TrailBlazer Health Enterprises

Education Makes the Difference

Part B Roster Billing Instructions for Mass Immunizers

Simplified Billing for Influenza and Pneumonia Vaccinations

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass pneumococcal and influenza virus vaccination programs offered by individuals and entities that give the vaccine to a group of beneficiaries.

Generally, providers will qualify to use the simplified process if they:

- Bill Medicare for flu and/or pneumonia vaccines for multiple beneficiaries.
- Agree to accept assignment for influenza and/or pneumonia vaccination claims. (When a provider accepts assignment, he may not collect any money from the beneficiary for the vaccination.)

Note: Only the CMS-approved paper simplified forms as shown in this publication will be accepted for claims processing. All other forms will be returned.

Please refer to the Flu and PPV Specialty Web page for information about current procedure codes and payment amounts.
http://www.trailblazerhealth.com/Specialty Services/Flu and PPV

Centralized Flu Billers: This packet is designed for mass immunizers who are not centralized flu billers. Centralized flu billers should refer to the “Criteria for Centralized Billing” job aid.
http://www.trailblazerhealth.com/Publications/Job Aid/Centralized Flu Biller.pdf

Flu Codes

90654©	Flu vaccine no preserv id
90655©	Flu vaccine no preserv 6-35m
90656©	Flu vaccine no preserv 3 & >
90657©	Flu vaccine, 6–35 mo, im
90660©	Influenza virus vaccine, live, for intranasal use
90662©	Flu vacc prsv free inc antig
Q2034	Agriflu (Effective October 1, 2012, for dates of service on or after July 1, 2012)
Q2035	Afluria
Q2036	Flulaval
Q2037	Fluvirin
Q2038	Fluzone
Q2039	Not Otherwise Specified (NOS) flu vaccine

TrailBlazer HEALTH ENTERPRISES, LLC

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

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© CDT codes and descriptions are copyright 2011 American Dental Association. All rights reserved. Applicable FARS/DFARS clauses apply.

Pneumococcal Pneumonia Vaccine (PPV) Codes

90669© Pneumococcal vacc 7 val im
90670© Pneumococcal vacc 13 val im
90732© Pneumococcal vaccine

Administration of the Vaccines

G0008 Administration of influenza virus vaccine
G0009 Administration of pneumococcal vaccine

Diagnosis Code

V0481 Influenza
V06.6 Pneumococcus and influenza

Note: Influenza vaccine claims with no diagnosis code will be rejected as unprocessable.

Completion of the CMS-1500 Claim Form

Providers must submit an original CMS-1500 claim form. Photocopies of the claim form are not acceptable. The following are the completion instructions for the CMS-1500 claim form for the influenza vaccine and PPV:

Item 1 An "X" in the Medicare block.
Item 2 (Patient's Name): "SEE ATTACHED ROSTER."
Item 11 (Insured's Policy Group or FECA Number): "NONE."
Item 20 (Outside Lab?): An "X" in the NO block.
Item 21 Enter the appropriate (influenza/pneumococcal vaccine) diagnosis code.
Item 24d Enter the appropriate influenza immunization procedure code.
Item 24f Enter the charge for the individual dose and the administration charge. **Do not** enter the total for all beneficiaries immunized.
Item 25 Enter the federal tax ID number.
Item 31 Enter the physician's signature or that of an authorized person in this block. A signature stamp may be used.
Item 32 Enter the name and complete address, including the ZIP code of the facility where the services were furnished.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA **Pneumococcal Pneumonia Vaccination Only** PICA

CARRIER

1. MEDICARE [X] (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): SEE ATTACHED FORMS

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: NONE

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

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V04 . 81
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1		60		G0008					NPI	
2		60		The provider must enter the appropriate influenza procedure code here.					NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $ 0 00

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. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

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

SAMPLE

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA **Pneumococcal Pneumonia Vaccination Only** PICA

1. MEDICARE [X] (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) 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): SEE ATTACHED FORMS

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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: NONE

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V03 . 82
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

SAMPLE

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1		60		G0009						NPI	
2		60		90732						NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $ 0 00

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. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

Completion of the Roster Form

Item	Description
Provider's Name/NPI	Enter the provider name and National Provider Identifier (NPI).
Patient's Medicare HIC Number	This is the beneficiary's Health Insurance Claim (HIC) number found on the beneficiary's Medicare card.
Patient's Name	This is the beneficiary's name found on the beneficiary's Medicare card.
Patient's Birth Date	Enter the beneficiary's birth date, if known. This will help identify the beneficiary if the HIC number is not correct.
Patient's Sex	Enter "F" for female or "M" for male.
Patient's Address	Enter the beneficiary's address.
Date Vaccine Administered	Enter the actual date the vaccine was administered.
Signature	Have the beneficiary sign the form, or a relative or agent if the beneficiary is unable to sign. A stamped "signature on file" is acceptable if the provider has a signed authorization on file to bill Medicare for services rendered.

Note: Roster forms may be reproduced from this publication.

INFLUENZA VACCINE ROSTER FOR MASS IMMUNIZERS

Provider Name ____Provider National Provider Identifier ___________________

For Internal Medicare Use Only. Do not write in the shaded areas –

PLEASE TYPE OR PRINT CLEARLY

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City ST/ZIP	Patient's Signature and *Date Vaccine Administered*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

For Internal Medicare Use Only. Do not write in the shaded areas –

PLEASE TYPE OR PRINT CLEARLY

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City ST/ZIP	Patient's Signature and *Date Vaccine Administered*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

PNEUMONIA VACCINE ROSTER FOR MASS IMMUNIZERS

Provider Name ____ Provider National Provider Identifier __________________

For Internal Medicare Use Only. Do not write in the shaded areas –

PLEASE TYPE OR PRINT CLEARLY

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City ST/ZIP	Patient's Signature and *Date Vaccine Administered*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

For Internal Medicare Use Only. Do not write in the shaded areas –

PLEASE TYPE OR PRINT CLEARLY

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City ST/ZIP	Patient's Signature and *Date Vaccine Administered*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Claims Filing Requirements

Send the paper simplified billing claims for the influenza virus vaccine to the following special post office box:

Influenza Special Claims
P.O. Box 660157
Dallas, TX 75266-0157

Send the paper simplified billing claims for PPV to the following special post office box:

Pneumococcal Special Claims
P.O. Box 660157
Dallas, TX 75266-0157

Put one CMS-1500 claim form with each group of influenza vaccine or PPV record forms (up to 100) and group these together (e.g., rubber band, etc.). Put one CMS-1500 claim form with five influenza or PPV roster forms and group these together. A stamped “signature on file” is acceptable on a simplified claim to qualify as an actual signature, provided that the provider has a signed authorization on file to bill Medicare for services rendered.

Note: The record **must** include the following information:

- Provider name and NPI.
- Date of service.
- Patient’s HIC number.
- Patient’s name.
- Patient’s address.
- Patient’s date of birth.
- Patient’s sex.

Electronic Billing

For providers who qualify for roster billing, Medicare offers free software that will enable them to submit these claims electronically. The PC-ACE Pro32 software is easy to use and will allow providers to take advantage of the 14-day payment floor. Providers qualifying as roster billers can contact the Electronic Data Interchange (EDI) Technology Support Center at (866) 749-4302 for information regarding the hardware and software requirements.

Roster billing of vaccinations is an exception to the mandatory electronic Medicare claims provision of the Health Insurance Portability and Accountability Act (HIPAA). Therefore, providers who submit their influenza vaccine and/or pneumococcal vaccine claims using the simplified roster bill may continue to submit the roster bill via paper after October 16, 2003.