



Washington State Department of
Labor & Industries
Workers' Compensation Services

CMS 1500 Billing Instructions

*Centers for Medicare and Medicaid Services
Formerly Health Care Finance Administration*

STATE OF WASHINGTON
DEPARTMENT OF LABOR & INDUSTRIES

CMS 1500 BILL FORM (F245-127-000)

BILLING INSTRUCTIONS

Ambulatory Surgery Center,
Anesthesiologist, Chiropractor, Hospital ER/Professional Services,
IME Services, Laboratories, Naturopath, Osteopathic Physician,
Outpatient Pain Management Program, Pathologist,
Physical Therapist, Physician, Physician Assistant, Physician Clinic,
Podiatric Physician, Psychologist, Radiologist

CMS 1500 BILL FORM BILLING INSTRUCTIONS

TABLE OF CONTENTS

PROVIDER ACCOUNT REQUIREMENTS	3
PROVIDER SPECIFIC INSTRUCTIONS.....	3
Ambulatory Surgery Center (ASC)	3
Anesthesiologist.....	3
Chiropractor	4
Hospital ER/Professional Services	4
Independent Medical Examination (IME) providers	5
Billing State Fund for IME services conducted WITHIN Washington State.....	5
Billing for IME services conducted OUTSIDE of Washington State	6
Laboratories	6
Naturopath.....	6
Osteopathic Physician.....	7
Outpatient Pain Management.....	7
Pathologist.....	7
Physical Therapist.....	7
Physician and Physician Clinics	7
Physician Assistant	8
Podiatric Physician.....	8
Psychologist.....	8
Radiologist.....	9
COMPLETING THE CMS 1500 FORM	10
CMS 1500 Bill Sample	14

PROVIDER ACCOUNT REQUIREMENTS

A provider must have an active L&I provider account number in order to treat Washington workers and receive payment for medical services. . Once the L&I provider account number is established, and the federally-issued National Provider Identifier (NPI) is registered with L&I, either number can be used on bills and correspondence submitted to the insurer.

Provider Accounts Website – www.becomeprovider.Lni.wa.gov/

Provider Accounts phone – 360-902-5140

PROVIDER SPECIFIC INSTRUCTIONS

The L&I website offers many resources to providers. Go to www.Lni.wa.gov/main/ForProviders.asp.

Ambulatory Surgery Center (ASC)

Modifiers:

CPT[®] modifiers: 50, 51, 52, 58, 59, 73, 74, 76, 77, 78, 79, 99

For the purposes of billing for services provided to Washington workers, an ASC is an outpatient facility where surgical services are provided and that meets the following 3 requirements:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure;
2. Must have at least 1 of the following credentials:
 - a. Medicare Certification as an ambulatory surgery center or
 - b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS) and
3. Must have an active ASC provider account with L&I.

Procedures not listed in the ASC fee schedule section of MARFS are not covered in an ASC. Find a list of all procedures covered in an ASC online at <http://feeschedules.Lni.wa.gov> (ASC Fee Schedules section).

For more ASC information, please refer to [WAC 296-23B](#) and to the Ambulatory Surgery Center section of the *Medical Aid Rules and Fee Schedules* at <http://feeschedules.Lni.wa.gov/> (Billing & Payment Policies section).

Anesthesiologist

Modifiers

CPT[®] Modifier: -99

HCPCS Modifier: -AA, -QK and -QY

Payment for anesthesia services will only be made to anesthesiologists and certified registered nurse anesthetists. The insurer does not cover anesthesia assistant services. Anesthesia is not payable for procedures that are not covered by L&I. For a list of non-covered procedures refer to the *Medical Aid Rules and Fee Schedules*, **Appendix D**, at <http://feeschedules.Lni.wa.gov> (Billing & Payment Policies Section).

The insurer pays most anesthesia services with base and time units. Bill these services with CPT[®] anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier. Bill for services in one-minute time units. List only the time in minutes, do not include base units. L&I's payment system automatically adds base units.

For more information, please refer to the Professional Services section of the *Medical Aid Rules and Fee Schedules* at <http://feeschedules.Lni.wa.gov>.

Chiropractor

Chiropractic physicians must bill for chiropractic care visits with the L&I local procedure codes listed in the Chiropractic Services Section of the [Medical Aid Rules and Fee Schedules](#). They must use the appropriate CPT[®] codes for radiology, office visits and case management services and HCPCS codes for miscellaneous materials and supplies.

