

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: All Medical Providers
Managed Care Organizations

Memo #: 09-02
Issued: January 29, 2009

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration (HRSA)

For information, contact:
1-800-562-3022, option 2, or go to:
<http://hrsa.dshs.wa.gov/contact/prucontact.asp>

Subject: General Information Booklet: Update to the Medicare Part C Payment Methodology

Effective March 1, 2009, the Department of Social and Health Services (DSHS) is updating the payment methodology for Managed Medicare - Medicare Advantage (Part C) Plans and clarify how co-payments are paid.

What has changed?

DSHS will update the payment methodology for Managed Medicare – Medicare Advantage (Part C) Plans.

How do I conduct business electronically with DSHS?

You may conduct business electronically with DSHS by accessing the WAMedWeb at <http://wamedweb.acs-inc.com>.

How Can I Get DSHS's/HRSA's Provider Documents?

1. To obtain DSHS's/HRSA's provider numbered memoranda and billing instructions, go to DSHS's/HRSA's website at <http://hrsa.dshs.wa.gov> (click the *Billing Instructions and Numbered Memos* link). These may be downloaded and printed.
2. To request a paper copy, contact DSHS using one of the following methods:
 - a. Internet: <http://hrsa.dshs.wa.gov/download/hardcopyplease.html>. Follow the instructions on the web page.
 - b. Facsimile: 1-360-725-2144. Please include the following in your fax: i) your name and provider number; ii) the name of the document you would like mailed; and iii) the address you want DSHS to send the document to.
 - c. Telephone: 1-800-562-3022, Option 2. (Orders take up to one week to fill.)

Table of Contents

Section A: Introduction

Important Contacts.....	A.1
Electronic Billing and HIPAA.....	A.3
Important Numbers.....	A.4
HRSA Addresses.....	A.5
Billing Information for HRSA Managed Care Organizations.....	A.7
List of HRSA Billing Instructions.....	A.8
Definitions & Abbreviations.....	A.9
About Medical Assistance.....	A.19

Section B: Provider Requirements

Eligibility for Enrollment.....	B.1
Enrollment.....	B.1
Providers that may Request Enrollment.....	B.2
General Provider Requirements.....	B.3
Denying, Suspending, and Terminating Enrollment.....	B.4
Voluntary Provider Disenrollment.....	B.5
General Conditions of Payment.....	B.6

Section C: Client Eligibility

Valid Types of Eligibility Identification.....	C.1
Medical Eligibility Verification (MEV) Services.....	C.2
MEV Vendors.....	C.2
Clients Enrolled in an HRSA Managed Care Organization.....	C.3

Section D: Medical Identification (ID) Card

Medical ID Card Information.....	D.1
TAKE CHARGE Medical ID Card Information.....	D.1
Sample Medical ID Card.....	D.2
Key to the Medical ID Card.....	D.3

Section E: Medical Program Descriptions

Program Descriptions.....	E.1
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Table of Contents (cont.)

Section F: Authorization

Prior Authorization	F.1
Expedited Prior Authorization	F.1
Limitation Extensions	F.2
Exceptions to Rule	F.2

Section G: Transportation (Nonemergency) and Interpreter Services

Transportation and Interpreter Services	G.1
HRSA’s Nonemergency Medical Transportation Program	G.1
Nonemergency Transportation Coverage	G.2
Transportation Brokers	G.3
Scheduling Nonemergency Medical Transportation	G.4
Nonemergency Transportation Broker List	G.5
Spoken Language Interpreter Services	G.7
Interpreter Services Coverage	G.7
Interpreter Broker List	G.9

Section H: Billing

What is the time limit for billing?	H.1
What fee should I bill HRSA for eligible clients?	H.2
How do I bill for services provided to PCCM clients?	H.2
Checking a Client’s Medical ID Card for Possible Payers	H.3
Common Billing Complaints	H.3
Billing an HRSA Client on a Fee-For-Service Program	H.4
Eligibility for a Service After the Service Has Been Provided	H.6
Other Requirements	H.7
How do I bill for clients eligible for Medicare and Medical Assistance?	H.7
Medicare Part A	H.8
Medicare Part B	H.9
Medicare Part C	H.10
Billing HRSA’s Managed Medicare – Medicare Advantage (Part C) Plans	H.11
Completing the CMS-1500 Claim Form	H.13
Sample of CMS-1500 Claim Form	H.19

Table of Contents (cont.)

