Wisconsin Medicaid and BadgerCare update

June 2003 • No. 2003-39
PHC 1971

Wisconsin Medicaid and BadgerCare Information for Providers

To:
School-Based Services Providers
HMOs and Other Managed Care Programs

Changes to local codes and paper claims for school-based services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for school-based services (SBS), effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for school-based services (SBS). These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., documentation requirements), but include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

Note: Use of the newly adopted national codes and revised paper claim instructions prior to implementation dates may result in claim denials. Specific implementation dates will be published in a future *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local codes for school-based services.

Allowable procedure codes

Wisconsin Medicaid will adopt *Current Procedural Terminology* procedure codes and Healthcare Common Procedure Coding System procedure codes to replace currently used local procedure codes for school-based services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers will be required to use the appropriate procedure code that describes the service performed.

Modifiers

School-based services providers will be required to use nationally recognized modifiers when submitting claims. Previously, SBS

providers did not use modifiers when submitting claims for school-based services.

Modifiers are used to identify Individualized Education Programs and/or the type of service that was performed (e.g., physical therapy, social work). Providers will need to include the appropriate modifier(s) for each procedure code as indicated in Attachment 1. If more than one modifier is listed in the attachment, providers will be required to include **both** when submitting a claim or the claim detail line may be denied.

Type of service codes

Type of service codes will no longer be required on Medicaid claims.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently. The only allowable POS code for school-based services will be **"03" (school)**.

Diagnosis code

International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis code **999.9** (other and unspecified complications of medical care, not elsewhere classified) will replace local diagnosis code S11. Tuberculosis (TB)-related diagnosis codes will remain the same. Refer to the School-Based Services Handbook for more information regarding the TB-related services only benefit. Refer to Attachment 2 for a complete list of diagnosis codes.

Service units

The unit guidelines for nursing services under the SBS benefit will change. One unit of service delivered as a **nursing service** under the SBS benefit will be equivalent to **15 minutes** of face-to-face time with the recipient (i.e., 15 minutes = 1 unit). (One unit of nursing services is currently equivalent to 10 minutes.) Reimbursement rates for nursing services will be adjusted to reflect the change. Refer to Attachment 3 for a complete table of unit guidelines.

Coverage for school-based services

Medicaid coverage and documentation requirements for SBS remain unchanged. Refer to the School-Based Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified SBS providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 is not being revised at this time. Refer to Attachment 4 for the revised instructions. Attachment 5 is a sample of a claim for school-based services that reflects the changes to the billing instructions.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the CMS 1500 claim form instructions

Revisions made to the CMS 1500 paper claim instructions include the following:

- Other insurance indicators were revised (Element 9).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes used currently.

- Up to four modifiers per procedure code may be entered (Element 24D).

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT 1
Procedure code conversion chart for school-based services

The following table lists the nationally recognized procedure codes that providers will be required to use when submitting claims for school-based services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation			After HIPAA implementation		
Service provided	**Local procedure code**	**Procedure code description**	**Replaced by procedure code***	**Procedure code description**	**Required modifier(s)**
Speech and language pathology, audiology, and hearing services	W6052	Speech, language, audiology and hearing service: face-to-face M-team assessment and IEP	**92506**	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	**TM** (Individualized education program [IEP])
	W6050	IEP speech, language, audiology and hearing service: Individual	**92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	**TM** (IEP)
	W6051	IEP speech, language, audiology and hearing service: Group	**92508**	group, two or more individuals	**TM** (IEP)
Occupational Therapy services	W6055	OT: face-to-face M-team assessment and IEP plan development	**97003**	Occupational therapy evaluation	**TM** (IEP)
	W6053	IEP OT service: Individual	**97110**	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**TM** (IEP) **GO** (Outpatient Occupational therapy)
	W6054	IEP OT service: Group	**97150**	Therapeutic procedure(s), group (2 or more individuals)	**TM** (IEP) **GO** (Occupational therapy)
Physical Therapy services	W6058	PT: face-to-face M-team assessment and IEP plan development	**97001**	Physical therapy evaluation (per 15 min)	**TM** (IEP)
	W6056	IEP PT service: Individual	**97110**	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**TM** (IEP) **GP** (Outpatient Physical therapy)
	W6057	IEP PT service: Group	**97150**	Therapeutic procedure(s), group (2 or more individuals)	**TM** (IEP) **GP** (Physical therapy)

* Procedure codes in the 90000 range are *Current Procedural Terminology* (CPT) codes. All others are Healthcare Common Procedure Coding System (HCPCS) codes.

Before HIPAA implementation			After HIPAA implementation		
Service provided	**Local procedure code**	**Procedure code description**	**Replaced by procedure code**	**Procedure code description**	**Required modifier(s)**
Psychological services	W6061	Psychological service: face-to-face M-team assessment and IEP plan development	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U1** (M-team assessment and IEP, psychological service)
	W6059	IEP psychological service: Individual	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U2** (Individual IEP, psychological service)
	W6060	IEP psychological service: Group	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U3** (Group IEP, psychological service)
Counseling services	W6064	Counseling: face-to-face M-team assessment and IEP plan development	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U4** (M-team assessment and IEP, counseling service)
	W6062	IEP counseling service: Individual	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U5** (Individual IEP, counseling service)
	W6063	IEP counseling service: Group	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U6** (Group IEP, counseling service)

Before HIPAA implementation			After HIPAA implementation		
Service provided	**Local procedure code**	**Procedure code description**	**Replaced by procedure code**	**Procedure code description**	**Required modifier(s)**
Social work services	W6067	Social work: face-to-face M-team assessment and IEP plan development	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U7** (M-team assessment and IEP, social work service)
	W6065	IEP social work service: Individual	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U8** (Individual IEP, social work service)
	W6066	IEP social work service: Group	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**U9** (Group IEP, social work service)
Nursing services	W6069	Nursing: face-to-face M-team assessment and IEP plan development	**T1001**	Nursing assessment/evaluation	**TM** (IEP)
	W6068	IEP nursing service: care and treatment	**T1002**	RN services, up to 15 minutes	**TM** (IEP)
			T1003	LPN/LVN services, up to 15 minutes	
M-Team assessment and IEP plan development by other school staff	W6070	Face-to-face M-team assessment and IEP plan development, Other staff	**T1024**	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (Short description: team evaluation & management)	**UA** (M-team assessment and IEP, other staff)
Durable medical equipment	W6072	Durable medical equipment	**E1399**	Durable medical equipment, miscellaneous	**TM** (IEP)
Special transportation services	W6074	SBS transportation daily base rate (first 20 miles included)	**T2003**	Non-emergency transportation; encounter/trip	**TM** (IEP)
	W6075	SBS transportation per mile rate (for miles over 20-mile base)	**A0425**	Ground mileage; per statue mile	**TM** (IEP)

ATTACHMENT 2
Diagnosis codes for school-based services

The following table lists the nationally recognized diagnosis codes that providers will be required to use when submitting claims for school-based services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Diagnosis code	**Description**
999.9	Other and unspecified complications of medical care, not elsewhere classified

Diagnosis code	**Description**
One of the following codes must be billed for nursing services related to tuberculosis (TB) for individuals with a "TR" medical status code.	
010-018.9	Primary TB infection Pulmonary TB Other respiratory TB Tuberculosis of meninges and central nervous system Tuberculosis of intestines, peritoneum, and mesenteric glands Tuberculosis of bones and joints Tuberculosis of genitourinary system Tuberculosis of other organs Miliary TB
137-137.4	Late effects of TB
771.2	Infections specific to the perinatal period; other congenital infections; congenital TB
795.5	Nonspecific abnormal histological and immunological findings; nonspecific reaction to tuberculin skin test without active TB
V01.1	Contact with or exposure to communicable diseases; TB
V12.01	Personal history of certain other diseases; infectious and parasitic diseases; TB
V71.2	Observation and evaluation for suspected conditions not found; observation for suspected TB
V72.5	Special investigations and examinations; radiological examination, not elsewhere classified
V74.1	Special screening examination for bacterial and spirochetal diseases; pulmonary TB

ATTACHMENT 3
Service units for school-based services

Listed below are the units of service providers will be required to use when submitting claims after Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers may bill fractional units of time for most services, except for durable medical equipment. Providers should round to the nearest whole or half unit. All time is for face-to-face services with the child present in the course of providing the service.

Service	Unit
• Audiology and hearing services • Counseling services • Nursing services • Occupational and physical therapy • Psychological services • Social work services • Speech and language pathology • IDEA assessment and Individualized Education Program development	15 minutes = 1 unit *face-to-face time with recipient only*
Durable medical equipment	1 piece of equipment = 1 unit
Nonemergency transportation; encounter/trip	1 day = 1 unit (includes first 20 miles)
Ground mileage, per statute mile	1 day = 1 unit (for miles over the 20-mile base)

ATTACHMENT 4
CMS 1500 claim form instructions for school-based services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Program Block/ Claim Sort Indicator

Enter claim sort indicator "M" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1994, would be 02/03/94) or in MM/DD/YYYY format (e.g., February 3, 1994, would be 02/03/1994). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address (not required)

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Refer to the Coordination of Benefits section of the School-Based Services Handbook for more information.

If the EVS indicates that the recipient has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number (not required)

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis code **999.9** (other and unspecified complications of medical care, not elsewhere classified) replaces local diagnosis code S11. Tuberculosis (TB)-related diagnosis codes remain the same. Refer to your School-Based Services Handbook for more information regarding the TB-related services only benefit. Refer to Attachment 2 of this *Update* for a complete list of diagnosis codes.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing **only** the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD). For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same family planning indicator, if applicable.

Element 24B — Place of Service

Enter place of service code "03" (school) for each service listed.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Example: Multiply the rate by the number of service units of school-based services for each line.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/ Family Plan (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice electronic transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

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

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, address, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 5

Sample CMS 1500 claim form for school-based services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

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

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. 999.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C 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 11 03 03	05 07	03		97110	TM GP	1	XX XX	6.0				
2 11 06 03		03		92506	TM	1	XX XX	1.5				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO. 1234JED

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

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
J.M. authorized MM/ DD/ YYYY
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 #
I.M. Billing
1 W. Williams
Anytown, WI 55555 12345678
PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)