The insurer will not pay chiropractic physicians for codes that are not specifically allowed. Refer to the appendices in the *Medical Aid Rules and Fee Schedules* <http://feeschedules.Lni.wa.gov> for more information on procedure codes and modifiers.

Evaluation and Management (E/M)

Chiropractic physicians may bill the first 4 levels of new and established patient office visit codes. L&I uses the CPT[®] definitions for *new* and *established* patients. If a provider has treated a patient for any reason within the last 3 years, the person is considered an *established patient*. Refer to a CPT[®] book for complete E/M code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is **payable only once** for the initial visit.
- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or that occur more than 60 days after the first date you treat the worker require **prior authorization**.
- Modifier –22 is not payable with E/M codes for chiropractic services.
- Established patient E/M codes are **not payable** in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section of the [Medical Aid Rules and Fee Schedules](#) for policies about the use of E/M office visit codes with chiropractic care visit codes.

For more information, please refer to the Professional Services section in the *Medical Aid Rules and Fee Schedules* at <http://feeschedules.Lni.wa.gov>. [WAC 296-23-195](#) pertains to chiropractic consultations.

Hospital ER/Professional Services

Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the CMS 1500 bill form using the provider account number(s) assigned by the department specifically for ambulance services and professional services.

ICD9-CM codes are not required on the billing form when billing for ambulance services.

For more information, please refer to the Hospital WACs in Chapter [296-23A](#), the "Hospital Payment Policies" section of the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>, and the [Hospital Billing Instructions](#) manual (F248-014-000).

Independent Medical Examination (IME) providers

For IME information on the L&I Website, go to www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/IME/.

Doctors and/or firms, who wish to provide IMEs for the department or self-insurers for workers covered under [Title 51 RCW](#) must be approved by the department per [WAC 296-23-312](#). Doctors and/or firms must submit a completed [Provider Account Application – IME \(F245-046-000\)](#) to the Provider Review and Education Unit at the Department of Labor & Industries, PO Box 44322, Olympia, WA 98504-4322.

- For IMEs performed in Washington State, examiners need 1 IME provider account number for each payee they wish to designate.
- An IME examiner not working through any IME firms will need just 1 IME number, which will also serve as their payee number.
- If an examiner works with multiple IME firms that are identified as the payee, then the examiner will need a different provider account number for each IME firm.

Billing State Fund for IME services conducted WITHIN Washington State

Billing by non-firm affiliated examiners

If you conduct IMEs in Washington State and you bill the department directly for these services, you must enter your IME examiner provider account number and/or your NPI in box 24J, “Rendering Provider ID. #”. Your NPI must be registered with L&I.

Billing by firms

If your firm conducts IMEs in Washington State, the table below shows which provider account number and/or National Provider Identifier (NPI) to use in 24J of the CMS 1500 form based on the IME service provided IN Washington State. The NPI must be registered with the department.

In-state codes

Use only the IME examiner’s provider account number/NPI for these codes:		Use only the IME firm provider account number/NPI for these codes:	The following codes may be billed by the IME examiner, the IME firm, or by the performing provider.
1028M	1118M	1100M	1124M
1038M	1120M	1101M	CPT® Code 90801
1048M	1123M	1132M	CPT® Codes 96101, 96102
1066M	1125M	1133M	CPT® Codes 96118, 96119
1104M 1105M	1128M		X-ray, diagnostic laboratory tests in conjunction with IME (Use modifier -7N.)
1108M	1129M		1045M
1109M	1130M		
1111M 1112M 1134M 1135M 1136M	1137M 1138M CPT® Codes 99441-99443		

NOTE: IME firms may use their own provider account number (box 33b) and/or NPI (box 33a) as the “payee” although it isn’t required if the same provider account number/NPI is in box 24J.

Billing for IME services conducted OUTSIDE of Washington State

IME providers and IME firms conducting IME services outside of Washington State must comply with the following requirements:

- IME examiners must meet L&I's criteria for approved examiners.
- A separate IME provider account number is required for IMEs conducted outside of Washington State.
- IME examiners must be approved by L&I. To obtain the procedures and an IME provider application, go to www.Lni.wa.gov/ClaimsIns/Providers/Becoming/IME/default.asp. When you submit your application include a copy of the doctor's license for the state where the exam will be conducted and current curriculum vitae (CV).
- Firms will not be required to put the examiner provider account number on State Fund bills.
- Bills for out-of-state IMEs must contain the IME firm's provider account number in box 33b of the CMS-1500 bill form.
- You must bill your usual and customary fees.
- Use billing code 1131M for all out-of-state IME services, **except** 1100M and 1101M, and the CPT® codes for neuropsychological evaluation and testing. Combine all 1131M charges into one line item on your bill. Also use 1131M for activities occurring after the IME, such as addendums.