Section I: Coordination of Benefits	
Coordination of Benefits.....	I.1
Types of Insurance Claims.....	I.3
Multiple Services	I.5
Rebilling.....	I.6
Remittance and Status Report.....	I.6
Evidence of Insurance Termination	I.6
Third-Party Time Limits	I.7
Requesting Reimbursement	I.7
Questions and Answers.....	I.8
Section J: Remittance and Status Report	
Remittance and Status Report.....	J.1
Key to the Paper Remittance and Status Report	J.2
Sample Medical Assistance Remittance and Status Report.....	J.4
Section K: Electronic Funds Transfer (EFT)	
How EFT Works	K.1
How to Set Up EFT.....	K.1
Section L: Rebilling and Adjustments	
How long do I have to rebill or adjust a claim?	L.1
Rebilling.....	L.1
Adjustments	L.2
How to Complete the Adjustment Request Form	L.4
Section M: UB-04 Claim Form	
Sample UB-04 Claim Form?	M.1

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

The Health and Recovery Services Administration (HRSA) has two timeliness standards, one for initial claims and one for resubmitted claims.

- **Initial Claims**

- ✓ HRSA requires providers to obtain an internal control number (ICN) for an **initial claim** within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders HRSA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.

- ✓ HRSA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to HRSA's satisfaction that there are extenuating circumstances.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill DSHS for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill DSHS for the service.

² **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill DSHS for the service.

- **Resubmitted Claims**

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- ✓ The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.
- ✓ The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - The provider fails to meet these listed requirements; and
 - HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the CMS-1500 Claim Form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

Note: Newborns of HRSA managed care clients that are connected with a PCCM are fee-for-service until a PCCM has been chosen. All services should be billed to HRSA.

Checking a Client's Medical ID Card for Possible Payers

- **Check the Insurance and Medicare columns** on the Medical ID Card:

Does the client have either private insurance or Medicare? If so, these are the primary payers and must be billed first.

- **Check the HMO columns** on the Medical ID Card:

If the client is enrolled in an HRSA managed care plan, you may need a referral and/or authorization from the plan to provide care for services provided through the managed care contract, except for emergency room visits. If the service is not an emergency and you do not have a referral or authorization, refer the client back to the client's plan or primary care provider (PCP), unless the client is seeking a service for which self-referral is permitted under the contract.

Note: Refer to page C.3 for information on checking a client's Medical ID Card for eligibility.

Common Billing Complaints

- One of the most common billing complaints is from clients who receive bills from laboratories or radiologists because the ancillary providers did not receive a copy of the Medical ID Card.

Note: It is the medical provider's responsibility to forward a copy of the Medical ID Card to all ancillary service providers (e.g., radiology, and laboratory) when the provider orders these services.

- Another common billing complaint is the pharmacist misinterpreting a Point-of-Sale (POS) message as a denial and billing the client instead of calling HRSA for prior authorization.

Note: It is the pharmacist's responsibility to call HRSA for prior authorization (PA) when the pharmacist receives a PA message from the POS system.

Billing an HRSA Client on a Fee-For-Service Program

[Refer to WAC 388-502-0160 (1) through (3)]

- A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if HRSA does not pay for the service because the provider failed to satisfy the conditions of payment in HRSA billing instructions, in chapter 388-502 WAC, and other WAC chapters regulating the specific type of service provided.
- The provider is responsible for verifying whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.
- A provider may bill a client only if one of the following situations apply:
- The client is enrolled in an HRSA managed care plan and the client and provider comply with the requirements in WAC 388-538-095;
 - ✓ The client is not enrolled in an HRSA managed care plan, and the client and provider sign an agreement regarding payment for the service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for DSHS review upon request;
 - ✓ The agreement must include each of the following elements to be valid:
 - A statement listing the specific service to be provided;
 - A statement that the service is not covered by HRSA;
 - A statement that the client chooses to receive and pay for the specific service; and
 - The client is not obligated to pay for the service if it is later found that the service was covered by HRSA at the time it was provided, even if HRSA did not pay the provider for the service because the provider did not satisfy HRSA's billing requirements;

Note: Providers may use their own agreement form as long as it includes the elements listed above.

- ✓ The client or the client's legal guardian was reimbursed for the service directly by a third party;

- ✓ The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by HRSA; HRSA is not considered insurance;
- ✓ The provider has documentation that the client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under an HRSA medical program. This documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for DSHS review upon request. In this case the provider may bill the client without fulfilling the requirements on page H.4 regarding the signed agreement for payment. However, if the patient later becomes eligible for HRSA coverage of a provided service, the provider must comply with the requirements on page H.6;
- ✓ The bill counts toward a spenddown liability, emergency medical expense requirement (EMER), deductible, or copayment required by HRSA; or
- ✓ The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a copayment may be imposed on the client by the hospital, except when:
 - Reasonable alternative access to care was not available;
 - The "indigent person" criteria in WAC 246-453-040 (1) applies;
 - The client was 18 years of age or younger;
 - The client was pregnant or within 60 days postpregnancy;
 - The client is an American Indian or Alaska Native;
 - The client was enrolled in an HRSA managed care plan, including primary care case management (PCCM);
 - The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
 - The client receives waived services such as community options program entry system (COPEs) and community alternatives program (CAP).

Eligibility for a Service after the Service Has Been Provided

[Refer to WAC 388-502-0160(4)]

- If a client becomes eligible for a covered service that has already been provided because the client:
 - ✓ Applied to DSHS for medical services later in the same month the service was provided (and is made eligible from the first day of the month) the provider must:
 - Not bill, demand, collect, or accept payment from the client or anyone on the client’s behalf for the service; and
 - Promptly refund the total payment received from the client or anyone on the client’s behalf, and then bill HRSA for the service.

-or-

 - ✓ Receives a delayed certification³, the provider must:
 - Not bill, demand, collect, or accept payment from the client or anyone on the client’s behalf for the service; and
 - Promptly refund the total payment received from the client or anyone on the client’s behalf, and then bill HRSA for the service;
- or-
- ✓ Receives retroactive certification⁴, the provider:
 - Must not bill, demand, collect, or accept payment from the client or anyone on the client’s behalf, and after refunding the payment, the provider may bill HRSA for the service; and
 - May refund any payment received from the client or anyone on the client’s behalf, and after refunding the payment, the provider may bill HRSA for the service.

Note: Many people apply for a medical program **after** receiving medical services that would be covered under that program. DSHS may take as long as 45 to 90 days to process medical applications. If eligible, the client receives a Medical ID Card dated the first day of the month of the application. The Medical ID is **not** noted with either the “retroactive certification” or “delayed certification” identifiers. Providers must treat these clients as the “delayed certification” procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

³ **Delayed Certification** – Department approval of a person’s eligibility for Medicaid made after the established application processing time limits. [WAC 388-500-0005]

⁴ **Retroactive Certification** – The 3 calendar months before the month of application. [WAC 388-500-0005]

Other Requirements [WAC 388-502-0160 (5) and (6)]

- Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstance described for hospital emergency rooms on page H.5.
- A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or HRSA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

This includes, but is not limited to:

- ✓ Medical charts;
- ✓ Radiological or imaging films; and
- ✓ Laboratory or other diagnostic test results.

How do I bill for clients eligible for both Medicare and Medical Assistance? [Refer to WAC 388-502-0150 (6)]

If a client is eligible for both Medicare and Medical Assistance, and the service is covered by Medicare, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations.** HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claims (see page H.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- ✓ Individuals who are 65 years of age and older;
- ✓ Certain individuals with disabilities (under 65 years of age); or
- ✓ Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white, and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if the client has Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

When billing Medicare for Medicare Part A:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical ID Card. Enter the Medical Assistance provider number;
- Accept assignment;
- If Medicare has allowed the service, in most cases Medicare will forward the claim to HRSA. HRSA then processes the claim for any supplemental payments;
- If Medicare does not forward the claim to HRSA **within 30 days** from its statement date, send the UB-04 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to HRSA for processing. (See *Important Contacts* section, page A.1); and
- When Part A services are totally disallowed by Medicare but are covered by HRSA, bill HRSA on the UB-04 claim form and attach copies of Medicare's EOMB with the denial reasons. See specific program billing instructions for information on using a UB-04 claim form.

Note: Medicare/Medical Assistance billing claims must be received by HRSA within six months of the Medicare EOMB paid date. A Medicare Remittance Notice or EOMB must be attached to each claim.

Medicare Part B

Benefits covered under Medicare Part B include:

- ✓ Physician services;
- ✓ Outpatient hospital services;
- ✓ Home health;
- ✓ Durable medical equipment; and
- ✓ Other medical services and supplies not covered under Part A.

Note: When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on the Medicare remittance notice, it means that the claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If a provider receives a payment or denial from Medicare, but it does not appear on the HRSA Remittance and Status Report (RA), the provider bills HRSA directly with the Medicare EOMB attached. Submit a CMS-1500 Claim Form:

- If Medicare has made payment, and there is a balance due from HRSA Bill only those lines Medicare paid. Do not submit paid lines with denied lines; this could cause a delay in payment.
- If Medicare denies services, but HRSA covers them, bill only those lines Medicare denied. Do not submit denied lines with paid lines; this may cause a delay in payment.
- If Medicare denies a service that requires prior authorization (PA) by HRSA. HRSA waives the PA requirement but still requires some form of HRSA authorization based on medical necessity.

Billing HRSA for Medicare Part B

- HRSA compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. Medicare's payment is deducted from the amount selected.
- For the Qualified Medicare Beneficiary if there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.
- If there *is* a balance due, payment is made towards the Medicare deductible and/or coinsurance up to HRSA's maximum allowable.

- HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:
 - ✓ The provider **accepts** assignment; and
 - ✓ The total combined reimbursement to the provider from Medicare and HRSA does not exceed Medicare or HRSA's allowed amount, whichever is less.

Medicare Part C

- Benefits covered under Medicare Part C include:
 - ✓ Physician services;
 - ✓ Outpatient hospital services;
 - ✓ Home health;
 - ✓ Durable medical equipment; and
 - ✓ Other medical services and supplies not covered under Part A.
- If a client is enrolled in a Managed Medicare - Medicare Advantage (Part C) plan submit the claim to the Managed Medicare - Medicare Advantage plan first. Managed Medicare - Medicare Advantage is the primary payer of claims.
- After receiving payment or denial from the Managed Medicare - Medicare Advantage plan, submit the claim to HRSA. Indicate "Managed Medicare" as follows:
 - ✓ CMS - 1500 Claim Form in field 19;
 - ✓ UB-04 in form locator 80; or
 - ✓ Electronic billing in the on-line comments.
- HRSA must receive claims within 6 months of the Managed Medicare – Medicare Advantage payment date and must include the Managed Medicare explanation of benefits (EOB) to avoid delayed or denied payment due to late submission.
- HRSA does not accept altered EOB's.
- If the Managed Medicare - Medicare Advantage plan allows a service that requires prior authorization (PA) by HRSA, HRSA waives the PA requirement.

Note: Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to your Managed Medicare - Medicare Advantage plan. If Managed Medicare - Medicare Advantage adjusts the payment and the claim has previously been paid, you may submit an adjustment request to HRSA. Submit a new claim if the original claim was denied.

Billing HRSA for Managed Medicare - Medicare Advantage (Part C) Plans

In order to receive payment from HRSA, it is necessary to follow the billing guidelines established from the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing HRSA.

If there is a capitated copayment due on a claim:

Capitated copayments do not require the biller to submit with an explanation of benefits (EOB); indicate “Managed Medicare capitated copayment” on billing forms as follows:

- CMS-1500 Claim Form in field 19;
- UB-04 in form locator 80; or
- Electronic billing in the online comments.

If there is coinsurance, a deductible, or a noncapitated copayment due on a claim:

Note: If no balance is due, the claim will be denied.

If a balance is due for services provided:

- Bill all services, paid or denied, to HRSA on one claim form, and attach an EOB.
- Indicate “Managed Medicare” on billing forms as follows:
 - ✓ CMS-1500 Claim Form in field 19;
 - ✓ UB-04 in form locator 80; or
 - ✓ Electronic billing in the on-line comments.
- HRSA will compare the allowed amount for HRSA and Managed Medicare – Medicare Advantage and select the lesser of the two.
- Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.

Note: If the Medicare Advantage plan covers a service that HRSA requires PA for, HRSA will waive the PA requirement.

QMB-Medicare Only

For QMB-Medicare Only clients:

- If Medicare and HRSA cover the service, HRSA pays only the deductible and/or coinsurance and/or copayment up to Medicare or Medicaid's allowed amount, whichever is less. Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.
- If only Medicare covers the service and HRSA does not, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicare does not cover the service, HRSA does not reimburse the service.

Completing the CMS-1500 Claim Form

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section

The CMS-1500 Claim Form is a universal claim form. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing HRSA. Some field titles may not reflect their usage for a particular claim type.

If you do not follow these instructions, your claims may be denied or suspended for further processing, also known as adjudication. Either one of these actions will extend the time period for payment.

Guidelines/Instructions for Paper Claim Submission:

- In order for the claim to be read by the OCR, red ink on the blank claim form must be either Sinclair Valentine J6983 or OCR Red Paper. Paper claims must be submitted using these scannable red inks. These inks cannot be duplicated by a computer printer.
- **Do not use red ink pens, highlighters, “post-it notes,” stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, “REBILL,” “TRACER,” or “SECOND SUBMISSION” or similar statements on claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form.** HRSA does not accept “continued” claim forms. If more than six detail lines are needed, use additional claim forms.
- **Total each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form. Do not indicate “continued” on claim forms.

CMS - 1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
1a.	Insured's ID No.	Yes	<p>Enter the Patient Identification Code (PIC) – an alphanumeric code assigned to each HRSA client – exactly as shown on the Medical ID Card which consists of the client's:</p> <ul style="list-style-type: none"> • First and middle initials (a dash [-] <i>must</i> be used if the middle initial is not available). • Six-digit birthdate, consisting of <i>numerals only</i> (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). • Apostrophes, hyphens and other special characters in a last name are valid and take the place of a letter. <p><i>For example:</i></p> <ul style="list-style-type: none"> ➤ Mary C. Johnson's PIC looks like this: MC010667JOHNSB. ➤ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B ➤ John O'Henry's PIC looks like this: J-102564O'HENA.
2.	Patient's Name	Yes	Enter the last name, first name, and middle initial of the client (the receiver of the services for whom you are billing).
3.	Patient's Birthdate	Yes	Enter the birthdate of the client.
4.	Insured's Name (Last Name, First Name, Middle Initial)		When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA) enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word <i>Same</i> may be entered.
5.	Patient's Address	Yes	Enter the address of the client who received the services you are billing for (the person whose name is in Field 2.)

General Information Booklet

Field No.	Name	Field Required	Entry
9.	Other Insured's Name		If there is other (secondary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a.	Other Insured's Policy or Group Number		Enter the other insured's policy or group number <i>and</i> insured's SSN.
9b.	Other Insured's Date of Birth and Gender		Enter the other insured's date of birth and gender.
9c.	Employer's Name or School Name		Enter the other insured's employer's name or school name.
9d.	Insurance Plan Name or Program Name		Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). Please note: DSHS, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are inappropriate entries for this field.
10.	Patient's Condition Related To	Yes	Check <i>yes</i> or <i>no</i> to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field 24. Indicate the name of the coverage source in field 10d (L&I, name of insurance company, etc.).
11.	Insured's Policy Group or FECA (Federal Employees Compensation Act) Number		Primary insurance, when applicable. This information applies to the insured person listed in Field 4. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid is the payer of last resort.
11a.	Insured's Date of Birth		Primary insurance. When applicable, enter the insured's birthdate, if different from Field 3.
11b.	Employer's Name or School Name		Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	Insurance Plan Name or Program Name		Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: <i>This may or may not be associated with a group plan.</i>)

Field No.	Name	Field Required	Entry
11d.	Is there another Health Benefit Plan?	Yes if secondary insurance.	Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i> . If yes, you should have completed Fields 9a.-d. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i> . If 11d. is left blank, the claim may be processed and denied in error.
17.	Name of Referring Physician or Other Source		When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name.
17a.	ID Number of Referring Physician		When applicable, 1) enter the 7-digit HRSA-assigned physician number. Refer to the Provider Number Reference website: http://pnrmaa.dshs.wa.gov ; 2) If the referring provider does not have an HRSA-assigned ID number, enter 8900946. Use this standard number only for referring providers who do not have an HRSA assigned ID number; or 3) When the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this Field when you bill HRSA, the claim will be denied.
19.	Reserved for Local Use		This field is used for comments that require an HRSA claims specialist to review a claim before payment is made. Examples of appropriate comments: <ul style="list-style-type: none"> • “B” for baby on a parent’s PIC • “Twin A” or “twin B” • “Triplet A”, “triplet B”, or “triplet C” • “ITA client” • “NDC” • “backup attached” Inappropriate comments may result in delayed processing of claims.
21.	Diagnosis or Nature of Illness or Injury		Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22.	Medicaid Resubmission		When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the <i>Remittance and Status Report</i> .)

General Information Booklet

Field No.	Name	Field Required	Entry										
23.	Prior Authorization Number		When applicable. If the service or hardware you are billing for requires prior authorization, enter the assigned 9-digit number. (See Field 24K for Expedited Prior Authorization (EPA) numbers). Only one authorization number is allowed per claim.										
24.	Enter only one (1) procedure code per detail line (Fields 24A - 24K). If you need to bill more than 6 lines per claim, please use an additional 1500 Claim Form.												
24a.	Date(s) of Service	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 04, 2005 = 060405).										
24b.	Place of Service	Yes	Enter the appropriate two digit code as follows: <table border="0" style="margin-left: 40px;"> <tr> <td style="text-align: center;">Code</td> <td style="text-align: center;">To Be</td> </tr> <tr> <td style="text-align: center;">Number</td> <td style="text-align: center;">Used For</td> </tr> <tr> <td style="text-align: center;">11</td> <td style="text-align: center;">Office</td> </tr> <tr> <td style="text-align: center;">31</td> <td style="text-align: center;">Skilled Nursing Facility</td> </tr> <tr> <td style="text-align: center;">32</td> <td style="text-align: center;">Nursing Facility</td> </tr> </table>	Code	To Be	Number	Used For	11	Office	31	Skilled Nursing Facility	32	Nursing Facility
Code	To Be												
Number	Used For												
11	Office												
31	Skilled Nursing Facility												
32	Nursing Facility												
24d.	Procedures, Services or Supplies CPT/HCPCS	Yes	Enter the appropriate procedure code for the service(s) being billed. Modifier: When appropriate enter a modifier. If there is more than one modifier, begin the list of modifiers with "99" (e.g., 99 80 59)										
24e.	Diagnosis Code	Yes	Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A valid diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume or relate each line item to Field 21 by entering a 1, 2, 3, or 4. The first diagnosis should be the principle diagnosis. Follow additional digit requirements per ICD-9-CM.										
24f.	\$ Charges	Yes	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.										
24g.	Days or Units	Yes	Enter the total number of days or units (up to 999) for each line. These figures must be whole units.										
25.	Federal Tax ID Number		Leave this field blank.										

Field No.	Name	Field Required	Entry
26.	Patient's Account Number		Not required (optional field for internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. Do not enter spaces or the following characters in this field: * (asterisk) ~ (tilde) : (colon) This number will be printed on your <i>Remittance and Status Report (RA)</i> under the heading <i>Patient Account Number</i> .
28.	Total Charge	Yes	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29.	Amount Paid		If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance explanation of benefits (EOB). If payment is received from a source(s) other than insurance, specify the source in Field 10d . Do not use dollar signs or decimals in this field or put prior Medicare or Medicaid payments here.
30.	Balance Due	Yes	Enter total charges minus any amount(s) in Field 29 . Do not use dollar signs or decimals in this field.
33.	Physician's, Supplier's Billing Name, Address, Zip Code And Phone #	Yes	Enter the provider's <i>Name</i> and <i>Address</i> on all claim forms. PIN #: This is the seven-digit number assigned by HRSA to identify the performing individual when the individual is part of a group (e.g., the MD/ARNP, etc. who performed the service). Grp #: This is the seven-digit number assigned by HRSA to the billing entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made to this number. Note: When billing a Grp#, you must include a performing provider number in the PIN# field.

For questions regarding claims information, call HRSA toll-free:

1-800-562-3022

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK/LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)									
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>									
CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
9a. OTHER INSURED'S POLICY OR GROUP NUMBER					9b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER									
9c. EMPLOYER'S NAME OR SCHOOL NAME					9d. INSURANCE PLAN NAME OR PROGRAM NAME					11a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
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 _____					11b. EMPLOYER'S NAME OR SCHOOL NAME									
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 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					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. _____ 2. _____ 3. _____ 4. _____					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ER/SPT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER									
1 2 3 4 5 6					25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.									
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 _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. TOTAL CHARGE \$ _____					29. AMOUNT PAID \$ _____					30. BALANCE DUE \$ _____									
33. BILLING PROVIDER INFO & PH # ()					a. NPI _____					b. _____									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.