.

2. Read the Prior Authorization Statement before dating and signing the attachment.

3. Date and sign the attachment.

APPENDIX 9
PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: ____________________

Address: ____________________

____

____

Medicaid Number: ____________ **Phone #:** ____________

Contact Person: ____________________

Type of Service(s) Provided: ____________________

Estimated Monthly Medicaid Claims Filed: ____________________

* *

1. Do you currently submit your Medicaid claims on paper? __YES __NO

2. Are your Medicaid claims computer generated on paper? __YES __NO

3. Do you use a billing service? __YES __NO

   If the answer is YES to #2 or #3, please complete the following:

   Name: ____________ Contact: ____________

   Address: ____________ Phone #: ____________

   ____

4. Do you have an in-house computer system? __YES __NO

   If YES, type of computer system:

   a. Large main frame (e.g., IBM 360, Burroughs 3800) Manufacturer: ____________ Model #: ____________
   b. Mini-Computer (e.g., IBM System 34, or 36 TI 990) Manufacturer: ____________ Model #: ____________
   c. Micro-Computer (e.g., IBM PC, COMPAQ, TRS 1000) Manufacturer: ____________ Model #: ____________

5. Please send the paperless claims manual for:

   __ magnetic tape submission

   __ telephone transmission (EDS free software) ___ 3-1/2" ___ 5-1/4"

   __ telephone transmission (3780 protocol transmission)

Return To: EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009