For more information on becoming an approved IME provider or performing impairment ratings, please see the *Medical Examiners' Handbook* at www.LNI.wa.gov/IPUB/252-001-000.pdf, or go to www.Lni.wa.gov/ClaimsIns/Providers/Becoming/IME/default.asp.

For general information regarding Washington State IMEs (including finding a medical examiner, how to receive a *Medical Examiners' Handbook*, etc.) go to <http://www.imes.Lni.wa.gov>.

Washington Administrative Codes (WAC) pertaining to IMEs are as follows: [WAC 296-20-200 through WAC 296-20-2030](#) (impairment ratings) and [WAC 296-23-302 through WAC 296-23-392](#) (IMEs). Information can be viewed and downloaded from www.Lni.wa.gov/ClaimsIns/Providers/Billing/.

Laboratories

Please refer to the Pathology and Laboratory Services chapter of the Professional Services section in the *Medical Aid Rules and Fee Schedules* at <http://feeschedules.Lni.wa.gov>.

Naturopath

Naturopathic physicians should use the local codes listed in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov> to bill for office visit services, CPT® codes 99367 and 99441-99444 to bill case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Refer to Case Management Services, in the Evaluation and Management section of the *Medical Aid Rules and Fee Schedule* for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed including consultations. Refer to WAC [296-23-205](#) and [296-23-215](#) for additional information.

Osteopathic Physician

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT[®] code 97140 **isn't covered** for osteopathic physicians.

OMT includes pre- and post-service work (For example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the –25 modifier.

The insurer **won't pay** for E/M codes billed on the same day as OMT without the –25 modifier.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

For more information, please refer to the Professional Services section in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

Outpatient Pain Management

Please refer to the Chronic Pain Management chapter of the Facilities Services section located in the Payment Policies manual at www.feeschedules.Lni.wa.gov

Pathologist

Please refer to the Pathology and Laboratory Services chapter of the Professional Services section in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

Physical Therapist

Physical therapy services must be ordered by the worker's:

- Attending doctor
- Nurse practitioner or
- By the physician assistant for the attending doctor.

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the supervision of a licensed physical therapist (see [WAC 296-23-220](http://wac.wa.gov/WAC%20296-23-220)).

For more information, please refer to the Physical Medicine Services chapter of the Professional Services section in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

Physician and Physician Clinics

Please refer to the Professional Services section in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

Physician Assistant

Physician assistants (PAs) must be certified and have valid individual L&I provider account numbers to be paid for services. PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of MARFS. For example, to bill for Assistant at Surgery, the PA would use modifier –80, –81 or –82 as appropriate.

Physician assistants may sign any documentation required by the department. Consultations and impairment ratings services related to workers' compensation benefit determinations are not payable to physician assistants as specified in [RCW 51.28.100](#) and [WAC 296-20-01501](#).

Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee. For more information about physician assistant services and payment, see [WAC 296-20-12501](#) and [WAC 296-20-01501](#).

Podiatric Physician

Please refer to the Professional Services section in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

Psychologist

Authorized psychiatric services **must** be performed by a psychiatrist (MD or DO), a psychiatric Advanced Registered Nurse Practitioner (ARNP), or a licensed clinical PhD or PsyD psychologist (see [WAC 296-21-270](#)).

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service. Psychiatric ARNPs are paid at 90% of the values listed in the fee schedule.

A psychiatrist or psychiatric ARNP can only be a worker's attending provider when the insurer has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist or psychiatric ARNP may certify a worker's time loss from work if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychiatric ARNP may **not** rate permanent partial disability.

Prior authorization is required for all psychiatric care referrals (see [WAC 296-21-270](#)). This requirement includes referrals for psychiatric consultations and evaluations. Refer to [WAC 296-20-045](#) and [WAC 296-20-051](#) for more information on consultation requirements.

Psychologists may not bill the E/M codes for office visits.

Psychiatrists and psychiatric ARNPs may **only** bill the E/M codes for office visits on the same day psychotherapy is provided **if** it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized. The provider must submit documentation of the event and request a review before payment can be made.

Please refer to [WAC 296-21-270](#), [WAC 296-21-280](#) and Professional Services section of the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

Radiologist

RT and LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) don't affect payment. They may be used with CPT® radiology codes 70010 – 79999 to identify duplicate procedures performed on opposite sides of the body.

Consultation Services

CPT® code 76140, isn't **covered**. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier -26. The insurer **won't pay separately** for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the X-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed. Payment for a radiological consultation will be made at the established professional component (modifier -26) rate for each specific radiology service. A written report of the consultation is required.

Radiology Reporting Requirements

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier -26 or as part of the global service. Documentation refers to charting of justification, findings, diagnoses, and test result integration.

Any provider who produces and interprets his/her own imaging studies, and any radiologist who overreads imaging studies must produce a report of radiology findings to bill for the professional component.

Chart notes such as "x-rays are negative" or "x-rays are normal" don't fulfill the reporting requirements outlined in the Radiology chapter of the Professional Services section of the [Medical Aid Rules and Fee Schedule](#), and the insurer will not pay for the professional component in these circumstances.

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes.

For more information, please refer to the Radiology section of [WAC Chapter 296-23](#), and Professional Services section of the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov>.

The CMS 1500 bill form (F245-127-000) is available on the L&I Website - www.Lni.wa.gov/FormPub/Detail.asp?DocID=1630

COMPLETING THE CMS 1500 FORM

Completed bill forms must be typed or printed and be clearly legible. All of the following boxes must be completed to ensure correct bill adjudication. Use the instructions below to complete the CMS-1500 Health Insurance Claim Form.

The CMS 1500 is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing for workers' compensation services. (The numbered boxes on the claim form are known as fields.) Only the fields that pertain to billing Labor & Industries, self-insured employers, and Crime Victims claims are addressed below.

FIELD DESCRIPTION / INSTRUCTIONS FOR COMPLETION

- 1a. **INSURED'S I.D. NO.:** Enter worker's social security number. This information will assist us in identifying the injured worker's claim number if the claim number is missing or invalid.
2. **PATIENT'S NAME:** Enter worker's last name, first name, and middle initial.
3. **PATIENT'S BIRTH DATE:** List the birth date of the worker.
5. **PATIENT'S ADDRESS:** Enter worker's current address.
11. **INSURED'S POLICY GROUP OR FECA (Federal Employees Compensation Act) NUMBER:** Enter worker's L&I claim number. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The first letter identifies the funding source, which is listed below.

STATE FUND INDUSTRIAL INSURANCE

State Fund Claims begin with the letters **B, C, F, G, H, J, K, L, M, N, P, X, or Y** followed by six digits, or double alpha letters (example AA) followed by five digits. Send bills for State Fund claims to:

Department of Labor & Industries
PO Box 44269
Olympia WA 98504-4269

CRIME VICTIMS COMPENSATION PROGRAM

Crime victims claims begin with a **V** followed by six digits, or double alpha letters (example VA) followed by 5 digits. Send bills for Crime Victims claims to:

Department of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

SELF-INSURED EMPLOYERS

Self-insured claims begin with **S**, **T** or **W** followed by six digits or double alpha letters (example SA) followed by five digits.

Send bills for self-insured claims directly to the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs, go to www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp.

14. **DATE OF INJURY/ILLNESS:** Enter the date of injury. A worker may have several claims, so the injury date helps the insurer apply charges to the proper claim.
17. **NAME OF REFERRING PHYSICIAN:** Enter the name of the provider referring the worker to you, if applicable.
- 17a. **ID. NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter L&I provider account number of referring provider if applicable.
- 17b. **NPI:** Enter the National Provider Identifier (NPI) of the referring physician. (Optional for Workers Compensation)
21. **DIAGNOSIS OR NATURE OF INJURY OR ILLNESS:**
ICD9-CM codes are required. You must indicate a specific diagnosis on line 24E for each line item. Designate left or right side of body when applicable.
24. **ENTER ONLY ONE SERVICE PER LINE**
- 24a. **DATE OF SERVICE:** Enter the month, day, and year of service numerically in mmddyy format (e.g., January 04, 2010 = **010410**).
- 24b. **PLACE OF SERVICE:** Enter the required 2-digit place of service code. **Don't use any Place of Service codes found on the back of the CMS-1500 forms.** Refer to the Professional Services section in the *Medical Aid Rules and Fee Schedule* at <http://feeschedules.Lni.wa.gov> for a list of valid codes.
- 24d. **PROCEDURE, SERVICE, OR SUPPLY:** Identify the procedure (CPT[®]/HCPCS/Local Code) performed. Enter only one code per line.

DESCRIPTION OF SERVICES: Describe services provided, (e.g., apply long leg cast). When service is coded "unlisted" in CPT-IV, the treatment or diagnostic study must be fully described.

Please Note: The department does not publish sufficient descriptive CPT[®] and HCPCS information to properly code provided services. Providers and self-insurers must refer to their own copies of these books to determine the appropriate code(s) for billing & payment.

CODE MODIFIER: A modifier indicates a performed service or procedure has been altered by a specific circumstance. Indicate modifier, if applicable, after the procedure code. Example: 20816 -80.

For a list of modifiers that affect payment, refer to the *Medical Aid Rules and Fee Schedules, Appendix E*, at <http://feeschedules.Lni.wa.gov>

24e. **DIAGNOSIS POINTER:** Enter the diagnosis number from box 21 for this procedure.

24f. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line.
(Do NOT bill negative charges)

24g. **DAYS OR UNITS:** Enter total number of units, minutes, or days for the services on each line.

24j. **RENDERING PROVIDER ID. #:**

- Upper (shaded) field - Enter a two digit qualifier (X5) in front of the L&I provider account number assigned by L&I for the rendering physician (e.g. X5 #####, # = L&I provider account number), and/or
- Lower field – Enter the rendering physician’s NPI. NPI must be registered with L&I.

Failure to enter at least one of the numbers (the performing provider’s L&I provider account number or NPI) will result in bill denial and return.

Due to system limitations, only one rendering provider number can be billed per paper bill form.

Bills submitted electronically do not have this limitation. Please contact electronic billing at (360) 902-6511 if you are interested in billing L&I electronically.

25. **FEDERAL TAX I.D. NUMBER:** Required. Enter either your employee identification number (EIN) or your Social Security number (SSN) (use the same number you supplied on your Provider Application with the department).

26. **PATIENT’S ACCOUNT NO.:** The number you use to identify your patient’s account. This is for your convenience only. The State Fund will include up to 12 characters on your remittance advice.

28. **TOTAL CHARGES:** Total of all charges.

31. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. The provider submitting the bill is responsible for its accuracy. For computer generated bills, the signature field may be left blank.

The signature “DATE” is the date the bill is prepared and sent to the department or self-insurer.

32. **SERVICE FACILITY LOCATION INFORMATION:** Enter the name and address of the physical location where services were rendered.

32a. **NPI:** Enter the facility’s NPI.

33. **PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE #:** Enter the name of the provider providing the services (enter last name first) and current address.

If your name, address or business status changes, submit a [Provider Account Change Form](#) (F245-365-000) found online at www.becomeprovider.Lni.wa.gov, or call Provider Accounts at 360-902-5140.

Fax completed Provider Accounts forms to 360-902-4484, or mail to the address on the form.

Indicating a new address on the bill won’t change the department’s record of your address and could delay payment.

33a. **NPI:** Enter the rendering provider's group NPI. The NPI must be registered with L&I.

33b. **Group Provider Number:** Enter a two digit qualifier (X5) in front of the L&I provider account number assigned by L&I for the group ((e.g., X5#####) . # = L&I provider account number) or the group's **registered** NPI.

CMS 1500 Bill Sample

Please do not staple in this area

CMS 1500 - (formerly L&I Health Ins Claim form)
 DEPARTMENT OF LABOR AND INDUSTRIES
 CLAIMS SECTION
 PO BOX 44269
 OLYMPIA WA 98504-4269

CARRIER

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05



PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999-99-9999 (SSN)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN					3. PATIENT'S BIRTH DATE MM DD YY 01 01 80					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 999 MAIN STREET # 9					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY OLYMPIA			STATE WA		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE																
ZIP CODE 98504			TELEPHONE (Include Area Code) (360) 999-9999							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 AA00000 (WORKER'S L&I CLAIM NUMBER)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME XYZ COMPANY					c. INSURANCE PLAN NAME OR PROGRAM NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO														
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? If yes, return to and complete Item 9 a-d.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.														
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.										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 _____ DATE _____										SIGNED _____																			
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Referring Provider Name					17a. Referrer's L&I Account					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI Referrer's NPI					19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER														
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPICUT I. D. QUAL J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN Provider SSN or EIN <input type="checkbox"/> <input checked="" type="checkbox"/>																			
26. PATIENT'S ACCOUNT NO. Optional										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 111 10					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.)										32. SERVICE FACILITY LOCATION INFORMATION Name and address of facility where services performed										33. BILLING PROVIDER INFO & PH # () Name & address of payee (group or firm)									
SIGNED _____ DATE _____										a. NPI					b.					a. Group NPI					b. Group L&I Acct number				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION