STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 8, 1997

Dear Administrator:

This letter serves as a notice to health care billing operations concerning services rendered in Article 28 Hospitals, Comprehensive Diagnostic and Treatment Centers, Freestanding Ambulatory Surgery Centers and Article 5 Licensed Laboratories which are transmitted via NSF or HCFA 1500 format. Certain services are now subject to surcharges as part of New York's Health Care Reform Act (HCRA) of 1996.

If you are responsible for billing third-party payors for these services, it is important that you read the enclosed materials and instructions. This notice may be disregarded for discrete physician practice or faculty practice plan billings performed for private practicing physicians.

In order to administer these surcharges, new rules and data specifications had to be established for billing both paper and electronic media claims. The enclosed packet contains those rules and data specifications.

If your facility provides or bills for these services, please pass this information along to the people responsible for those billings. If you have technical questions regarding these new billing rules, please contact the Bureau of Health Economics at (518) 473-8822.

Sincerely,

Mark H. Van Gieson

for Robert W. Barnett
Assistant Director
Division of Health Care Financing

Enclosure

Notice to health care billing operations concerning:

SERVICES RENDERED IN:

ARTICLE 28 HOSPITALS

ARTICLE 28 COMPREHENSIVE DIAGNOSTIC AND TREATMENT CENTERS

ARTICLE 28 FREESTANDING AMBULATORY SURGICAL CENTERS

AND

ARTICLE 5 LICENSED LABORATORIES

These services are now subject to surcharge as part of the Health Care Reform Act (HCRA) of 1996. If you are responsible for the billing of third-party payors for these services, it is important that you read the enclosed materials.

Calculation and administration of these surcharges may require that additional pieces of information be included on the bill, whether in electronic format or on paper. The enclosed instructions explain this additional information and the rules regarding inclusion in the bill.

The enclosed rules apply to claims for surchargeable services submitted using the NSF electronic format or the HCFA 1500 paper format. If you bill for surcharge services using other billing formats, these instructions are not applicable to your operation.

* **If your organization does not perform or bill for these services, you may disregard this notice. This notice may also be disregarded for discrete physician practice or faculty practice plan billing performed for <u>private practicing physicians</u>.**

BILLING INSTRUCTIONS

NYHCRA ASSESSMENTS AND ADJUSTMENTS

PROFESSIONAL PROVIDERS - ELECTRONIC UDS NATIONAL STANDARD FORMAT (NSF) 2.0 OR PAPER HCFA 1500

NOTE: THE FOLLOWING THREE FIELDS (APPEARING IN CAPS) MUST BE COMPLETED:

GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT APPLICABLE - WILL APPEAR IN THE ELECTRONIC UDS IN RECORD TYPE DA1, FIELD 26, OR ON THE PAPER HCFA 1500 IN BLOCK 24 D CPT/HCPCS, LINE 6

Field used to identify whether all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment.

The New York Health Care Reform Act (NYHCRA) of 1996 established two pools to fund indigent care and health care initiatives. Third-party payers make an election to pay amounts for these two initiatives directly to the pool administrator.

Certain claims are exempt from application of the General Hospital Indigent Care/Health Care Initiatives Assessment. For example, Medicare, CHAMPUS, CHAMPVA, Veterans Department, Black Lung, Federal Employees Health Benefit Plan, Home Health, Residential Health Care Facilities, Hospice Facilities, and physicians in private practice.

The Yes code indicates that all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment. Services need to be separated between those subject to the Assessment and those not subject to the Assessment.

The No code indicates that none of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment.

GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT PERCENT - WILL APPEAR IN THE ELECTRONIC UDS IN RECORD TYPE DA1, FIELD 27, OR ON THE PAPER HCFA 1500 IN BLOCK 24 D MODIFIER, LINE 6

When all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment, this field indicates the applicable percentage.

For payers making an election to pay the General Hospital Indigent Care/Health Care Initiatives Assessment directly to the assigned pool administrator, the following percentages and instructions apply:

00.00% The General Hospital Indigent Care/Health Care Initiatives Assessment Applicable (Record Type DA1, field 26 or Block 24 D CPT/HCPCS) indicates that the assessment is applicable. The provider has not indicated the assessment percent in this record type, has not included any assessment amount in Record Type DA1, field 24 or Block 28 Total Charge. However, the payer is not relieved of its obligation to pay the assessment at the appropriate rate (08.18% or 05.98% for Medicaid) directly to the pool administrator.

05.98% State Government Agencies; Health Maintenance Organizations for Medicaid Patients and Prepaid Health Service Plans; and Local Governments for Correctional Facility Inmates are responsible for payment of the General Hospital Indigent Care/Health Care Initiatives Assessment at this rate. The dollar amount of this assessment (Record Type DA1, field 28 or Block 24 F Charges) is included in the Balance Due (Record Type DA1, field 24 or Block 28 Total Charge). This percentage should appear only when the provider has submitted the Provider Election Form For Medicaid Withholding (Attachment 6 in the November 4 letter), but has elected to include the assessment in the Balance Due.

08.18% Payers pursuant to the New York State Workers' Compensation Law; Volunteer Firefighters' Benefits Law; Ambulance Workers' Benefit Law; Comprehensive Motor Vehicle Insurance Reparations Act; Insurance Law Article 43 Corporations; New York State Licensed Commercial Insurers; Health Maintenance Organizations (non-Medicaid); and Self-Insured Plans are responsible for payment of the General Hospital Indigent Care/Health Care Initiatives Assessment at this rate. The dollar amount of this assessment (Record Type DA1, field 28 or Block 24 F Charges) is included in the Balance Due (Record Type DA1, field 24 or Block 28 Total Charges).

Certain payers choosing to pay into these pools through encounter payments (point-of-service) are subject to an additional 24 percent surcharge.

For payers not making an election to pay these assessment amounts for the General Hospital Indigent Care/Health Care Initiatives Assessment directly to the assigned pool administrator, the following instructions apply:

00.00% The General Hospital Indigent Care/Health Care Initiatives Assessment Applicable (Record Type DA1, field 26 or Block 24 D CPT/HCPCS) indicates that the assessment is applicable. The provider has not indicated the assessment percent in this record type, has not included any assessment amount in Record Type DA1, field 28 or Block 24 F Charges (General Hospital Indigent Care/Health Care Initiatives Assessment Amount) and has not included any assessment amount in the Balance Due (Record Type DA1, field 24 or Block 28 Total Charges). However, the payer is not relieved of its obligation to pay the assessment at the appropriate rate (32.18% or 05.98% for Medicaid) directly to the provider.

05.98% State Government Agencies; Health Maintenance Organizations for Medicaid Patients and Prepaid Health Service Plans; and Local Governments for Correctional Facility Inmates are responsible for payment of the General Hospital Indigent Care/Health Care Initiatives Assessment at this rate. The dollar of this assessment (Record Type DA1, field 28 or Block 24 F Charges) is included in the Balance Due (Record Type DA1, field 24 or Block 28 Total Charges). This percentage and amount should appear only when the provider has submitted the Provider Election Form For Medicaid Withholding (Attachment 6 in the November 4 letter), but has elected to include the assessment in the Balance Due.

32.18% Payers pursuant to the New York State Workers' Compensation Law; Volunteer Firefighters' Benefit Law; Ambulance Workers' Benefit Law; Comprehensive Motor Vehicle Insurance Reparations Act; Insurance Law Article 43 Corporations; New York State Licensed Commercial Insurers; Health Maintenance Organizations (non-Medicaid); and Self-Insured Funds are responsible for payment of the General Hospital Indigent Care/Health Care Initiatives Assessment at this rate. The dollar amount of this assessment (Record Type DA1, field 28 or Block 24 F Charges) is included in the Balance Due (Record Type DA1, field 24 or Block 28 Total Charges).

GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT AMOUNT - WILL APPEAR IN THE ELECTRONIC UDS IN RECORD TYPE DA1, FIELD 28, OR ON THE PAPER HCFA 1500 IN BLOCK 24 F CHARGES, LINE 6

When all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment, this field contains the dollar amount of the assessment calculated at the percentage from DA1, field 27 or Block 24 D Modifier. The Assessment Amount indicated in this field is included in the Balance Due (Record Type DA1, field 24 or Block 28 Total Charges).

NEW YORK STATE

UNIVERSAL DATA SET

PROFESSIONAL SERVICES

ELECTRONIC SPECIFICATIONS

INSURANCE INFORMATION RECORD - PAYOR DATA 2 RECORD TYPE DA1

FORMAT RULES:

Must be preceded by Record Type DA0.

Must be followed by Record Type DA0, DA2, or EA0.

PURPOSE: To supply additional information for identifying the payor and/or to provide prior adjudication status information from primary payors.

When requesting payment from a secondary payor it is extremely important that the Explanation Of Benefits/remittance information be provided from the primary payor(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy Explanation Of Benefits.

REQUIREMENTS: When filing 'secondary' claims a "DA1" record is required for every payor who has received and/or processed the claim prior to this submission.

	RECORD TYPE/ FIELD	FORMAT	JUST-IFY	LENGTH	RECORD POSITIONS
Record Indicator "DA1"	DA1-01	Alpha-Numeric	Left	3	1- 3
Sequence Number	DA1-02	Alpha-Numeric	Left	2	4- 5
Patient Control Number	DA1-03	Alpha-Numeric	Left	17	6- 22
Payor Information:					
Street Address 1	DA1-04	Alpha-Numeric	Left	30	23- 52
Street Address 2	DA1-05	Alpha-Numeric	Left	30	53- 82
City	DA1-06	Alpha-Numeric	Left	20	83-102
State	DA1-07	Alpha-Numeric	Left	2	103-104
ZIP Code:					
US Postal ZIP:					
5 Digit ZIP	DA1-08A	Alpha-Numeric	Left	5	105-109
Plus 4 Digit ZIP	DA1-08B	Alpha-Numeric	Left	4	110-113
Canadian Postal ZIP	DA1-08C	Alpha-Numeric	Left	9	105-113
Disallowed Cost Containment Amount	DA1-09	Numeric	Right	7	114-120
Disallowed Other Amount	DA1-10	Numeric	Right	7	121-127

Allowed Amount	DA1-11	Numeric	Right	7	128-134
Deductible Amount	DA1-12	Numeric	Right	7	135-141.
Coinsurance Amount	DA1-13	Numeric	Right	7	142-148
Payor Amount Paid	DA1-14	Numeric	Right	7	149-155
Zero Payment Indicator	DA1-15	Alpha-Numeric	Left	1	156-156
Adjudication Indicator 1	DA1-16	Alpha-Numeric	Left	2	157-158
Adjudication Indicator 2	DA1-17	Alpha-Numeric	Left	2	159-160
Adjudication Indicator 3	DA1-18	Alpha-Numeric	Left	2	161-162
CHAMPUS Information:					
Sponsor Branch	DA1-19	Alpha-Numeric	Left	1	163-163
Sponsor Grade	DA1-20	Alpha-Numeric	Left	2	164-165
Sponsor Status	DA1-21	Alpha-Numeric	Left	1	166-166
Insurance Card:					
Effective Date (MMDDCCYY)	DA1-22	Alpha-Numeric	Left	8	167-174
Termination Date (MMDDCCYY)	DA1-23	Alpha-Numeric	Left	8	175-182
Balance Due	DA1-24	Numeric	Right	7	183-189
National Use Filler	DA1-25	Alpha-Numeric	Left	63	190-252
NYHCRA General Hospital Indigent Care/Health Care Initiatives Assessment Applicable	DA1-26	Alpha-Numeric	Left	1	253-253
General Hospital Indigent Care/ Health Care Initiatives Assessment Percent	DA1-27	Numeric	Right	4	254-257
General Hospital Indigent Care/ Health Care Initiatives Assessment Amount	DA1-28	Numeric	Rigth	7	258-264
State Use Filler	DA1-29	Alpha-Numeric	Left	56	265-320

PROVIDER BILLING FIELDS:

All Except 25, 29

DEFINITIONS:

RECORD IDENTIFIER "DA1" - FIELD DA1-01

Field used to identify the "Insurance Information - Payor Data 2" record. Must be "DA1". A claim may have up to three "DA1" records. Each must have a corresponding "DA0" record. Multiple "DA1" records must have corresponding "DA0" records. The records are 'matched' by "Sequence Number" (DA0-02 and DA1-02).

SEQUENCE NUMBER - FIELD DA1-02

A numeric value from 01 through 03 used to sequence the "DA1" records and to associate "DA1" records with "DA0" and "DA2" records. The value entered must match the "Sequence Number" (DA0-02) submitted in the preceding "DA0" record.

NOTE: For New York State reporting purposes, up to six sequences are permitted to accommodate up to six payors of the claim.

PATIENT CONTROL NUMBER - FIELD DA1-03

An identification assigned to the patient by the provider to identify the patient. The patient control number is used by the Electronic Media Claim system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number. Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents. Must be identical to the "Patient Control Number" (CA0-03) of this claim.

PAYOR ADDRESS LINE 1 - FIELD DA1-04
PAYOR ADDRESS LINE 2 - FIELD DA1-05
PAYOR CITY - FIELD DA1-06
PAYOR STATE - FIELD DA1-07
PAYOR ZIP CODE - FIELD DA1-08

Payor's claim mailing address for this particular payor identification and claims office.

DISALLOWED COST CONTAINMENT AMOUNT - FIELD DA1-09

The amount disallowed by the payor due to the failure of either the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract, or Preferred Provider Organization contract under which payment had been requested for this claim. Must be a positive, unsigned numeric value. Under some state (federal?) Coordination of Benefit statutes and regulations, secondary payors do not have any liability for amounts disallowed by the primary payor because of the failure of the provider or insured to fulfill a cost containment provision under the primary contract.

DISALLOWED OTHER AMOUNT - FIELD DA1-10

The mount disallowed by the payor for reasons OTHER than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract, or Preferred Provider Organization contract under which payment had been requested for this claim. Must be a positive, unsigned numeric value.

ALLOWED AMOUNT - FIELD DA1-11

The maximum amount determined by the payor as being "allowable" under the provisions of the contract prior to the determination of actual payment. Must be a positive, unsigned numeric value. This field may be used to report the total amount allowed on the claim for Medicare Secondary Payor submission purposes.

DEDUCTIBLE AMOUNT - FIELD DA1-12

The amount deducted, by the payor, from the allowed amount in order to meet the contract "deductible" provision. The amount applied toward the deductible by this payor. Must be a positive, unsigned numeric value. This field may be used to report the total amount of deductible on the claim for Medicare Secondary Payor submission purposes.

COINSURANCE AMOUNT - FIELD DA1-13

The amount deducted, by the payor, from the allowed amount in order to meet the "coinsurance" provisions of the contract. The amount applied toward the coinsurance by this payor. Must be a positive, unsigned numeric value. This field may be used to report the total amount of coinsurance on the claim for Medicare Secondary Payor submission purposes.

PAYOR AMOUNT PAID - FIELD DA1-14

The amount paid by the payor on this claim. Must be a positive, unsigned numeric value. This field may be used to report the total amount paid on the claim for Medicare Secondary Payor submission purposes.

ZERO PAYMENT INDICATOR - FIELD DA1-15

An indicator showing that:

1 the claim has been filed to the payor
2 that the payor has processed the claim and so informed the provider and
3 that the "Payor Paid Amount" (DA0-04) is the entire amount paid by the payor on this claim.

A payment of ZERO may be the result of the payor determining that they have no liability for the claim or that the entire liability was applied to deductibles and coinsurance. The purpose of this indicator is to allow payors to process secondary claims with zero payments by the primary payor without having to obtain an Explanation Of Benefits from the payor or insured. The provider is certifying that he has filed the claim to the indicated payor, the payor has processed the claim to completion, informed the provider of the results of that processing, and that the amount shown in "Payor Amount Paid" (DA1-14) is the actual amount that the payor paid on the claim.

ADJUDICATION INDICATOR 1 - FIELD DA1-16
ADJUDICATION INDICATOR 2 - FIELD DA1-17
ADJUDICATION INDICATOR 3 - FIELD DA1-18

Codes indicating the reason(s) why the payor denied or reduced benefits on this claim. Use all of the codes that apply, up to the maximum of three (3).

CHAMPUS SPONSOR BRANCH - FIELD DA1-19

CHAMPUS sponsor's military branch of service obtained from the military identification card. Required if the "Source Of Payment" (DA0-05) equals H (CHAMPUS) and the "Claim Filing Indicator" (DA0-04) is "P" (payment is being requested of this payor. "P" also indicates that a payment request is being made to only one payor).

CHAMPUS SPONSOR GRADE - FIELD DA1-20

CHAMPUS sponsor's military grade obtained form the military identification card. Required if the "Source Of Payment" (DA0-05) = H (CHAMPUS) and the "Claim Filing Indictor" (DA0-04) is "P" (payment is being requested of this payor. "P" also indicates that a payment request is being made to only one payor).

CHAMPUS SPONSOR STATUS - FIELD DA1-21

CHAMPUS sponsor's military status obtained form the military identification card. Required if the "Source Of Payment" (DA0-05) = H (CHAMPUS) and the "Claim Filing Indictor" (DA0-04) is "P" (payment is being requested of this payor. "P" also indicates that a payment request is being made to only one payor).

INSURANCE CARD EFFECTIVE DATE - FIELD DA1-22

The effective date is obtained from the insurance identification card. Required if the "Source Of Payment" (DA0-05) = H (CHAMPUS) and the "Claim Filing Indictor" (DA0-04) is "P" (payment is being requested of this payor. "P" also indicates that a payment request is being made to only one payor).

INSURANCE CARD TERMINATION DATE - FIELD DA1-23

The termination date is obtained form the insurance identification card. Required if the "Source Of Payment" (DA0-05) = H (CHAMPUS) and the "Claim Filing Indictor" (DA0-04) is "P" (payment is being requested of this payor. "P" also indicates that a payment request is being made to only one payor).

BALANCE DUE - FIELD DA1-24

Amount of total charges remaining if partial payment is made by the patient. If no balance remains, show zeros.

GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT APPLICABLE - FIELD DA1-26

Field used to identify whether all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment.

The New York Health Care Reform Act (NYHCRA) of 1996 established two pools to fund indigent care and health care initiatives. Third-party payers make an election to pay amounts for these two initiatives directly to the pool administrator.

Certain claims are exempt from application of the General Hospital Indigent Care/Health Care Initiatives Assessment. For example, Medicare, CHAMPUS, CHAMPVA, Veterans Department, Black Lung, Federal Employees Health Benefit Plan, Home Health, Residential Health Care Facilities, Hospice Facilities, and physicians in <u>private</u> practice.

The YES code indicates that <u>all</u> of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment. Services need to be separated between those subject to the Assessment and those not subject to the assessment.

The No code indicates that none of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment.

GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT PERCENT - FIELD DA1-27

When all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment, this field indicates the applicable percentage.

GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT AMOUNT - FIELD DA1-28

When all of the services on the claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment, this field contains the dollar amount of the assessment calculated at the percentage from DA1-27. The Assessment amount indicated in this field is included in the Balance Due (Record Type DA1-24).

CODE STRUCTURES:

CODE STRUCTURE - SEQUENCE NUMBER - FIELD DA1-02

01 Identifies the primary payor record.

02 Identifies the secondary payor record.

03 Identifies the tertiary payor record.

For New York State purposes:

04 Fourth Payor record

05 Fifth Payor record

06 Sixth Payor record

CODE STRUCTURE - PATIENT CONTROL NUMBER - FIELD DA1-03

First position must not be blank

May contain:

A - Z

0 - 9

Forward slash (/)

Period (.)

Comma (,)

Hyphen (-)

Number Sign (#)

Blank ( )

No other special characters are allowed.

CODE STRUCTURE - PAYOR ADDRESS LINE 1 - FIELD DA1-04
CODE STRUCTURE - PAYOR ADDRESS LINE 2 - FIELD DA1-05

Address 1 May not contain a blank in the first position.

Must contain at least one embedded blank.

May contain:

A - Z

0 - 9

Forward slash (/)

Period (.)

Comma (,)

Number sign (#)

Ampersand (&)

Parentheses ' ( ) '

Percent sign (%) - for: In Care Of

Blank ( )

No other special characters are allowed.

Address 2 If entered, may not contain a blank in the first position.

Must contain at least one embedded blank.

May contain:

A - Z

0 - 9

Forward slash (/)

Period (.)

Comma (,)

Number sign (#)

Ampersand (&)

Parentheses ' ( ) '

Percent sign (%) - for: In Care Of

Blank ( )

No other special characters are allowed.

CODE STRUCTURE - PAYOR CITY - FIELD DA1-06

First position must not be a blank.

May Contain:

A - Z

Period (.)

Comma (,)

Ampersand (&)

Blank ( )

No other special characters are allowed.

CODE STRUCTURE - PAYOR STATE - FIELD DA1-07

AL	Alabama	MT	Montana
Ak	Alaska	NE	Nebraska
AZ	Arizona	NV	Nevada
AR	Arkansas	NH	New Hampshire
CA	California	NJ	New Jersey
CO	Colorado	NM	New Mexico
CT	Connecticut	NY	New York
DE	Delaware	NC	North Carolina
DC	District Of Columbia	ND	North Dakota
FL	Florida	OH	Ohio
GA	Georgia	OK	Oklahoma
HI	Hawaii	OR	Oregon
ID	Idaho	PA	Pennsylvania
IL	Illinois	RI	Rhode Island
IN	Indiana	SC	South Carolina
IA	Iowa	SD	South Dakota
KS	Kansas	TN	Tennessee
KY	Kentucky	TX	Texas
LA	Louisiana	UT	Utah
ME	Maine	VT	Vermont
MD	Maryland	VA	Virginia
MA	Massachusetts	WA	Washington
MI	Michigan	WV	West Virginia
MN	Minnesota	WI	Wisconsin
MS	Mississippi	WY	Wyoming
MO	Missouri		

AS	American Samoa	FM	Micronesia
CZ	Canal Zone	PW	Palau
GU	Guam	PR	Puerto Rico
MP	Mariana Islands	VI	Virgin Islands
MH	Marshall Islands		

CN	Canada		
AB	Alberta	NS	Nova Scotia
BC	British Columbia	ON	Ontario
LB	Labrador	PE	Price Edward Island
MB	Manitoba	PQ	Quebec
NB	New Brunswick	SK	Saskatchewan
NF	NewFoundland	YT	Yukon
NT	Northwest Territories		

MX Mexico

FC All Other

CODE STRUCTURE - PAYOR ZIP CODE - FIELD DA1-08

Position 1-3 Must be a code from the table below

Position 4-5 Must be numeric

Position 6-9 Optional, but must be numeric if entered

If the State Code is a foreign country, ZIP Code is not required.

350-369	Alabama	590-599	Montana
995-999	Alaska	680-693	Nebraska
850-865	Arizona	890-898	Nevada
716-729	Arkansas	030-038	New Hampshire
900-966	California	070-089	New Jersey
800-816	Colorado	870-884	New Mexico
060-069	Connecticut	090-149	New York
197-199	Delaware	270-289	North Carolina
200-205	District Of Columbia	580-588	North Dakota
320-349	Florida	430-458	Ohio
300-319	Georgia	730-749	Oklahoma
967-968	Hawaii	970-979	Oregon
832-838	Idaho	150-196	Pennsylvania
600-629	Illinois	028-029	Rhode Island
460-479	Indiana	290-299	South Carolina
500-528	Iowa	570-577	South Dakota
660-679	Kansas	370-385	Tennessee
400-427	Kentucky	750-799	Texas
700-714	Louisiana	840-847	Utah
039-049	Maine	050-059	Vermont
206-219	Maryland	220-246	Virginia
010-027	Massachusetts	980-994	Washington
480-499	Michigan	247-268	West Virginia
550-567	Minnesota	530-549	Wisconsin
386-567	Mississippi	820-831	Wyoming
630-658	Missouri		
	American Samoa		Micronesia
	Canal Zone		Palau
969	Guam	006-009	Puerto Rico
	Mariana Islands	006-009	Virgin Islands
	Marshall Islands		

Canada

Alberta	Nova Scotia
British Columbia	Ontario
Labrador	Price Edward Island
Manitoba	Quebec
New Brunswick	Saskatchewan
NewFoundland	Yukon
Northwest Territories	

Mexico

All Other

CODE STRUCTURE - ZERO PAYMENT INDICATOR - FIELD DA1-15

Z	Zero Payment
N	Payment amount is greater than zero.
SPACE	Claim has not been filed or payment notification has not been received from this payor.

CODE STRUCTURE - ADJUDICATION INDICATOR 1 - FIELD DA1-16
CODE STRUCTURE - ADJUDICATION INDICATOR 2 - FIELD DA1-17
CODE STRUCTURE - ADJUDICATION INDICATOR 3 - FIELD DA1-18

01	Benefits exhausted
02	Non-covered benefits
03	Insured coverage lapsed or did not exist
04	Cost containment disallowed
05	Entire amount applied to deductible
06	Charges exceeded allowance

CODE STRUCTURE - CHAMPUS SPONSOR BRANCH - FIELD DA1-19

1	Army
2	Air Force
3	Marines
4	Navy
5	Coast Guard
6	Public Health Service
7	NOAA (National Oceanic & Atmospheric Administration)

CODE STRUCTURE - CHAMPUS SPONSOR GRADE - FIELD DA1-20

PAY GRADES OF COMMISSIONED OFFICERS

ARMY, AIR FORCE & MARINE CORPS RANKS	NAVY, COAST GUARD & ENVIRONMENTAL SERVICE ADM RANKS	PUBLIC HEALTH SERVICE RANKS	PAY GRADES
General,	Admiral		G1
Lieutenant General	Vice Admiral		09
Major General	Rear Admiral (Upper Half)	Surgeon General, Deputy Surgeon General, Assistant Surgeon General	08

Brigadier General	Rear Admiral (Lower Half) & Commodore	Assistant Surgeon General	07
Colonel	Captain	Director Grade	06
Lieutenant Colonel	Commander	Senior Grade	05
Major	Lieutenant Commander	Full Grade	04
Captain	Lieutenant	Senior Assistant Grade	03
First Lieutenant	Lieutenant (Junior Grade)	Assistant Grade	02
Second Lieutenant	Ensign	Junior Assistant Grade	01
Chief Warrant Officer	Chief Warrant Officer		W4
Chief Warrant Officer	Warrant Officer		W3
Chief Warrant Officer	Warrant Officer		W2
Warrant Officer	Warrant Officer		W1

CODE STRUCTURE - SPONSOR STATUS - FIELD DA1-21

1 Active military

2 Retired military

3 Deceased

CODE STRUCTURE - INSURANCE CARD EFFECTIVE DATE - FIELD DA1-22
CODE STRUCTURE - INSURANCE CARD TERMINATION DATE - FIELD DA1-23

Format: CCYYMMDD

CC Century - Must have a value of '19' or '20'. Exception: May have a value of '18', '19' or '20' for birth dates.

YY Year - Must have a value of '00' through '99'.

MM Month - Must have a value of '01' through '12'.

DD Day - Must have a value of '01' through '31' dependent on MM.

MM (month) value	DD (day) value
01, 03, 05, 07 08, 10, 12	01 through 31
04, 06, 09, 11	01 through 30

02	01 through 29 if YY is divisible by 4
02	01 through 28 if YY is not divisible by 4

CODE STRUCTURE - GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT APPLICABLE - FIELD DA1-26

Y Yes, all services on this claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment.

N None of the services on this claim are subject to the General Hospital Indigent Care/Health Care Initiatives Assessment.

CODE STRUCTURE - GENERAL HOSPITAL INDIGENT CARE/HEALTH CARE INITIATIVES ASSESSMENT PERCENT - FIELD DA1-27

For payers making an election to pay the General Hospital Indigent Care/Health Care Initiatives Assessment directly to the assigned pool administrator, the following percentages and instructions apply:

00.00% The General Hospital Indigent Care/Health Care Initiatives Assessment Applicable (Record Type DA1-26) indicates that the assessment is applicable. The provider has not indicated the assessment percent in this record type, has not included any assessment amount in Record Type DA1-28 (General Hospital Indigent Care/Health Care Initiatives Assessment Amount, and has not included any assessment amount in the Balance Due (Record Type DA1-24). However, the payer is not relieved of its obligation to pay the assessment at the appropriate rate (8.18% or 5.98% for Medicaid) directly to the pool administrator.

05.98% State Government Agencies; Health Maintenance Organizations for Medicaid Patients and Prepaid Health Service Plans; and Local Governments for Correctional Facility Inmates are responsible for payment of the assessment at this rate. The dollar amount of this assessment (Record Type DA1-28) is included in the Balance Due (Record Type DA1-24). This percentage should appear only when the provider has submitted the Provider Election Form For Medicaid Withholding (Attachment 6 in the November 4 letter), but has elected to include the assessment in the Balance Due.

08.18% Payers pursuant to the New York State Workers' Compensation Law; Volunteer Firefighters' Benefit Law; Ambulance Workers' Relief Law; Comprehensive Motor Vehicle Insurance Reparations Act; Insurance Law Article 43 Corporations; New York State Licensed Commercial Insurers; Health Maintenance Organizations (non-Medicaid); and Self-Insured Funds are responsible for payment of the assessment at this rate. The dollar amount of this assessment (Record Type DA1-28) is included in the Balance Due (Record Type DA1-24).

Certain payers choosing to pay into these pools through encounter payments (point-of-service) are subject to an additional 24 percent surcharge.

For payers not making an election to pay these assessment amounts for the General Hospital Indigent Care/Health Care Initiatives Assessment directly to the assigned pool administrator, (payment is made to the provider instead), the following instructions apply:

00.00% The General Hospital Indigent Care/Health Care Initiatives Assessment Applicable (Record Type DA1-26) indicates that the assessment is applicable. The provider has not indicated the assessment percent in this record type, has not included any assessment amount in Record Type DA1-28 (General Hospital Indigent Care/Health Care Initiatives Assessment Amount and has not included any assessment amount in the Balance Due (Record Type DA1-24). However, the payer is not relieved of its obligation to pay the assessment at the appropriate rate (32.18% or 5.98% for Medicaid), directly to the provider.

05.98% State Government Agencies; Health Maintenance Organizations for Medicaid Patients and Prepaid Health Service Plans; and Local Governments for Correctional Facility Inmates are responsible for payment of the assessment at this rate. The dollar amount of this assessment (Record Type DA1-28) is included in the Balance Due (Record Type DA1-24). This percentage should appear only when the provider has submitted the Provider Election Form For Medicaid Withholding (Attachment 6 in the November 4 letter), but has elected to include the assessment in the Balance Due.

32.18% Payers pursuant to the New York State Workers' Compensation Law; Volunteer Firefighters' Benefit Law; Ambulance Workers' relief Law; Comprehensive Motor Vehicle Insurance Reparations Act; Insurance Law Article 43 Corporations; New York State Licensed Commercial Insurers; Health Maintenance Organizations (non-Medicaid); and Self-Insured Funds are responsible for payment of the assessment at this rate. The dollar amount of this assessment (Record Type DA1-28) is included in the Balance Due (Record Type DA1-24).

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

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

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 Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

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

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION