



## CMS 1500 (08/05) Claim Form Revision PROVIDER TRAINING

Fall 2007

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

## FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

# THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES. TO REQUEST THEM CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY IN YOUR AREA. (See listing of numbers on attachment)

#### MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3 please contact EarlySteps at 1-866-327-5978.)

#### SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately. Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE

AGE OF 21 WHO HAVE A MEDICAL NEED.

TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955

(or TTY 1-877-544-9544)

#### MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive Mental Health Rehabilitation Services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by mental health prior authorization unit.

#### **PSYCHOLOGICAL AND BEHAVIORAL SERVICES**

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

#### **EPSDT/KIDMED EXAMS AND CHECKUPS**

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.

#### **PERSONAL CARE SERVICES**

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. Personal Care Services do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid Home Health program or Extended Home Health program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

#### **EXTENDED SKILLED NURSING SERVICES**

Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

### PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. *EARLYSTEPS* CAN BE CONTACTED (toll free) AT 1-866-327-5978. CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

#### MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical Equipment and Supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

#### **TRANSPORTATION**

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544).

IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED,

CALL 1-888-758-2220 FOR ASSISTANCE.

#### OTHER MEDICAID COVERED SERVICES

- ° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
- ° Ambulatory Surgery Services
- ° Certified Family and Pediatric Nurse Practitioner Services
- ° Chiropractic Services
- ° Developmental and Behavioral Clinic Services
- ° Diagnostic Services-laboratory and X-ray
- ° Early Intervention Services
- ° Emergency Ambulance Services
- ° Family Planning Services
- ° Hospital Services-inpatient and outpatient
- ° Nursing Facility Services
- ° Nurse Midwifery Services
- ° Podiatry Services
- Prenatal Care Services
- ° Prescription and Pharmacy Services
- Health Services
- Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

#### Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

- \*Doctor's Visits
- \*Hospital (inpatient and outpatient) Services
- \*Lab and X-ray Tests
- \*Family Planning
- \*Home Health Care
- \*Dental Care
- \*Rehabilitation Services
- \*Prescription Drugs
- \*Medical Equipment, Appliances and Supplies (DME)
- \*Support Coordination
- \*Speech and Language Evaluations and Therapies
- \*Occupational Therapy
- \*Physical Therapy
- \*Psychological Evaluations and Therapy
- \*Psychological and Behavior Services
- \*Podiatry Services
- \*Optometrist Services
- \*Hospice Services
- \*Extended Skilled Nurse Services

- \*Residential Institutional Care or Home and Community Based (Waiver) Services
- \*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
- \*Immunizations
- \*Eyeglasses
- \*Hearing Aids
- \*Psychiatric Hospital Care
- \*Personal Care Services
- \*Audiological Services
- \*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
- \*Appointment Scheduling Assistance
- \*Substance Abuse Clinic Services
- \*Chiropractic Services
- \*Prenatal Care
- \*Certified Nurse Midwives
- \*Certified Nurse Practitioners
- \*Mental Health Rehabilitation
- \*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

If you need a service that is not listed above call the referral assistance coordinator at KIDMED (toll free) 1-877-455-9955 (or TTY 1-877-544-9544). If they cannot refer you to a provider of the service you need call 225-342-5774.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office. If you are a Medicaid recipient under age 21, and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

## OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES CSRAs

## METROPOLITAN HUMAN SERVICES DISTRICT

Janise Monetta, CSRA 1010 Common Street, 5<sup>th</sup> Floor New Orleans, LA 70112 Phone: (504) 599-0245 FAX: (504) 568-4660

Toll Free: 1-800-889-2975

## CAPITAL AREA HUMAN SERVICES DISTRICT

Pamela Sund, CSRA 4615 Government St. – Bin#16 – 2<sup>nd</sup> Floor Baton Rouge, LA 70806

Phone: (225) 925-1910 FAX: (225) 925-1966 Toll Fee: 1-800-768-8824

#### **REGION III**

John Hall, CSRA 690 E. First Street Thibodaux, LA 70301 Phone: (985) 449-5167 FAX: (985) 449-5180 Toll Free: 1-800-861-0241

#### **REGION IV**

Celeste Larroque, CSRA 214 Jefferson Street – Suite 301 Lafayette, LA 70501 Phone (337) 262-5610 FAX: (337) 262-5233

Toll Free: 1-800-648-1484

#### **REGION V**

Connie Mead, CSRA 3501 Fifth Avenue, Suite C2 Lake Charles, LA 70607 Phone: (337) 475-8045 FAX: (337) 475-8055

Toll Free: 1-800-631-8810

**REGION VI** 

Nora H. Dorsey, CSRA 429 Murray Street – Suite B Alexandria, LA 71301 Phone: (318) 484-2347 FAX: (318) 484-2458 Toll Free: 1-800-640-7494

#### **REGION VII**

Rebecca Thomas, CSRA 3018 Old Minden Road – Suite 1211 Bossier City, LA 71112

Phone: (318) 741-7455 FAX: (318) 741-7445 Toll Free: 1-800-862-1409

#### **REGION VIII**

Deanne W. Groves, CSRA 122 St. John St. – Rm. 343 Monroe, LA 71201 Phone: (318) 362-3396 FAX: (318) 362-5305 Toll Free: 1-800-637-3113

## FLORIDA PARISHES HUMAN SERVICES AUTHORITY

Marie Gros, CSRA 21454 Koop Drive – Suite 2H Mandeville, LA 70471 Phone: (985) 871-8300 FAX: (985) 871-8303 Toll Free: 1-800-866-0806

#### <u>JEFFERSON PARISH HUMAN SERVICES</u> AUTHORITY

Stephanie Campo, CSRA Donna Francis, Asst CSRA 3300 W. Esplanade Ave. –Suite 213 Metairie, LA 70002 Phone (504) 838-5357 FAX: (504) 838-5400

#### ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Fall 2007 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained by downloading it from the Louisiana MEDICAID website, <a href="www.lamedicaid.com">www.lamedicaid.com</a>.

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#### **OVERVIEW**

The CMS-1500 (08-05) claim form was introduced to Louisiana Medicaid for all dates of submission beginning March 5, 2007, but was mandated for use on June 4, 2007.

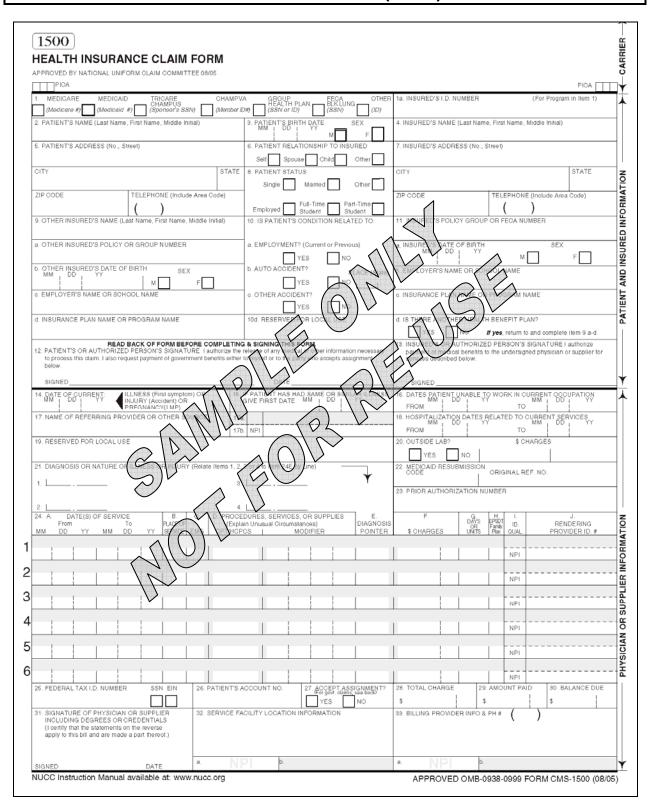
Effective June 4, 2007, the Form CMS-1500 (12-90) was discontinued and only the Form CMS-1500 (08-05) is now accepted. This includes all rebilling of claims even though earlier submissions may have been on the Form CMS-1500 (12-90).

Health plans, clearinghouses, and other information support vendors were required to handle and accept the Form CMS-1500 (08-05) by June 4, 2007.

Failure to submit all hard copy claims on the revised form results in the rejection of those claims and delays payment.

The changes from Form CMS-1500 (12-90) to Form CMS-1500 (08-05) were significant. Among the more important changes are the fact that the CMS-1500 (08-05) accommodates the entry of NPIs for service and billing providers and the entry of National Drug Codes (NDCs) for drugs and biologicals. Other differences are highlighted in a special Alert column in the instructions that are provided here. Please note that the repositioning of certain data fields and special instructions related to Louisiana Medicaid billing are indicated in the Alert column.

#### **SAMPLE CMS 1500 (08/05)**



# PROFESSIONAL AND GENERAL SERVICES

CMS-1500 (08/05) Instructions

## CMS 1500 (08/05) INSTRUCTIONS FOR PROFESSIONAL AND GENERAL SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.	
		NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	Patient Status	Optional.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank.	
		If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files link).	
		Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth	<b>Situational</b> – Complete if appropriate or leave blank.	
	Sex		
9c	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth	Situational – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.  In the following circumstances, entering the name of the appropriate physician is required:  If services are performed by a CRNA, enter the name of the directing physician.  If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.  If services are performed by an independent laboratory, enter the name of the referring physician.	
17a	Unlabelled	Situational – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is required to be entered.	The PCP's 7-digit referral authorization number must be entered in block 17a.

Locator #	Description	Instructions	Alerts
17b	NPI	Optional.	The revised form accommodates the entry of the referring provider's NPI.
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	Situational – Complete if appropriate or leave blank.  If the services being billed must be Prior Authorized, the PA number is required to be entered.	
24	Supplemental Information	Situational – Applies to the detail lines for drugs and biologicals only.  In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and shall be entered in the shaded section of 24A through 24G.  Claims for these drugs shall include the NDC from the label of the product administered.  To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the NDC. Do not enter a space between the qualifier and the NDC.  Do not enter hyphens or spaces within the NDC.	Physicians and other provider types who administer drugs and biologicals must enter this new drugrelated information in the SHADED section of 24A – 24G of appropriate detail lines only.  This information must be entered in addition to the

Locator #	Description	Instructions	Alerts
		Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.	procedure code(s).
		The following qualifiers are to be used when reporting NDC units:	
		F2 International Unit ML Milliliter GR Gram UN Unit	
24A	Date(s) of Service	Required Enter the date of service for each procedure.	
		Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> Enter the appropriate place of service code for the services rendered.	
24C	EMG	Situational – Complete if appropriate or leave blank.  When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	This indicator was formerly entered in block 24I.
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block.	
		More than one diagnosis/reference number may be related to a single procedure code.	

Locator #	Description	Instructions	Alerts
24F	\$Charges	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	The revised form accommodates the entry of I.D. Qual.
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	The revised form accommodates the entry of NPIs for Rendering Providers
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.  If TPL does not apply to the claim, leave blank.	

Locator #	Description	Instructions	Alerts
30	Balance Due	Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Required The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computergenerated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	The revised form accommodates entry of the Service Location NPI.
32b	Unlabelled	Situational – Complete if appropriate or leave blank.  When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the Qualifier LU followed by the three digit site number. Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)	If PCP, enter Site Number and Qualifier of the service location.
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	

Locator #	Description	Instructions	Alerts
33a	NPI	Optional.	The revised form accommodates the entry of the Billing Provider's NPI.
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number.	Format change with addition of 33a and 33b for provider numbers.

SAMPLE CMS-1500 (08/05) FOR HOSPITAL PROGRAM

1500		
HEALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
TIPICA	TAMENTA OPOLIE FEGA OTTI	PICA (See December 1)
— CHAMPUS —	HAMPVA GROUP FECA OTHE HEALTH PLAN BLK LUNG (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567891011
PATIENT'S NAME (Last Name, First Name, Middle Initial)  Smith, Maureen	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
6340 Westwind Street	Self Spouse Child Other	LOVANCE.
Deten Deven	STATE 8. PATIENT STATUS  LA Single Married Other	CITY STATE
TIP CODE TELEPHONE (Include Area Code	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)
I. OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	Employed Student Student    10 IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER HIGHERING BOLLOV OR ORGANIA WHATE	- FMDLOWMENTO (O	
OTHER INSURED'S POLICY OR GROUP NUMBER (TPL Carrier Code, if applicable)	a. EMPLOYMENT? (Current or Previous)  YES NO	a. INSURED'S DATE OF BIRTH SEX
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State	b EMPLOYER'S NAME OR SCHOOL NAME
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO # yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMP 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author	LETING & SIGNING THIS FORM. rize the release of any medical or other information peopessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier to
to process this claim. I also request payment of government benefit below.		payment of medical behalfs to the undersigned physician or supplier to services described below.
SIGNED_	DATE	signed
4 DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Assidont) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNES	S. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a CommunityCARE auth #	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
9. RESERVED FOR LOCAL USE	17b. NPI if applicable	FROM TO 20. OUTSIDE LAB? \$ CHARGES
		YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Her     250 00	ns 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
230.00	3	23. PRIOR AUTHORIZATION NUMBER
2. L	4. L	(Prior Auth # if applicable)
From To PLACE OF	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOS PT/HCPCS   MODIFIER POINTER	
		1333333
04   01   07   04   01   07   23       9	9282       1	75 00 1 NPI 1234567890
		NPI NPI
		NPI NPI
		NPI NPI
		NPI NPI
		NPI
	ENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	# here YES NO	s 75 00   sTPL Pmt   s 75 0
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		Moon Medical Center HBP
apply to this bill and are made a part the reof.)		1020 Main St. Sunny, LA 70821
Cole James 04/04/2007		

#### SAMPLE CMS-1500 (08/05) FOR MENTAL HEALTH REHAB (ADULT EXAMPLE)

(Medicare #) (Medicaid #) (Sponso 2. PATIENT'S NAME (Last Name. First Name. Mic Smith, John	RE CHAMPVA GRO PUS P'S SSN) (Member ID#) (SSN	UP LTH PLAN FECA BLK LUNG (D)	1a. INSURED'S I.D. NUMBER 1234999999999	(For Program in Ite
Smith John		S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, M	iddle Initial)
5. PATIENT'S ADDRESS (No., Street)		4 60 MX F	7. INSURED'S ADDRESS (No., Street)	
CITY	Solf	Spouse Child Other	0.00	STA
	STATE 8. PATIENT Single	Married Other	CITY	312
ZIP CODE TELEPHONE (	Include Area Code) Employed	Full-Time Part-Time	ZIP CODE TELEPHONE	(Include Area Code
9. OTHER INSURED'S NAME (Last Name, First N		NT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUM	IBER
a. OTHER INSURED'S POLICY OR GROUP NUM		MENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
<ul> <li>6 digit TPL number here, if applice</li> <li>b. OTHER INSURED'S DATE OF BIRTH</li> </ul>	SEX b. AUTO AC	YES NO CIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	F
MM DD YY	F	YES NO		
c. EMPLOYER'S NAME OR SCHOOL NAME	o. OTHER A	CCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NA	ME
d. INSURANCE PLAN NAME OR PROGRAM NAM	ME 10d. RESER	VED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLA	N? and complete item
12. PATIENT'S OR AUTHORIZED PERSON'S SIG	A BEFORE COMPLETING & SIGNING SHATURE I authorize the release of any	medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SI payment of medical benefits to the undersigne	IGNATURE I autho
to process this claim. I also request payment of below.	government benefits either to myself or to	the party who accepts assignment	services described below.	-,-,
SIGNED	DA		SIGNED	DDENT OCCUDAT
14. DATE OF CURRENT: ILLNESS (First s)  MM DD YY  INJURY (Accident PREGNANCY(LIA		AS HAD SAME OR SIMILAR ILLNESS.	16. DATES PATIENT UNABLE TO WORK IN CUI	MM DD
17. NAME OF REFERRING PROVIDER OR OTHE			18 HOSPITALIZATION DATES RELATED TO CU	IRRENT SERVICE
19. RESERVED FOR LOCAL USE	17b. NPI			ARGES
		A 45 hours	YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR IN	JJURY (Relate Items 1, 2, 3 or 4 to Item	Z4C by Une)	22. MEDICAID RESUBMISSION ORIGINAL REP	NO.
	ŷ. L		23. PRIOR AUTHORIZATION NUMBER 123456700	
24. A. DATE(S) OF SERVICE	4. L		F. G. H. I.	J.
	CE OF (Explain Unusual City CE EMG CPT/HCPCS	roumstances) DIAGNOSIS MODIFIER POINTER	\$ CHARGES UNITS Pan QUAL	RENDER PROVIDER
03 01 07 03 01 07 1	1 H2014	1 1		123456789
03   01   07   03   01   07   1	11 H2015	1		1234567 1234567890
	1 1			
			Psychiatrist Medicaid ID # and NPI if billing medication	
			management codes	
			NPI	<del></del>
		1 1 1 1		
25. FEDERALTAXID. NUMBER SSN E	IN 26 PATIENT'S ACCOUNT NO	27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID	
		YES NO	28. TOTAL CHARGE 29. AMOUNT PAID \$ 232 81 \$ TPL Amt.	\$ 23
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Loefily that the statements on the reverse	IN 26 PATIENT'S ACCOUNT NO 32 SERVICE FACILITY LOCA	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID S 232 81 S TPL Amt. 33. BILLING PROVIDER INFO & PH # ( MHR'S R US	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCA	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID \$ 232 81 \$ TPL Amt.   33. BILLING PROVIDER INFO & PH #	

#### **SAMPLE CMS-1500 (08/05) FOR DME**

MEDICARE MEDICAII     (Medicare #) (Medicald		CHAMP\	IA ODC:		FECA OTHER	1a. INSURED'S I.D. NU	#PED		PIC or Program in Item
	#) CHAMPUS (Sponsor's SSN	(Member	- HEALT	H PLAN	FECA BLK LUNG (SSN) (ID)	123456789		(1-)	or Program in item
2. PATIENT'S NAME (Last Name Carabella, Tra		ial)	3. PATIENT'S MM   DI 08   13		MX F∏	4. INSURED'S NAME (L	ast Name, Fi	rst Name, Midd	tle Initial)
5. PATIENT'S ADDRESS (No., S	Street)		6. PATIENT R	ELATIONSHIP		7. INSURED'S ADDRES	S (No., Stree	t)	
CITY		STATE		pouse Ch TATUS	ild Other	CITY			STAT
ZIP CODE	TELEPHONE (Include	Area Code)	Single	Married	Other	ZIP CODE	TE	LEPHONE (Inc	clude Area Code)
9. OTHER INSURED'S NAME (L	( )	fiddla (nifal)	Employed	Student	Part-Time Student Student N RELATED TO:	11. INSURED'S POLICY	GROUP OR	( )	ED
		alddie initial)						FECA NUMBE	EH
a. OTHER INSURED'S POLICY (TPL Carrier code if a			a. EMPLOYME	NT? (Current of	or Previous)	a. INSURED'S DATE OF	BIRTH YY	м	SEX F
b. OTHER INSURED'S DATE OF	1 -		b. AUTO ACCI	DENT?	PLACE (State)	b. EMPLOYER'S NAME	OR SCHOOL	. NAME	
o. EMPLOYER'S NAME OR SCH	HOOL NAME	F	c. OTHER ACC	YES CIDENT?	□ NO	c. INSURANCE PLAN N	AME OR PR	OGRAM NAME	
d INSURANCE PLAN NAME OF	R PROGRAM NAME		10d. RESERVE	YES ED FOR LOCA	NO L USE	d. IS THERE ANOTHER	HEALTH BF	NEFIT PLAN?	
						YES	i≎ #ye	s, return to and	d complete item 9
12. PATIENT'S OR AUTHORIZE to process this claim. I also re-	BACK OF FORM BEFO D PERSON'S SIGNATUI quest payment of government	RE Lauthorize the	release of any me	edical or other is	nformation necessary septs assignment	<ol> <li>INSURED'S OR AUT payment of medical services described b</li> </ol>	enetits to the		
below.			DATE			SIGNED			
14. DATE OF CURRENT:	ILLNESS (First symptom INJURY (Accident) OR	i) OR 15.	_		OR SIMILAR ILLNESS.	16. DATES PATIENT UI	IABLE JO W	ORK IN CURR	RENT OCCUPATI
17. NAME OF REFERRING PRO	PREGNANCY(LMP)				# if needed	FROM 18. HOSPITALIZATION MM DD	DATES RELA	TO TO CUR	RENT SERVICES
	_	17	b. NPI			FROM	"	TO	
19. RESERVED FOR LOCAL US	SE					20. OUTSIDE LAB?	10	\$ CHAR	GES
21. DIAGNOSIS OR NATURE O	FILLNESS OR INJURY	(Relate Items 1, 2	3 or 4 to Item 24	E by Line)	$\overline{}$	22. MEDICAID RESUBN	IISSION OR	IGINAL REF. N	NO.
1. 1. 783 . 41		3	L		Ť	23. PRIOR AUTHORIZA	TION NUMB	ER	
1		4	1			423456789			J.
2. L	DE B.	C. D. PROCE		CES. OR SUPP	PLIES E.	F.	G H	. 1.	
24. A. DATE(S) OF SERVICE From	To PLACE OF	C. D. PROCE (Expl EMG CPT/HCF	EDURES, SERVI	CES, OR SUPF imstances) MODIFIER	DIAGNOSIS POINTER	F.	G H DAY'S EPSI CIC Fam UNITS Pla	I. ID. QUAL.	PROVIDER I
24. A. DATE(S) OF SERVICE From	To PLACE OF DD YY SERVICE E	(Expl	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F.	G H DAY'S EPSI CIQ UNITS Fam UNITS Plan	I. ID. OUAL.	PROVIDER I
24. A. DATE(S) OF SERVICE From MM DD YY MM I	To PLACE OF DD YY SERVICE E	EMG CPT/HCF	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F. \$ CHARGES		NPI	RENDERIN PROVIDER I
24. A. DATE(S) OF SERVICE From MM DD YY MM I	To PLACE OF DD YY SERVICE E	EMG CPT/HCF	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F. \$ CHARGES		NPI NPI	RENDERIN PROVIDER I
24 A DATE(S) OF SERVICE From MM DD YY MM	To PLACE OF DD YY SERVICE E	EMG CPT/HCF	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F. \$ CHARGES		NPI	RENDERIN PROVIDER I
24. A. DATE(S) OF SERVICE From MM DD YY MM I	To PLACE OF DD YY SERVICE E	EMG CPT/HCF	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F. \$ CHARGES		NPI NPI	RENDERIN PROVIDER I
24. A. DATE(S) OF SERVICE From MM DD YY MM I	To PLACE OF DD YY SERVICE E	EMG CPT/HCF	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F. \$ CHARGES		NPI NPI NPI	RENDERIN PROVIDER I
24. A. DATE(S) OF SERVICE From MM DD YY MM I	To PLACE OF DD YY SERVICE E	EMG CPT/HCF	EDURES, SERVI ain Unusual Circu PCS	imstances)	DIAGNOSIS	F. \$ CHARGES		NPI NPI NPI	RENDER III
24. A. DATE(S) OF SERVICE From MM DD YY MM I	To Place of DD YY SERMOE I I	EMG CPT/HCF	EDURES, SERVI	matanoes) MODIFIER	DIAGNOSIS POINTER  1  1  1  1  1  1  1  1  1  1  1  1  1	F. \$ CHARGES 250 00	120	NPI NPI NPI NPI NPI NPI OUNT PAID	RENDERIN PROVIDER I
24 A DATE(S) OF SERVIC MM DD YY MM DD YY MM DD YY MM DD	TO PRUCE OF DD YY SERMOE I	A435	EDURES, SERVI	matanoss) MODIFIER	DIAGNOSIS POINTER  1 1 EPT ASSIGNMENT? See 6560	F. \$ CHARGES 250 00	120	NPI NPI NPI NPI NPI NPI L NPI NPI L NPI NPI L NPI NPI L Amt	PROVIDER I
24 A DATE(S) OF SERVIC MM OD YY MM OD OD YY MAN OD YY MM OD YY MAN	TO PLUCE OF DD YY SERMICE IS  31 07 12   R SSN EIN  N OR SUPPLIER OREDENTIALS ON the reverse	A435	EDURES, SERVI ain Unusual Circ. OS	matanoss) MODIFIER	DIAGNOSIS POINTER  1 1 EPT ASSIGNMENT? See 6560	## \$ CHARGES  250 00	120 29 AM 0 STPI INFO & PH E Agency	NPI NPI NPI NPI NPI NPI NPI NPI API NPI NPI NPI NPI NPI NPI NPI NPI NPI N	PROVIDER I
24 A DATE(S) OF SERVICE MM FORM TO THE METERS OF SERVICE MM FORM TO THE METERS OF SERVICE MANAGEMENT OF THE METERS	TO PLUCE OF DD YY SERMICE IS  31 07 12   R SSN EIN  N OR SUPPLIER OREDENTIALS ON the reverse	A435	EDURES, SERVI ain Unusual Circ. OS	matanoss) MODIFIER	DIAGNOSIS POINTER  1 1 EPT ASSIGNMENT? See 6560	## \$ CHARGES  250 00	120   29. AM O STP! INFO & PH : Agency	NPI NPI NPI NPI NPI NPI NPI NPI API NPI NPI NPI NPI NPI NPI NPI NPI NPI N	PROVIDER I

#### SAMPLE CMS-1500 (08/05) FOR EPSDT HEALTH SERVICES

(Medicare #) X (Medicaid #)	TRICARE	CHAMPV	A GBO	JP TH PLAN =	FECA BLK LUN	OTHER					Pi (For Program in Ite
0.0000000000000000000000000000000000000	(Spansors SSN)		D#) (SSN	or ID)	(SSN)	(ID)	1234567				
2. PATIENT'S NAME (Last Name, 8 Smith, Johnny	rirst Name, Middle Initia	90)	3. PATIENT'S	8   97	MX	SEX F	4. INSURED'S NA	AE (Last Na	ime, Fin	st Name, Mi	ddle Initial)
5. PATIENT'S ADDRESS (No., Stre	eet)		6. PATIENT	_	Child NS		7. INSURED'S AD	RESS (No	. Street	)	
OITY		STATE	8. PATIENT	Spouse	Office	Other	CITY				STA
ZIP CODE	TELEPHONE (Include /	Area Code)	Single	Mar	ried	Other	ZIP CODE		TE	EPHONE (	Include Area Code
	( )	,	Employed	Full-T Stude		art-Time				(	)
9. OTHER INSURED'S NAME (Las	st Name, First Name, Mi	ddle Initial)	10. IS PATIE	NT'S COND	ITION RELA	TED TO:	11. INSURED'S PO	LICY GRO	UP OR	FECA NUM	BER
a. OTHER INSURED'S POLICY OF			a. EMPLOYN	MENT? (Our	rent or Previo	ous)	a. INSURED'S DA'	E OF BIRT	Н		SEX
(TPL info here if applic b. OTHER INSURED'S DATE OF B			b. AUTO ACC	YES DIDENT?	□ NC		b. EMPLOYER'S N	-		M	F
MM DD YY	M M	F		YES	□ NO	PLACE (State)					
o. EMPLOYER'S NAME OR SCHO	OL NAME		c. OTHER AC	YES	— □ NO	)	c. INSURANCE PL	AN NAME (	OR PRO	GRAM NAI	ME
d. INSURANCE PLAN NAME OR P	PROGRAM NAME		10d. RESER				d. IS THERE ANO	HER HEAL	TH BE	NEFIT PLAN	43
READ B	ACK OF FORM BEFOR	RE COMPLETING	S & SIGNING	HIS FORM			YES 13. INSURED'S OF	NO AUTHORI			and complete item
12. PATIENT'S OR AUTHORIZED I to process this claim. I also reque	PERSON'S SIGNATUR	E. Lauthorize the	release of any r	nedical or or	ther information	on necessary signment		tical benefit			d physician or sup
below.			DA	TE			SIGNED				
	LNESS (First symptom) IJURY (Accident) OR	OR 15.	IF PATIENT HA		ME OR SIMI	LAR ILLNESS.	16. DATES PATIEI	T UNABLE	JQ W	RK IN CUF	RENT OCCUPAT
17. NAME OF REFERRING PROVI	REGNANCY(LMP)					7 *	FROM	į		TO	
	.c.n on office 300	178	-++				18. HOSPITALIZAT	DD	YY	TO	MM DD
19. RESERVED FOR LOCAL USE			•				20. OUTSIDE LAB	_		\$ CHA	RGES
21. DIAGNOSIS OR NATURE OF I	ILLNESS OR INJURY (F	Relate Items 1, 2,	3 or 4 to Item 2	24E by Line)	_		22. MEDICAID RES	NO	N	ONA, 55-	
, 1 714 30		3.	L			*				GINAL REF	. NO.
							23. PRIOR AUTHO				
1.		4	1				(Prior Auth	# if app	olicat	le)	
2. L 24. A. DATE(S) OF SERVICE From To	PLACE OF	(Expli	DURES, SERV	cumstances	)	E. DIAGNOSIS	F.	DAY'S	H. EPS0	I.	J. RENDERI
2. L 24. A. DATE(S) OF SERVICE	PLACE OF	D. PROCE	DURES, SERV	/ICES, OR Soumstances MODIFI	)		F.		H. EPS0	I. ID. QUAL.	PROVIDER
2. L DATE(S) OF SERVICE From To	PLACE OF SERVICE E	D. PROCE	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F.	G DAYS OR UNITS	H. EPS0	I. ID. QUAL.	RENDERI PROVIDER 234567 234567890
2. L	PLACE OF SERVICE E	D. PROCE (Expli	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F. \$ CHARGES	G DAYS OR UNITS	H. EPS0	I. ID. QUAL.	234567
2. L	PLACE OF SERVICE E	D. PROCE (Expli	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F. \$ CHARGES	G DAYS OR UNITS	H. EPS0	I. ID. OUAL.	234567
2. L 24 A DATE(S) OF SERVICE From To MM DD YY MM DD 44 20 07 4 20	PLACE OF SERVICE E	D. PROCE (Expli	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F. \$ CHARGES	G DAYS OR UNITS	H. EPS0	I. ID. QUAL.	234567
2. L 24 A DATE(S) OF SERVICE From To MM DD YY MM DD 44 20 07 4 20	PLACE OF SERVICE E	D. PROCE (Expli	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F. \$ CHARGES	G DAYS OR UNITS	H. EPS0	I. ID. OUAL.	234567
2. L DATE(S) OF SERVICE From DD YY MM DD  4 20 07 4 20	PLACE OF SERVICE E	D. PROCE (Expli	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F. \$ CHARGES	G DAYS OR UNITS	H. EPS0	I ID. GUAL. NPI 1	234567
2. L 24 A DATE(S) OF SERVICE MM DD YY MM DD 4 20 07 4 20	PLACE OF SERVICE E	D. PROCE (Expli	DURES, SERV ain Unusual Cir CS	cumstances	)	DIAGNOSIS	F. \$ CHARGES	G DAYS OR UNITS	H. EPS0	I ID. OUAL IT ID. OUAL IT.	234567
2. L 24 A DATE(S) OF SERVICE From To	YY SERVICE E	D. PROCE (Expline) MG P7003	DURES, SERV ain Unusual Cin CCS	MODIFI	) ER	DIAGNOSIS POINTER  1	F. \$ CHARGES	O 1	H. EPSON EPSON Plan	NPI NPI	234567
2. L 24 A DATE(S) OF SERVICE MM DD YY MM DD  4 20 07 4 20	D YY SERVICE EI	D. PROCE (Explination of the control	IDURES, SERVI ON THE SERVICE OF THE	MODIFI  27	ACCEPTASS For good data  VES	DIAGNOSIS	F. \$ CHARGES 56 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 1	H EPSOS Familia Plan	NPI TO NP	PROVIDER 234567 234567890
2. L 24 A DATE(S) OF SERVICE MM DD YY MM DD  4 20 07 4 20  4 20 07 4 20  5 FEDERAL TAX I D. NUMBER  31. SIGNATURE OF PHYSICIAN C INCLUDING DEGREES OR OR	SSN EIN SSN EIN SSN EID SOR SUPPLIER RECENTALS	D. PROCE (Expline) MG P7003	IDURES, SERVI ON THE SERVICE OF THE	MODIFI  27	ACCEPTASS For good data  VES	DIAGNOSIS POINTER  1 SIGNMENT'S Leeb bad	F. \$ CHARGES \$ 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	DANS DANS DANS DANS DANS DANS DANS DANS	H EPSOS Frank Plan Plan Plan Plan Plan Plan Plan Plan	NPI TO NP	234567 234567 234567890
2. L 24 A DATE(S) OF SERVICE FROM DD YY MM DD  4 20 07 4 20  25 FEDERAL TAX I D. NUMBER  31 SIGNATURE OF PHYSICIAN C	SSN EIN  SSN SUPPLIER REDENTIALS	D. PROCE (Explination of the control	IDURES, SERVI ON THE SERVICE OF THE	MODIFI  27	ACCEPTASS For good data  VES	DIAGNOSIS POINTER  1 SIGNMENT'S Leeb bad	F. \$ CHARGES 56 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	DAY	H EPSOS Frank Plan Plan Plan Plan Plan Plan Plan Plan	NPI TO NP	234567 234567 234567890
2. L DATE(S) OF SERVICE From DD YY MM DD  4 20 07 4 20  25 FEDERAL TAX I D NUMBER  31 SIGNATURE OF PHYSICIAN C INCLUDING DEGREES OR OR (I Centum the statements on	SSN EIN  SSN SUPPLIER REDENTIALS	D. PROCE (Explination of the control	IDURES, SERVI ON THE SERVICE OF THE	MODIFI  27  CION INFOR	ACCEPTASS For good data  VES	DIAGNOSIS POINTER  1 SIGNMENT'S Leeb bad	F. SCHARGES  56 0  28 TOTAL CHARGES  \$ 56  33 BILLING PROVABC School	DATE OF THE COLUMN TERMS O	H EPSON Frank	NPI TO NP	234567 234567 234567890

#### SAMPLE CMS-1500 (08/05) FOR PCS (EPSDT)

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05				PICA [T
1. MEDICARE MEDICAID TRICARE CHAMPUS	HAMPVA GROUP HEALTH PLAN	FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	(SSN or ID)  3. PATIENT'S BIRTH MM   DD	(SSN) (ID)	0001001235101 4. INSURED'S NAME (Last Name	, First Name, Middle Initial)
FRAN, LIONEL 5. PATIENT'S ADDRESS (No., Street)	05   18   8	8 M F	7. INSURED'S ADDRESS (No., S	tree1)
. Allen Caballes (III., Silvery	Self Spouse	Child Other	The state of the s	1100-17
CITY	STATE 8. PATIENT STATUS	Married Other	CITY	STATE
ZIP CODE TELEPHONE (Include Area Code	9)		ZIP CODE	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	Employed Stu	II-Time Part-Time Ident Student Student NDITION RELATED TO:	11. INSURED'S POLICY GROUP	OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (C		a. INSURED'S DATE OF BIRTH	M SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME OR SCH	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT		c. INSURANCE PLAN NAME OR	PROGRAM NAME
	YES			
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR	LOCAL USE	d. IS THERE ANOTHER HEALTH	BENEFIT PLAN?  f yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMP 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthor	rize the release of any medical or	r other information necessary	13. INSURED'S OR AUTHORIZED payment of medical benefits to	D PERSON'S SIGNATURE I authorize the undersigned physician or supplier for
to process this claim. I also request payment of government benefit below.	s either to myself or to the party	who accepts assignment	services described below.	
SIGNED	DATE		SIGNED	
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD: GIVE FIRST DATE M	SAME OR SIMILAR ILLNESS.	16. DATES PATIENT UNABLE JS	WORK IN CURRENT OCCUPATION TO DD VY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		18. HOSPITALIZATION DATES R	ELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE	17b. NPI		20. OUTSIDE LAB?	\$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Iter	na 1.2.3 or4 to Item 24F hv Li	ne)	YES NO 22. MEDICAID RESUBMISSION	
1 343 . 1	3	+	CODE	ORIGINAL REF. NO.
2.1	4.1		23. PRIOR AUTHORIZATION NU 400010022	MBER
2	PROCEDURES, SERVICES, O     (Explain Unusual Circumstance)			H. I. J.  EPSOT ID. RENDERING Plan OUAL PROVIDER ID. #
		DIFIER POINTER	\$ CHARGES UNITS	Pan QUAL PROVIDER ID. #
08   04   07   08   31   07   12       T	1019 EP	1	1133   44   448	NPI 1234567890
				NPI
	1			
				NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIE	ENT'S ACCOUNT NO. 2	7. ACCEPT ASSIGNMENT?		AMOUNT PAID 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERV	/ICE FACILITY LOCATION INF	YES NO ORMATION	\$ 1133   44   \$	\$ 1133   4
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse			A-1 PCS Provider	\ /
spply to this bill and are made a part thereof.)  Sharup Smith 09/01/07			Baton Rouge, LA	
Signed Date Date	NIDI b.		* 111111111 b	1111111

#### SAMPLE CMS-1500 (08/05) FOR PROFESSIONAL SERVICES

1. MEDICARE MEDICAID TRICARE	HAMPVA GROUP FECA OTHER	R 1a. INSURED'S I.D. NUMBER (For Program in
(Medicare #) (Medicald #) (Sponsor's SSN) (2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	fember ID#) (SSN or ID) (SSN) (ID)	1234567891234  4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Adalam, Mary	3. PATIENT'S BIRTH DATE SEX SEX 90 M F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED  Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY	STATE 8. PATIENT STATUS	OITY
ZIP CODE TELEPHONE (Include Area Co		ZIP CODE TELEPHONE (Include Area Co
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Init	Employed Student Part-Time Student Student II. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER  TPL carrier code if applicable	a. EMPLOYMENT? (Current or Previous)  YES NO	a. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
© EMPLOYER'S NAME OR SCHOOL NAME	o. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO  10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
DE AD DANK AS SANIA SECONDA		YES NO # yes, return to and complete ite
READ BACK OF FORM BEFORE CON 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I auth to process this claim. I also request payment of government bene	rize the release of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I aur payment of medical benefits to the undersigned physician or si services described below.</li> </ol>
below. SIGNED	DATE	SIGNED
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP
PREGNANCY(LMP)  17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. PCP Auth # if applicable	FROM TO  18. HOSPITALIZATION DATES RELATED TO CURRENT SERVI
	17b. NPI PCP NPI if applicable	FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate In	ms 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1. <u>V22</u> . <u>2</u>	3. L T	23. PRIOR AUTHORIZATION NUMBER
2. L	4. L PROCEDURES, SERVICES, OR SUPPLIES E.	
From To PLACE OF	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS PT/HCPCS MODIFIER POINTER	
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N45390509910 UN10 Proleukin		1234567
04 16 07 04 16 07	9015	125 00 1 NPI 09876543
		NPI
		NPI NPI
		NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PAT	ENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALA
	YES NO	s 190 00 s s
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	JICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (264) 555-00 Angel Giggles
apply to this bill and are made a part thereof.)		123 Smiley St.
Ima Biller 5/1/07  SIGNED DATE  8.	N P   b.	Sunny, LA 70000 a 1357901357
orane orane	g	APPROVED OMB-0938-0999 FORM CMS-1

#### SAMPLE CMS-1500 (08/05) FOR WAIVER SERVICES

(Medicare #) X (I	MEDICAID	TRICARE CHAMPUS	CHAMPV	THEA	UP LTH PLAN	FECA BLK LUN	NGOTHER				(For Program in Iter
Z. PATIENT O NAME (E		(Sponsor's SSN) ame, Middle Initial)	(Member E	3. PATIENT	(or ID)	(SSN)	SEX (ID)	695523154 4. INSURED'S NAME			Middle Initial)
JAYCO, 7					31   19	72 M	F	7. INSURED'S ADDRE	SS (No. S	tree fi	
	- (,			Self	Spouse	Child	Other		,,,,,,		
CITY			STATE	8. PATIENT Single	STATUS Mai	ried	Other	CITY			STAT
ZIP CODE	TELE	PHONE (Include Ar	ea Code)	Employed	Full-1		art-Time	ZIP CODE		TELEPHONE	E (Include Area Code)
9. OTHER INSURED'S	NAME (Last Nam	ie, First Name, Midd	fle Initial)	10. IS PATIE	0.000			11. INSURED'S POLIC	Y GROUP	OR FECA NU	JMBER
a. OTHER INSURED'S	POLICY OR GRO	OUP NUMBER		a. EMPLOYI				a. INSURED'S DATE (	OF BIRTH		SEX
b. OTHER INSURED'S MM , DD , Y	DATE OF BIRTH	SEX		b. AUTO AC	YES CIDENT?	NO	PLACE (State)	b. EMPLOYER'S NAM	E OR SCH	OOL NAME	F
c. EMPLOYER'S NAME		M F		c. OTHER A	YES	NO		c. INSURANCE PLAN	NAME OF	PROGRAM N	IAME
					YES	NC					
d. INSURANCE PLAN N	IAME OR PROGI	HAM NAME		10d. RESER	VED FOR L	OCAL USE		d. IS THERE ANOTHE			AN? o and complete item 9
12. PATIENT'S OR AUT to process this claim.	HORIZED PERS	OF FORM BEFORE ON'S SIGNATURE	Lauthorize the r	release of any	medical or o	her informati	ion necessary	13. INSURED'S OR AL payment of medical services described	i benefits to		SIGNATURE I authori ned physician or suppi
below.	, , , , , , , , , , , , , , , , , , , ,										
14. DATE OF CURREN	T: ILLNES:	S (First symptom) C (Accident) OR ANCY(LMP)	R 15.	IF PATIENT H		ME OR SIMI	ILAR ILLNESS.	SIGNED	JNABLE JS	WORK IN C	URRENT OCCUPATE
17. NAME OF REFERR					7116			FROM 18. HOSPITALIZATION	- 1	TO	
19. RESERVED FOR LO	OCAL USE		17b	NPI .				FROM 20. OUTSIDE LAB?	1 "	то	mm 1 00
19. NEOENVED I ON E	DONLOGE										
								YES	NO		INNUES
21. DIAGNOSIS OR NA	TURE OF ILLNE	SS OR INJURY (Re	late Items 1, 2,		24E by Line	_	+	YES 22. MEDICAID RESUB	RMISSION	ORIGINAL RI	
1, 351, 0	TURE OF ILLNE	SS OR INJURY (Re	3.	L	24E by Line	_	+	22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ	BMISSION	ORIGINAL RI	
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## RHC/FQHC SERVICES

CMS-1500 (08/05) Instructions

## CMS 1500 (08/05) INSTRUCTIONS FOR RHC/FQHC

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.  NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	Patient Status	Optional.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank.  If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at <a href="https://www.lamedicaid.com">www.lamedicaid.com</a> under the Forms/Files link).  Make sure the EOB or EOBs from other	
9b	Other Insured's Date of Birth	insurance(s) are attached to the claim.  Situational – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth	Situational – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.  In the following circumstances, entering the name of the appropriate physician is required:  If services are performed by a CRNA, enter the name of the directing physician.  If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.	
17a	Unlabelled	<b>Situational</b> – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is <b>required</b> to be entered.	The PCP's 7-digit referral authorization number must be entered in block 17a.

Locator #	Description	Instructions	Alerts
17b	NPI	Optional.	The revised form accommodates the entry of the referring provider's NPI.
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	Situational – Complete if appropriate or leave blank.  If the services being billed must be Prior Authorized, the PA number is required to be entered.	
24	Supplemental Information	Situational – Applies to the detail lines for drugs and biologicals only.  In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and shall be entered in the shaded section of 24A through 24G. Claims for these drugs shall include the NDC from the label of the product administered.  To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the NDC. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.	RHC/FQHCs who administer drugs and biologicals must enter this new drugrelated information in the SHADED section of 24A – 24G of appropriate detail lines only.  This information must be entered in addition to the

Locator #	Description	Instructions	Alerts
		then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.  The following qualifiers are to be used when reporting NDC units:	procedure code(s).
		F2 International Unit ML Milliliter GR Gram UN Unit	
24A	Date(s) of Service	Required Enter the date of service for each procedure.	
		Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> Enter the appropriate place of service code for the services rendered.	
24C	EMG	Situational – Complete if appropriate or leave blank.  If the CommunityCARE emergency indicator is needed, the indicator number ("3") is required to be entered.	This indicator was formerly entered in block 24I.
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered.  Enter the appropriate encounter procedure code on the first line.  Encounter Codes: RHC/FQHC encounter visit: T1015 RHC/FQHC obstetrical services: T1015 with modifier TH RHC/FQHC KIDMED services: T1015 with modifier EP  In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.	If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.

Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block.	
		More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	<b>Required</b> Enter usual and customary (U&C) charges <u>or</u> zero for detail lines.	
24G	Days or Units	<b>Required</b> Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	The revised form accommodates the entry of I.D. Qual.
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	The revised form accommodates the entry of NPIs for Rendering Providers
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

Locator #	Description	Instructions	Alerts
29	Amount Paid	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.	
		If TPL does not apply to the claim, leave blank.	
30	Balance Due	<b>Situational</b> – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Required The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computergenerated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	The revised form accommodates entry of the Service Location NPI.
32b	Unlabelled	Situational – Complete if appropriate or leave blank.  When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the Qualifier LU followed by the three digit site number. Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)	If PCP, enter Site Number and Qualifier of the service location.
33	Billing Provider Info & Ph #	<b>Required</b> Enter the provider name, address including zip code and telephone number.	

Locator #	Description	Instructions	Alerts
33a	NPI	Optional.	The revised form accommodates the entry of the Billing's Provider's NPI.
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number.	Format change with addition of 33a and 33b for provider numbers.

## SAMPLE CMS-1500 (08/05) FOR RHC/FQHC

MEDICARE MEDICAID TRICARE	CHAMPVA GR	OUP	FECA OTHER	1a. INSURED'S I.D. NUMBEI	P (For Program in It
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicare #) (Medicaid #) (Sponsor's SSN)	HE	OUP ALTH PLAN W or ID)	FECA BLK LUNG (SSN) (ID)	12345678912	34
PATIENT'S NAME (Last Name, First Name, Middle Initial)     Gardner, June		O4 170	M SEX F X	4. INSURED'S NAME (Last N	lame, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)		T RELATIONSHIP	TO INSURED	7. INSURED'S ADDRESS (N	o., Street)
CITY	STATE 8. PATIEN		other	CITY	STA
ZIP CODE TELEPHONE (Include Are	Singl a Code)	e Married	Other	ZIP CODE	TELEPHONE (Include Area Cod
( )	Employe	full-Time Student	Part-Time Student		( )
OTHER INSURED'S NAME (Last Name, First Name, Midd	e Initial) 10. IS PAT	ENT'S CONDITIO	ON RELATED TO:	11. INSURED'S POLICY GR	OUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLO	YMENT? (Current		a. INSURED'S DATE OF BIR	~
(TPL 6 Digit carrier code if applicable)  b. OTHER INSURED'S DATE OF BIRTH  SEX	b. AUTO A	OCIDENT?	NO PLACE (State)	b. EMPLOYER'S NAME OR :	M F
M F		YES	No L	c. INSURANCE PLAN NAME	
o. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER	ACCIDENT? YES	NO	G. INSUMANCE PLAN NAME	OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESE	RVED FOR LOCA	AL USE	d IS THERE ANOTHER HEA	
READ BACK OF FORM BEFORE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	COMPLETING & SIGNING	THIS FORM.	information necessary	13. INSURED'S OR AUTHOR	# yes, return to and complete item RIZED PERSON'S SIGNATURE I auth- its to the undersigned physician or sup
to process this claim. I also request payment of government below.	benefits either to myself or t	o the party who ac	cepts assignment	payment of medical benefices described below.	and an unitersigned physician of SUD
SIGNED		ATE		SIGNED	
14. DATE OF CURRENT: MM   DD   YY   ILLNESS (First symptom) O   INJURY (Accident) OR   PREGNANCY (LMP)	15. IF PATIENT GIVE FIRST	HAS HAD SAME DATE MM	OR SIMILAR ILLNESS.	16. DATES PATIENT UNABL	E TO WORK IN CURRENT OCCUPA:  TO DD DD
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		P Authoriz	ation#		ES RELATED TO CURRENT SERVICE
19 RESERVED FOR LOCAL USE	17b. NPI if a	pplicable		FROM 20. OUTSIDE LAB?	TO I
				YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Re	ate Items 1, 2, 3 or 4 to Iter	n 24E by Line)		22. MEDICAID RESUBMISSI CODE	ON ORIGINAL REF. NO.
1. 140, 0	3		'	23. PRIOR AUTHORIZATION	
2	4. L	PVICES OR SUP	PLIES E.	(Prior Auth # if ap	
From To PLACE OF MM DD YY SERVICE EMO	(Explain Unusual C		DIAGNOSIS POINTER	\$ CHARGES UN	
01 06 07 01 06 07 72	T1015	1 1	1	95 00 1	1234567 NPI 123456789
	1 1010	-		h 1 1	1234567
01   06   07   01   06   07   72	99213		1	0 00 1	NPI 1234567890 1234567
01 06 07 01 06 07 72	85025		1	0 00 1	NPI 123456789
N45390509910 UN10 Proleukin	J9015	1 1	1	0 00 1	1234567 NPI 1234567890
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					NP1
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25 FEDERAL TAX I D. NUMBER SSN EIN 26	PATIENT'S ACCOUNT N	O. 27. ACC	CEPT ASSIGNMENT? povt. daims, see back)	\$ 95 00	\$TPL Amt   \$
INCLUDING DEGREES OR CREDENTIALS	. SERVICE FACILITY LOC	ATION INFORMA	TION	33. BILLING PROVIDER INF	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)				200 Anywhere Stre	
oppry to this bill sets are made a part elevery				Central, LA	
7ed Johnson 1/7/07	KIPU	h		a 0987654321	b. 1333330

# KIDMED SERVICES

CMS-1500 (08/05) Instructions

## CMS 1500 (08/05) INSTRUCTIONS FOR KIDMED

Immunizations, laboratory tests, interperiodic screenings, consultations, and low level visits in conjunction with a KIDMED screening are billed on the CMS-1500 claim form.

CMS-1500 claim forms should be mailed to the following address for processing:

#### Unisys P.O. Box 91020 Baton Rouge, LA 70821

Certain items on the CMS-1500 are required, as noted in the Instructions column.

Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted by the provider.

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – <u>Insured's ID Number</u> - Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS, or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.  Note: If the ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.	
2	Patient's Name	Required – Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through the REVS, MEVS, or e-MEVS eligibility systems.	

Locator #	Description	Instructions	Alerts
3	Patient's Birth Date	Situational – Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, REVS, or e-MEVS using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero.	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address, or leave blank.	
6	Patient Relationship to Insured	Situational – Complete if appropriate, or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	Patient Status	Leave blank.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – Leave Blank; unless the recipient has other coverage. In that case, indicate the 6-digit TPL carrier code assigned by the state in this block (the carrier code list can be found at <a href="https://www.lamedicaid.com">www.lamedicaid.com</a> under the Forms/Files/User Guides link). Make sure to attach the EOB(s) from the other insurance(s) to the claim.	
9b	Other Insured's Date of Birth	Situational – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	Situational – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth	Situational – Complete if appropriate or leave blank.	
11b	Sex Employer's Name or	Situational – Complete if appropriate or leave blank.	
	School Name		
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Leave blank.	
15	If Patient Has Had Same or Similar Illness Give First Date	Leave blank.	

Locator #	Description	Instructions	Alerts
16	Dates Patient Unable to Work in Current Occupation	Leave blank.	
17	Name of Referring Provider or Other Source	Situational – If services are performed by a nurse practitioner or clinical nurse specialist, the name of the collaborating physician is <b>required</b> in this field. If the recipient is a lock-in recipient and has been referred to the billing provider for services, the lock-in physician's name is <b>required</b> here.	
17a	Unlabelled	<b>Situational</b> – If the recipient is linked to a PCP, the 7-digit Primary Care Physician referral authorization number is <b>required</b> to be entered. This information should be identical to item 9 on the KM3 form.	The PCP's 7-digit referral authorization number must be entered in block 17a.
17b	NPI	Optional. If the recipient is linked to a PCP, the 10-digit referring PCP's NPI number is entered here; however it is not required.	The revised form accommodates the entry of the referring provider's NPI.
18	Hospitalization Dates Related to Current Services	Leave blank.	
19	Reserved for Local Use	Leave blank.	Usage to be determined.
20	Outside Lab?	Leave blank.	
21	Diagnosis or Nature of Illness or Injury	Required Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.	
22	Medicaid Resubmission Code	Leave blank.	

Locator #	Description	Instructions	Alerts
23	Prior Authorization Number	Leave blank.	
24	Supplemental Information	Situational – Applies to the detail lines for drugs and biologicals only.  In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and shall be entered in the shaded section of 24A through 24G. Claims for these drugs shall include the NDC from the label of the product administered.  To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the NDC. Do not enter a space between the qualifier ad the NDC. Do not enter hyphens or spaces within the NDC.  Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.  The following qualifiers are to be used when reporting NDC units:  F2 International Unit ML Milliliter GR Gram UN Unit	Providers who administer drugs and biologicals must enter this new drugrelated information in the SHADED section of 24A – 24G of appropriate detail lines only.  This information must be entered in addition to the procedure code(s).
24A	Date(s) of Service	Required Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.	
24B	Place of Service	Required Enter the appropriate place of service code. Only 2 digit POS service codes are acceptable.	
24C	EMG	Situational – Complete if appropriate, or	This indicator

Locator #	Description	Instructions	Alerts
		leave blank. When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	was formerly entered in block 24I.
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s)	If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", "3", or "4").	
		More than one diagnosis/reference number may be related to a single procedure. Do not enter an ICD-9-CM diagnosis code in this item.	
24F	\$Charges	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	The revised form accommodates the entry of I.D. Qual.
24J	Rendering Provider I.D. #	Situational – Complete if appropriate, or leave blank.  If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	The revised form accommodates the entry of NPIs for Rendering Providers
25	Federal Tax I.D. Number	Leave blank.	

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	Optional – Enter the recipient's medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Leave blank.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – Leave this space blank unless payment has been made by a third party insurer. If such payment has been made, indicate the amount paid.	
30	Balance Due	Situational – If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Required The claim form MUST be signed. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. If this item is left blank, or if the stamped or computer-generated signature does has not been initialed in handwriting, the claim will be returned unprocessed.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	The revised form accommodates entry of the Service Location NPI.

Locator #	Description	Instructions	Alerts
32b	Unlabelled	Situational. Complete if appropriate, or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the Qualifier LU followed by the three digit site number. Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)	If PCP, enter Site Number and Qualifier of the service location.
33	Billing Provider Info & Ph #	<b>Required</b> Enter the provider name, address including zip code and telephone number.	
33a	NPI	<b>Optional.</b> Enter the billing provider's 10-digit NPI number.	The revised form accommodates the entry of the Billing's Provider's NPI.
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number.	Format change with addition of 33a and 33b for provider numbers.

# SAMPLE CMS-1500 (08/05) FOR KIDMED

(Medicare #) (Medicald #) CHAMPUS (Sponsor's SSN) (Memb	PVA GROUP FECA OTHER	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Memb	er (D#) (SSN or ID) (SSN) (ID)  3. PATIENT'S BIRTH DATE SEX	9752432916523 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Jenkins, Claire	05   01   06 ML F	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED  Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
ITY STA	] 0	CITY
IP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Co
OTHER INSURED'S NAME (Last Name, First Name, Middle Inital)	Employed Student Stude	11. INSURED'S POLICY GROUP OR FECA NUMBER
	IN IN PATIENTS CONDITION REDATED TO	T. MOONED OF OLD TANGET ON TECK HOWELT
OTHER INSURED'S POLICY OR GROUP NUMBER TPL carrier code if applicable	a. EMPLOYMENT? (Current or Previous)  YES NO	a. INSURED'S DATE OF BIRTH SEX
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
EMPLOYER'S NAME OR SCHOOL NAME	o, OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OF PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO # yes. return to and complete iter
READ BACK OF FORM BEFORE COMPLET 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE L'authorize	he release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I auth payment of medical benefits to the undersigned physician or su
to process this claim. I also request payment of government benefits eit below.	her to myself or to the party who accepts assignment	services described below.
SIGNED	DATE	SIGNED
4. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANOY(LMP)	IS. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.  GIVE FIRST DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP, FROM DD TO TO TO TO TO TO THE TOTAL THE TOTAL TO THE TOTAL
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	PCP Auth # if applicable	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVE
9. RESERVED FOR LOCAL USE	PCP NPI # if applicable	FROM TO TO 20. OUTSIDE LAB? \$ CHARGES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1)	2. 9 or 4 to Hom 24E by Lines	YES NO
V20 2	3	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER (Prior Auth # if applicable)
	4. L CEDURES, SERVICES, OR SUPPLIES (plain Unusual Circumstances)  E. DIAGNOSIS	F. G. H. L. J.
	CPCS   MODIFIER POINTER	
05 01 07   05 01 07   11   904	71 1	12 00 1 NPI 998877665
05 01 07   05   01   07   11   907	13     1	0 00 1 NPI 998877665
		NPI
		NPI
		NPI NPI
5. FEDERAL TAX I D. NUMBER SSN EIN 26. PATIENT	S ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALAI
	YES NO FACILITY LOCATION INFORMATION	\$ 12 00 s s
A SIGNATURE OF DHYSIOIAN OF SUPPLIED AS ACCURA	FAULU I LOUATION INFORMATION	33. BILLING PROVIDER INFO & PH# (264) 555-000 Angel Giggles
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		I .
INCLUDING DEGREES OR CREDENTIALS		123 Smiley St. Sunny, LA 70000

# LIST OF FIELD ANALYSTS

FIELD ANALYST	PARISHES SERVED				
<b>Kellie Conforto</b> (225) 216-6269	Jefferson Orleans Plaquemines	St. Bernard St. Tammany (Slidell Only)			
<b>Stacey Fairchild</b> (225) 216-6267	Ascension Assumption Calcasieu Cameron Jeff Davis Lafourche St. Charles	St. James St. John St. Martin (below Iberia) St. Mary Terrebonne Vermillion Beaumont (TX)			
<b>Tracey Guidroz</b> (225) 216-6201	West Baton Rouge Iberville Tangipahoa St. Tammany (except Slidell)	Washington Centerville (MS) McComb (MS) Woodville (MS)			
<b>Ursula Mercer</b> (225) 216-6273	Bienville Bossier Caddo Caldwell Claiborne Catahoula Concordia East Carroll Franklin Jackson	LaSalle Lincoln Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Vicksburg (MS) Marshall (TX)			
<b>Kelli Nolan</b> (225) 216-6260	East Baton Rouge East Feliciana Livingston	Pointe Coupee St. Helena West Feliciana			
<b>LaQuanta Robinson</b> (225) 216-6249	Acadia Allen Evangeline Iberia	Lafayette St. Landry St. Martin <b>(above Iberia)</b>			
Sherry Wilkerson (225) 216-6306	Avoyelles Beauregard DeSoto Grant Natchitoches Rapides	Red River Sabine Vernon Winn Jasper (TX) Natchez (MS)			

## **HOW DID WE DO?**

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us**.

Location of Seminar (City):\_\_\_\_\_

FACILITY	Poor				Excellen
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT					
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES					
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Reps provided effective response to question	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION:					
Do you have internet access in the workplace?  Do you use <a href="www.lamedicaid.com">www.lamedicaid.com</a> ?  What topic was most beneficial to you?  Please provide us with your business email address:  Please specify your Provider Number so we can cross reference  Please provide constructive comments and suggestions:	it with your	email add	ress:		

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040

Seminar Date: