

North Carolina
Medicaid Special Bulletin



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2006

Attention: All Providers

New Claim Form Instructions

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INTRODUCTION

The CMS-1500 (12/90), the UB-92 and the American Dental Association (ADA) 2002 paper forms have been revised and will be replaced with the new CMS-1500 (08/05), the UB-04 and the ADA 2006 claim forms, respectively. Medicaid will begin accepting the claim forms effective with the dates shown below. Paper claims submitted on the old forms will not be processed after the date shown in the last column and will be returned to the provider.

| Claim form | Medicaid will accept the new paper form on: | Claim forms must be on new format no later than: |
|------------------|---|---|
| CMS-1500 (08/05) | Jan. 1, 2007 | April 1, 2007 |
| UB-04 | March 1, 2007 | May 18, 2007 |
| ADA 2006 | March 1, 2007 | May 18, 2007 |

The revised paper claim forms coincide with the implementation of the National Provider Identifier (NPI) as the standard unique health identifier for providers (see <http://www.ncdhhs.gov/dma/> for more information). N.C. Medicaid will allow a transition period to convert from the old paper claim forms to the new claim forms. Each form contains specific changes that will affect Medicaid claims processing, and specific time periods within which particular information must be submitted. Explanation of Benefits (EOB) verbiage will be changing to reflect the use of the revised paper claim formats. Please carefully review the Medicaid-related guidelines in this Bulletin.

DEFINITIONS

Atypical Provider: Provider who does not render health care services and is not eligible for an NPI. Example: a contractor who builds a wheelchair ramp on a recipient’s home.

CA PCP: Carolina ACCESS Primary Care Physician

National Provider Identifier (NPI): New identifier issued through the National Plan and Provider Enumeration System (NPPES) developed by CMS. NPI will replace all Medicaid provider numbers currently used for billing purposes.

Qualifier: Identifies whether the number to the immediate right on the claim represents a Medicaid provider number (1D) or a taxonomy code (ZZ)

Taxonomy number: Code identifying a provider type and specialty

OVERVIEW OF CLAIM FORM CHANGES

The following table provides a brief overview of changes for all claim forms. These changes will affect claims processing. Explanations of these changes and definitions of terms will be provided in the following pages.

| UB-04 | CMS-1500 | ADA |
|---|---|---|
| Carolina ACCESS NPI or Medicaid Provider Number | Carolina ACCESS NPI or Medicaid Provider Number | NPI—Billing, Attending |
| No Signature field | NPI—Billing, Attending or Referring | Taxonomy—Billing, Attending |
| NPI—Billing, Attending and Referring | Qualifier | ZIP + 4 Code |
| Payer Code | Taxonomy—Billing, Attending | Medicaid Number for Prior Approval Purposes |
| Qualifier | Timeline | |
| Taxonomy—Billing, Attending | ZIP + 4 Code | |
| Value Codes | | |
| ZIP + 4 Code | | |

CLAIM FORM INSTRUCTIONS

Because providers are allowed to submit both Medicaid provider information *and* NPI information on claims during the transition period, there are two claim examples for each claim form: one for revised claim transition and one for NPI implementation. Refer to NPI publications for NPI implementation dates.

CMS-1500 (08/05) Changes Effective Jan. 1, 2007: Revised Claim Transition

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at www.nucc.org.

- Field 17a: Enter either the referring provider or CA PCP provider number (the Medicaid provider number) or the CA ACCESS override number assigned by EDS in the shaded field 17a. Qualifier 1D must precede either of these numbers in the delimited block immediately to the right of the field identifier “17a.”
- Field 17b: The referring provider’s NPI or CA PCP provider number may be entered in this field. N.C. Medicaid requests that providers immediately start submitting the NPI in addition to the Medicaid provider number.
- Fields 24i and 24j, Attending Provider Number: If the procedure requires an attending provider number, the attending number must be entered.
 - Field 24j, NPI (lower portion of the field): The attending provider’s NPI may be entered in this field. N.C. Medicaid requests that providers immediately start submitting the NPI and taxonomy in addition to the Medicaid provider number.
 - Fields 24i and 24j (upper shaded portion of the field): Enter qualifier 1D in field 24i and the attending provider’s Medicaid number in 24j.
- Field 32, Service Facility Location: Address where service was rendered, including ZIP + 4 Code.
- Field 33, Billing Provider Information: Provider address must include ZIP + 4 Code.
- Field 33a: Enter the Medicaid billing provider’s NPI. N.C. Medicaid requests that providers immediately start submitting the NPI and taxonomy in addition to the Medicaid provider number.
- Field 33b: Enter the legacy Medicaid number, preceded by qualifier 1D. (This field is not specifically delimited.) It is not necessary to enter a space between qualifier 1D and the legacy Medicaid number.

CMS-1500 (08/05) Line-by-Line Instructions Effective Jan. 1, 2007

Instructions for completing the standard CMS-1500 claim form are listed below. Changes are highlighted. Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by NUCC. The NUCC instruction manual can be found at www.nucc.org. Refer to NPI publications for NPI implementation dates.

| Block | Block Name | Explanation |
|-------|---|--|
| 1. | Type of Coverage | Place an (X) in the Medicaid block. |
| 1a. | Insured's ID Number | Enter the recipient's 10-character identification number found on the MID card. |
| 2. | Patient's Name | Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card. |
| 3. | Patient's Birth Date | Enter the recipient's date of birth using eight digits (e.g., July 19, 1960, would be entered as 07191960). Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claim. |
| | Sex | Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female). |
| 5. | Patient's Address | Enter the recipient's street address including city, state and ZIP code. |
| | Telephone | Entering the recipient's telephone number is optional. |
| 9. | Other Insured's Name | If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement. |
| 10. | Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident? | If applicable, check the appropriate block. |

| Block | Block Name | Explanation |
|--------------|--|--|
| 15. | If Patient Has Had Same or Similar Illness, Give First Date | <p>Leave blank EXCEPT when billing for: OB Antepartum Care Package Codes: Enter the first date recipient care was rendered for current pregnancy. Health Check: The next screening date (NSD) may be entered in block 15. Dialysis Treatment or Supervision: Enter the dialysis start date. If the date the provider enters in block 15 is within the periodicity schedule, the system will keep this date. If the NSD entered by the provider is out-of-range with the periodicity schedule or the provider chooses one of the three options listed below, an appropriate NSD will be systematically entered during claims processing according to the Medicaid periodicity schedule. To leave block 15 blank: Place zeros in block 15 (example: 00/00/0000), or Place all ones in block 15 (11/11/1111) Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.</p> |
| 16. | Dates Patient Unable to Work in Current Occupation "From" and "To" | If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time per follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the April 1999 Special Bulletin II, Modifiers, for billing guidelines. |
| 17. | Name of Referring Provider or Other Source | Use for referring provider's name. |
| 17a. | Other ID Number | Use for CA override or current Medicaid provider number with qualifier 1D, or taxonomy code with qualifier ZZ. |
| 17b. | NPI | Use for referring provider or Carolina ACCESS PCP's NPI. |
| 19. | Reserved for Local Use | Please be aware that Medicaid will no longer use block 19 for Carolina ACCESS. |
| 20. | Outside Lab? | Check "yes" or "no." "No" indicates that the lab work was performed in the office. |
| 21. | Diagnosis or Nature of Illness or Injury | The written description of the primary diagnosis is not required unless using diagnosis code V900. However, the claim must be ICD-9-CM coded to describe the primary diagnosis. |

| Block | Block Name | Explanation |
|-------------------------------|------------------------------------|--|
| 23. | Prior Authorization Number | Any provider billing for laboratory services must enter the CLIA number in this field. It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file. |
| 24A. | Date(s) of Service "From" and "To" | Enter the eight-digit date of service in the "From" block. Example: Record the date of service Jan. 31, 2003, as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |
| 24B. | Place of Service | Enter the appropriate code from the Place of Service Code Index. |
| 24C. | Emergency Indicator | Not used at this time. |
| 24D. | Procedures, Services or Supplies | Enter the appropriate five-digit CPT or HCPCS code. Note: Providers mandated to bill modifiers can bill up to three modifiers per procedure code, if applicable. Health Check claims may also contain modifiers. Refer to guidelines listed in the April 2006 Special Bulletin I, Health Check Billing Guide 2006. |
| 24F. | Charges | Enter the usual and customary charge for each service rendered. |
| 24G. | Days or Units | Enter the number of visits or units. |
| 24H. | EPSDT Family Plan | If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F." |
| 24I. (upper shaded portion) | Qualifier | Enter qualifier 1D if entering Medicaid provider number or ZZ if entering taxonomy. |
| 24J. (upper shaded portion) | Rendering Provider ID Number | Enter Medicaid attending provider number or taxonomy. |
| 24J. (lower unshaded portion) | Rendering provider ID number | Enter attending provider NPI. |
| 26. | Patient's Account No. | A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first 9 characters of this number will appear on the RA. |
| 28. | Total Charge | Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has third-party coverage.) |
| 29. | Amount Paid | For dates of service after Oct. 1, 2002, but before |

| Block | Block Name | Explanation |
|-------|---|--|
| | | <p>Sept. 6, 2004, enter the total amount received from Medicare, including penalties and outpatient psychiatric reductions and other third-party payment source(s) (TPL). If there is a payment from Medicare and a TPL, leave block 29 blank and submit the claim with the appropriate EOBs attached. Refer to the Sept. 2002 Draft Special Bulletin IV (Revised Nov. 14, 2002) Medicare Part B Billing Guidelines, for detailed instructions on billing for Medicare Part B. Effective with date of service Sept. 6, 2004, professional charges will be reimbursed a specific percentage of the co-insurance and deductible in accordance with the Part B reimbursement schedule. Do not enter Medicare payments on the claim. Attach the Medicare voucher when submitting the claim to Medicaid. Refer to the August 2004 Special Bulletin V, Medicare Part B Billing, for detailed instructions.</p> |
| 31. | Signature of Physician or Supplier Including Degrees or Credentials | <p>The physician, supplier or an authorized representative must either:</p> <ol style="list-style-type: none"> 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script-style stamps and black ink stamp pads are acceptable), or 3. if a Provider Certification for Signature on File form has been completed and submitted to EDS, leave the signature block blank and enter the date only. <p>Printed initials and printed signatures are not acceptable and will result in denied claims.</p> |
| 32. | Service Facility Location Information | Enter the ZIP + 4 Code. |
| 33. | Billing Provider Info and Phone Number | Enter the billing provider's name, street address including ZIP + 4 Code and phone number. |
| 33a. | NPI | Enter the billing provider's NPI. |
| 33b. | Other ID Number | Enter the taxonomy with ZZ qualifier or Medicaid provider number with 1D qualifier. |

CMS 1500 Example Effective Jan. 1, 2007: Revised Claim Transition. Refer to NPI publications for NPI implementation dates.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|-------------------------------|--|---|--|--|--|---|--|--|--|---|--|-------------------------------|--|--|--|--|--|---|--|--|--|--------------|--|--|--|----------------------------|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> PICA <input type="checkbox"/> PICA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare #) | | | | MEDICAID <input type="checkbox"/> (Medicaid #) | | | | TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) | | | | CHAMPVA <input type="checkbox"/> (Member ID#) | | | | GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) | | | | FECA BLK LUNG <input type="checkbox"/> (SSN) | | | | OTHER <input type="checkbox"/> (ID) | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY | | | | | | | | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | | | 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 | | | | | | STATE | | | | | | 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 | | | | b. EMPLOYMENT? (Current or Previous) | | | | a. INSURED'S DATE OF BIRTH | | | | SEX | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. OTHER INSURED'S DATE OF BIRTH | | | | b. AUTO ACCIDENT? | | | | a. INSURED'S DATE OF BIRTH | | | | SEX | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | c. OTHER ACCIDENT? | | | | a. INSURED'S DATE OF BIRTH | | | | SEX | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | 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, 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 REPRESENTATIVE'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described 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 | | | | | | | | | | | | SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS MM DD YY | | | | | | | | | | | | 15. HAD SAME OR SIMILAR ILLNESS. 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 PHYSICIAN (Last Name, First Name, Middle Initial) | | | | | | | | | | | | 17b. NPI | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | 20. OUTSIDE LOCALITY <input type="checkbox"/> YES | | | | | | | | | | | | 21. MEDICAID FAVORABLE DETERMINATION CODE | | | | | | | | | | | | | | | | | | | | | | | |
| 19: No longer used for Carolina ACCESS. | | | | | | | | | | | | 24J: Attending provider NPI. | | | | | | | | | | | | 24I and J: Enter Qualifier 1D and Medicaid attending provider number. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | | | B. PLACE OF SERVICE EMG | | | | C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) | | | | D. DIAGNOSIS POINTER | | | | E. \$ CHARGES | | | | F. DAYS OR UNITS | | | | G. ER/SPT Party Plan | | | | H. ID. QUAL. | | | | I. RENDERING PROVIDER ID.# | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | 28. TOTAL CHARGE \$ | | | | | | | | | | | | 29. AMOUNT PAID \$ | | | | | | | | | | | |
| 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 | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PHONE NUMBER | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED | | | | | | | | | | | | DATE | | | | | | | | | | | | a. NPI | | | | | | | | | | | | b. NPI | | | | | | | | | | | |

17a: Enter qualifier 1D and Medicaid CA PCP, referring provider or CA override number (if applicable).

17b: NPI for CA PCP or referring provider.

19: No longer used for Carolina ACCESS.

24I and J: Enter Qualifier 1D and Medicaid attending provider number.

24J: Attending provider NPI.

32: Rendering location address. Must include ZIP + 4 Code.

33: Billing provider information. Must include ZIP + 4 Code.

33a: NPI for billing provider. 33b: Enter qualifier ZZ and taxonomy or qualifier 1D and Medicaid provider number.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Example: NPI Implementation. Refer to NPI publications for NPI implementation dates.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|-------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | 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 | | | | | STATE | | | | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | | | | | CITY | | | | | STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | | | | | ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, return to and complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described 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 _____ DATE _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | 17a. NAME | | | | | | | | | | 17b. NPI | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 20. OUTSIDE LOCALITY <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | 21. MEDICAID FEE CODE | | | | | | | | | | 22. PRIOR AUTHORIZATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | | | | | | | | | B. PLACE OF SERVICE EMG | | | | | | | | | | C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | | | | | | | | | D. DIAGNOSIS POINTER | | | | | | | | | | E. \$ CHARGES | | | | | | | | | | F. G. DAYS OR UNITS | | | | | | | | | | H. ICD-9-CM | | | | | | | | | | I. RENDERING PROVIDER ID. # | | | | | | | | | |
| 1 | | | | | | | | | | 2 | | | | | | | | | | 3 | | | | | | | | | | 4 | | | | | | | | | | 5 | | | | | | | | | | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | | | | | | 27. ACCEPT ASSIGNMENT? (For gov claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 28. TOTAL CHARGE \$ | | | | | | | | | | 29. AMOUNT PAID \$ | | | | | | | | | | 30. BILLING PROVIDER INFO & PH # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. NPI | | | | | | | | | | 33. BILLING PROVIDER INFO & PH # a. NPI b. NPI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

17a: Enter qualifier 1D and CA override number (if applicable) OR qualifier ZZ and PCP/referring provider's taxonomy number.

19: No longer used for Carolina ACCESS.

17b: NPI for CA PCP or referring provider.

24 I and J: Enter qualifier ZZ and attending taxonomy code.

24J: Attending provider NPI. Required if billing with group NPI.

32: Rendering location address. Must include ZIP + 4 Code.

33: Billing provider information. Must include ZIP + 4 Code.

33a: NPI for billing provider. 33b: Enter qualifier ZZ and taxonomy.

UB-04 Changes Effective March 1, 2007: Revised Claim Transition

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC instruction manual can be found at www.nubc.org. Refer to NPI publications for NPI implementation dates.

- Form locator 1: Billing provider name and address must include ZIP + 4 Code.
- Form locators 39–41 (Value Codes): Use value codes to identify covered days (80), non-covered days (81), co-insurance days (82) and lifetime days (83). Refer to the UB-04 manual for other value code definitions.
- Form locator 56 (NPI): Billing provider's NPI. Enter the Medicaid billing provider NPI. N.C. Medicaid requests that providers immediately start submitting the NPI and taxonomy in addition to the Medicaid provider number.
- Form locator 57 (Other Payer ID): Enter the billing provider's Medicaid number, preceded by the qualifier 1D on line A, B or C, to correspond with the Medicaid payer name.
- Form locator 76A and B: Attending provider information. The attending provider's NPI may be entered in this form locator, if applicable. When an attending provider's Medicaid provider number is entered, it must be preceded by the qualifier 1D.
- Form locator 78 (Other) A and B: Enter either the CA PCP Medicaid provider number, referring provider or the CA ACCESS override number assigned by EDS. Qualifier 1D must be entered in the QUAL field, preceding the CA PCP number or the CA override number assigned by EDS, regardless of which number is entered.
 - The NPI of the CA PCP or the referring provider number may be entered in form locator 78A, in the first entry position identified as NPI. N.C. Medicaid requests that providers immediately start submitting the NPI and taxonomy in addition to the Medicaid provider number during this time period.

UB-04 Line-by-Line Instructions

Instructions for completing the standard UB-04 claim form are listed below. Changes are highlighted. These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by NUBC. The NUBC instruction manual can be found at www.nubc.org. Refer to NPI publications for NPI implementation dates.

| Form Locator/Description | Requirements | Explanation |
|---|--------------------------|--|
| 1. Provider Name/Address/ City/State/Zip | Required | Enter the provider's name as it appears on the RA and up to three lines of the address. The ZIP code must be in the ZIP + 4 format. Note: Do not abbreviate the provider's name. |
| 3a. Patient Control Number | Optional | Enter the recipient control number or medical record number that the provider has selected to appear on the RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. The first nine characters of this number will appear on the RA. |
| 3b. Medical Record Number | Optional | If a number is entered, it will not appear on the RA. |
| 4. Type of Bill | Required Three Digits | 11X Hospital Inpatient (including Medicare Part A) 12X Hospital Inpatient (Medicare Part B only) 13X Hospital Outpatient 14X Hospital Laboratory services provided to non-patients 18X Hospital Swing Beds 21X Skilled Nursing—Inpatient (including Medicare Part A) 22X Skilled Nursing—Inpatient (Medicare Part B) 23X Skilled Nursing—Outpatient 28X Skilled Nursing—Swing Beds 32X Home Health—Inpatient (plan of treatment under Part B only) 33X Home Health—Outpatient (plan of treatment under part A, including DME under part A) 34X Home Health—Other (for medical and surgical services not under a plan of treatment) 41X Religious Non-Medical Health Care Institutions—Hospital Inpatient 43X Religions Non-Medical Health Care Institutions—Outpatient Services 65X Intermediate Care—Level 1 66X Intermediate Care—Level 2 71X Clinic—Rural Health 72X Clinic—Hospital-Based or Independent Renal Dialysis Center 73X Clinic—Freestanding 74X Clinic—Outpatient Rehabilitation Facility 75X Clinic—Comprehensive Outpatient Rehabilitation Facility |

| Form Locator/Description | Requirements | Explanation |
|--|----------------------------|--|
| | | 76X Clinic—Community Mental Health Center 79X Clinic—Other 81X Special Facility—Hospice (non-hospital-based) 82X Special Facility—Hospice (hospital-based) 83X Special Facility—Ambulatory Surgical Center 84X Special Facility—Free Standing Birthing Center 85X Special Facility—Critical Access Hospital 86X Special Facility—Residential Facility 89X Special Facility—Other |
| 5. Federal Tax Number | Required, where applicable | |
| 6. Statement Covers Period “From” and “Through” | Required | Enter the eight-digit beginning service date in the “From” block. Enter the eight-digit ending service date in the “Through” block. Example: Record the date of service Jan. 31, 2004, as 01312004. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |
| 8a. Patient Name—ID | Required | Enter the recipient’s Medicaid Identification Number. |
| 8b. Patient Name | Required | Enter the recipient’s full name exactly as shown on the MID card (last name, first name, middle initial). |
| 9a. Patient Address—Street | Required | Enter the recipient’s street. |
| 9b. Patient Address—City | Required | Enter the recipient’s city. |
| 9c. Patient Address—State | Required | Enter the recipient’s state. |
| 9d. Patient Address—Zip | Required | Enter the recipient’s ZIP code. |
| 10. Patient Birth Date | Required | Enter the recipient’s date of birth using eight digits. Example: July 19, 1960, would be entered as 07191960. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |
| 11. Patient Sex | Required | Enter one alpha character indicating the sex of the recipient. Valid characters are “M,” “F” or “U.” |
| 12. Admission Date | Required | Enter the eight-digit date that the recipient was admitted. Example: Record the date Jan. 31, 2004, as 01312004. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |

| Form Locator/Description | Requirements | Explanation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------|--------------------------------|---|--------------------------|----|-----------|----|----|------------------------------|----|--------------------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|----|-------------|
| 13. Admission Hour | Required (Hospital, Ambulance) | <p>For multiple outpatient visits on the same day, indicate the admission hour and submit each visit on a separate claim.</p> <table border="1" data-bbox="816 327 1463 863"> <thead> <tr> <th>Time Code</th> <th>AM</th> <th>Time Code</th> <th>PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00 midnight through 12:59</td> <td>12</td> <td>12:00 noon through 12:59</td> </tr> <tr> <td>01</td> <td>01:00–01:59</td> <td>13</td> <td>01:00–01:59</td> </tr> <tr> <td>02</td> <td>02:00–02:59</td> <td>14</td> <td>02:00–02:59</td> </tr> <tr> <td>03</td> <td>03:00–03:59</td> <td>15</td> <td>03:00–03:59</td> </tr> <tr> <td>04</td> <td>04:00–04:59</td> <td>16</td> <td>04:00–04:59</td> </tr> <tr> <td>05</td> <td>05:00–05:59</td> <td>17</td> <td>05:00–05:59</td> </tr> <tr> <td>06</td> <td>06:00–06:59</td> <td>18</td> <td>06:00–06:59</td> </tr> <tr> <td>07</td> <td>07:00–07:59</td> <td>19</td> <td>07:00–07:59</td> </tr> <tr> <td>08</td> <td>08:00–08:59</td> <td>20</td> <td>08:00–08:59</td> </tr> <tr> <td>09</td> <td>09:00–09:59</td> <td>21</td> <td>09:00–09:59</td> </tr> <tr> <td>10</td> <td>10:00–10:59</td> <td>22</td> <td>10:00–10:59</td> </tr> <tr> <td>11</td> <td>11:00–11:59</td> <td>23</td> <td>11:00–11:59</td> </tr> </tbody> </table> | Time Code | AM | Time Code | PM | 00 | 12:00 midnight through 12:59 | 12 | 12:00 noon through 12:59 | 01 | 01:00–01:59 | 13 | 01:00–01:59 | 02 | 02:00–02:59 | 14 | 02:00–02:59 | 03 | 03:00–03:59 | 15 | 03:00–03:59 | 04 | 04:00–04:59 | 16 | 04:00–04:59 | 05 | 05:00–05:59 | 17 | 05:00–05:59 | 06 | 06:00–06:59 | 18 | 06:00–06:59 | 07 | 07:00–07:59 | 19 | 07:00–07:59 | 08 | 08:00–08:59 | 20 | 08:00–08:59 | 09 | 09:00–09:59 | 21 | 09:00–09:59 | 10 | 10:00–10:59 | 22 | 10:00–10:59 | 11 | 11:00–11:59 | 23 | 11:00–11:59 |
| Time Code | AM | Time Code | PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 00 | 12:00 midnight through 12:59 | 12 | 12:00 noon through 12:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 01 | 01:00–01:59 | 13 | 01:00–01:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02 | 02:00–02:59 | 14 | 02:00–02:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 03 | 03:00–03:59 | 15 | 03:00–03:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 04 | 04:00–04:59 | 16 | 04:00–04:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 05 | 05:00–05:59 | 17 | 05:00–05:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 06 | 06:00–06:59 | 18 | 06:00–06:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 07 | 07:00–07:59 | 19 | 07:00–07:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 08 | 08:00–08:59 | 20 | 08:00–08:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 09 | 09:00–09:59 | 21 | 09:00–09:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | 10:00–10:59 | 22 | 10:00–10:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 | 11:00–11:59 | 23 | 11:00–11:59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. Admission Type | Required (Hospital) | <p>Indicate the applicable code for all inpatient visits. A “1” must be used to indicate an emergency department visit that meets emergency criteria to ensure that a co-payment amount is not deducted during the claim processing.</p> <p>1 Emergency: The patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling conditions. Generally, the patient is admitted through the emergency department.</p> <p>2 Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.</p> <p>3 Elective: The patient’s condition permits adequate time to schedule the availability of a suitable accommodation.</p> <p>4 Newborn: Any newborn infant admitted to the hospital within the first 24 hours of life.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Source of Admission | Required (Hospital) | <p>1 Physician Referral: <u>Inpatient:</u> The patient was admitted to this facility upon the recommendation of his or her personal physician. <u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician, or the patient independently requested outpatient services (self-referral).</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Form Locator/Description | Requirements | Explanation |
|---|----------------------------|---|
| | | <p>2 Clinic Referral: <u>Inpatient:</u> The patient was admitted to this facility upon recommendation of this facility’s clinic physician. <u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by this facility’s clinic or other outpatient department physician.</p> <p>3 HMO Referral: <u>Inpatient:</u> The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. <u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by a health maintenance organization physician.</p> <p>4 Transfer from a Hospital: <u>Inpatient:</u> The patient was admitted to this facility as a transfer from an acute care facility where s/he was an inpatient. <u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.</p> |
| <p>15. Source of Admission, continued</p> | <p>Required (Hospital)</p> | <p>5 Transfer from a Skilled Nursing Facility: <u>Inpatient:</u> The patient was admitted to this facility as a transfer from a skilled nursing facility where s/he was an inpatient. <u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the skilled nursing facility where s/he was an inpatient.</p> <p>6 Transfer from Another Health Care Facility: <u>Inpatient:</u> The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities and skilled nursing facility patients that are at a nonskilled level of care. <u>Outpatient:</u> The patient was referred to this facility for outpatient services or referenced diagnostic services by a physician of another health care facility where s/he is an inpatient.</p> <p>7 Emergency Department: <u>Inpatient:</u> The patient was admitted to this facility upon the recommendation of this facility’s emergency department physician. <u>Outpatient:</u> The patient was referred to the facility for outpatient services or referenced diagnostic services by this facility’s emergency department physician.</p> |

| Form Locator/Description | Requirements | Explanation | | | |
|--------------------------|--|---|------------------------------|-----------|--------------------------|
| | | <p>For Newborns: 1 Normal Delivery: A baby delivered without complications. 2 Premature Delivery: A baby delivered with time or weight factors qualifying it for premature status. 3 Sick Baby: A baby delivered with medical complications, other than those relating to premature status. 4 Extramural Birth: A baby born in a nonsterile environment. 5-8 Reserved for National Assignment 9 Information Not Available</p> | | | |
| 16. Discharge Hour | Required (Hospital) | Time Code | AM | Time Code | PM |
| | | 00 | 12:00 midnight through 12:59 | 12 | 12:00 noon through 12:59 |
| | | 01 | 01:00-01:59 | 13 | 01:00-01:59 |
| | | 02 | 02:00-02:59 | 14 | 02:00-02:59 |
| | | 03 | 03:00-03:59 | 15 | 03:00-03:59 |
| | | 04 | 04:00-04:59 | 16 | 04:00-04:59 |
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| | | 08 | 08:00-08:59 | 20 | 08:00-08:59 |
| | | 09 | 09:00-09:59 | 21 | 09:00-09:59 |
| | | 10 | 10:00-10:59 | 22 | 10:00-10:59 |
| | | 11 | 11:00-11:59 | 23 | 11:00-11:59 |
| 17. Patient Status | Required (except for ambulance and personal care services) | <p>01 Discharged to home or self care (routine discharge). 02 Discharged/transferred to another short-term general hospital. 03 Discharged/transferred to skilled nursing facility. 04 Discharged/transferred to an intermediate care facility. 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired. 30 Still a patient or expected to return for outpatient services. 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed.</p> | | | |

| Form Locator/Description | Requirements | Explanation |
|---|----------------------------|--|
| | | 62 Discharged/transferred to another rehabilitation facility, including rehabilitation-distinct part units of a hospital. 63 Discharged/transferred to a long-term care hospital. 64 Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare. |
| 18-28. Condition Codes | Required, where applicable | D7 Medicare Part A noncovered service or does not meet Medicare criteria for Part A. D9 Medicare Part B noncovered service or does not meet Medicare criteria for Part B. Refer to the July 1999 N.C. Medicaid Ambulance Services Manual for applicable ambulance condition codes. Note: Condition codes should not be entered for entitlement issues. |
| 31-34., a-b Occurrence Codes and Dates | Required, where applicable | Accident-Related Codes: 24 Date Insurance Denied: This code should be used when a provider receives a denial from the recipient's third party insurance. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. 25 Date Benefits Terminated By Primary Payer: This code should be used when a recipient's third party insurance has been terminated. It allows the provider to file the claim to Medicaid without the voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. Note: Medicare crossover claims require a paper insurance denial. Special Codes: A3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer A. B3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer B. C3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer C. |

| Form Locator/Description | Requirements | Explanation |
|---|----------------------------|---|
| | | 11 Date of Initial Treatment: Providers should use this code to indicate the first date of dialysis treatment. |
| 39.-41., a-d Value Codes and Amounts | Required, where applicable | 23 Recurring Monthly Income: This code indicates that Medicaid eligibility requirements are determined at the state level. Applicable deductible/patient liability amounts should be indicated with a value code of 23. Value code 23 and amounts only pertain to a long-term care facility, hospital, psychiatric residential treatment facility or, if the recipient lives in a nursing facility, a hospice. Note: Include code 23 and value (even if it is 0) for any inpatient stay extending beyond the first of the month following the 30 th consecutive day of admission. 80 Covered Days 81 Noncovered Days 82 Co-insurance Days 83 Lifetime Reserve Days |
| 42. Revenue Code | Required | Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes. |
| 43. Revenue Code Description | Not required | |
| 44. HCPCS/Rates | Required, where applicable | Enter the appropriate HCPCS procedure code. Refer to program-specific Medicaid services information for applicable codes. |
| 45. Service Date | Required, where applicable | Enter an eight-digit service date for each line item billed. Required if multiple dates of services are billed on one outpatient claim. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |
| 46. Unit of Service | Required, where applicable | Enter the number of units for each detail line. Refer to program-specific Medicaid services information for unit definitions. |
| 47. Total Charges | Required | Enter the total of the amounts in this column. Enter the revenue code 001 on the corresponding line in form locator 42. |
| 50. Payer Name | Required | Enter the name of the insurance payer and the two-character payer code. Payer Codes 09 Self pay 10 Central certification 11 Other non-Federal programs 12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity insurance 16 Health Maintenance Organization (HMO) Medicare risk |

| Form Locator/Description | Requirements | Explanation |
|--|--------------------------------------|--|
| | | AM Automobile risk BL Blue Cross/Blue Shield CH Champus CI Commercial insurance company DS Disability HM Health Maintenance Organization LI Liability LM Liability medical MA Medicare Part A MB Medicare Part B MC Medicaid OF Other Federal program TV Title V VA Veteran Administration Plan WC Workers' compensation health plan ZZ Unknown |
| 54. A, B, C, Prior Payments (from payers) | Required, where applicable | For dates of service before Oct. 1, 2002, enter any applicable third-party amount. Enter the Medicare Part B payment amount in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. For dates of service after Oct. 1, 2002: 54A Enter any applicable Medicare payment or third party. 54B If the Medicare payment is indicated in field locator 54A, enter any applicable third party payments in form locator 54B. The Medicare Part B payment amount should be entered for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. Include penalties and outpatient psychiatric reductions with Medicare Part B payments. Refer to the August 2004 Special Bulletin V, Medicare Part B Billing, for detailed instructions. Amounts entered in this block will be deducted from allowable payment. |
| 55. Estimated Amount Due | Required (hospital outpatient) | For claims filed to Medicaid for dates of service after Oct. 1, 2002, where Medicare Part B has made a payment, enter the sum of both the co-insurance and the deductible. |
| 56. NPI | Required | Enter your National Provider Identification number. |
| 57. Other Provider ID | Required | Enter the Medicaid provider number or taxonomy with qualifiers. ZZ will represent the taxonomy number and ID will represent the Medicaid provider number. |
| 63. A, B, C, Treatment Authorization Code | Not required | It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file. |

| Form Locator/Description | Requirements | Explanation |
|--|----------------------------|--|
| 67. Principal Diagnosis Code | Required | Enter the applicable ICD-9-CM diagnosis code. |
| 67., A–Q. Other Diagnosis Codes | Required, where applicable | Enter any additional diagnosis codes. |
| 69. Admitting Diagnosis | Required, inpatient only | Enter the ICD-9-CM code for the admitting diagnosis. |
| 74. Principal Procedure Code and Date | Required, where applicable | Enter the codes for any surgical or diagnostic procedures performed during this period. Use only ICD-9-CM procedure codes. Enter the eight-digit date of service. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |
| 74., A–E. Other Procedure Codes and Dates | Required, where applicable | Enter the codes for any additional surgical or diagnostic procedures performed during this period. Enter the eight-digit date of service. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. |
| 76. Attending Provider Information | Required, where applicable | Enter the attending provider's NPI with their taxonomy number and ZZ qualifier, or Medicaid provider number and 1D qualifier. |
| 78. Carolina Access PCP/Referring Provider | Required, where applicable | For paper claims for services provided to CA enrollees, enter the PCP NPI referral authorization or the CA override number with the 1D qualifier. For electronic claims, enter the PCP's referral authorization in field locator 11. For referring provider, enter their NPI and Medicaid provider number with 1D qualifier. |
| 80. Remarks | Required, where applicable | Enter any information applicable to the specific claim billed. |

UB-04 Example Effective March 1, 2007: Revised Claim Transition. Refer to NPI publications for NPI implementation dates.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------------------|--------------------------------|------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|--------------------------|----|----|------------------|----|-----|----|----|----|----|----|-----|----|----|----|----|-----|----|----|----|----|----|----|----|-----|----|----|----|-----|----|----|----|-----|----|----|----|-----|----|----|----|----|----|----|-----|
| 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 TYPE (IF BILL) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 PATIENT ADDRESS | a | b | c | d | e | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 SRC | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 ACCT STATE | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31 OCCURRENCE DATE | 32 OCCURRENCE DATE | 33 OCCURRENCE DATE | 34 OCCURRENCE DATE | 35 OCCURRENCE DATE | 36 OCCURRENCE DATE | 37 | 38 CODE | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
| 98 | 99 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | |
| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | |
| PAGE | OF | CREATION DATE | TOTALS | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | | | | | |
| 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 AFF. REL. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | | | | | | | | | |
| 58 INSURED'S NAME | 59 P.REL. | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 69 ADMIT DX | 70 PATIENT REASON DX | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 74 PRINCIPAL PROCEDURE CODE | 75 OTHER PROCEDURE CODE | 76 OTHER PROCEDURE CODE | 77 OTHER PROCEDURE CODE | 78 OTHER PROCEDURE CODE | 79 OTHER PROCEDURE CODE | 80 OTHER PROCEDURE CODE | 81 OTHER PROCEDURE CODE | 82 OTHER PROCEDURE CODE | 83 OTHER PROCEDURE CODE | 84 OTHER PROCEDURE CODE | 85 OTHER PROCEDURE CODE | 86 OTHER PROCEDURE CODE | 87 OTHER PROCEDURE CODE | 88 OTHER PROCEDURE CODE | 89 OTHER PROCEDURE CODE | 90 OTHER PROCEDURE CODE | 91 OTHER PROCEDURE CODE | 92 OTHER PROCEDURE CODE | 93 OTHER PROCEDURE CODE | 94 OTHER PROCEDURE CODE | 95 OTHER PROCEDURE CODE | 96 OTHER PROCEDURE CODE | 97 OTHER PROCEDURE CODE | 98 OTHER PROCEDURE CODE | 99 OTHER PROCEDURE CODE | 100 OTHER PROCEDURE CODE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 80 REMARKS | 81CC a | 81CC b | 81CC c | 81CC d | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FL1: Billing provider (must include ZIP + 4 Code).

New value codes to report covered/non-covered days, co-insurance and lifetime reserve.

FL 50: New two-digit code identifying payer.

FL 56: Billing provider NPI.

FL 57: Qualifier 1D and Medicaid provider number (required).

FL 76: Attending NPI.

FL 76: Attending Medicaid provider number. Use qualifier 1D.

FL 78: CA PCP or referring provider's NPI.

FL 78: Medicaid CA number, referring provider number or CA override number. Use qualifier 1D.

UB-04 Example: NPI Implementation. Refer to NPI publications for NPI implementation dates.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------------------|----------------------------|------------------------------|--------------------------------|--------------------|--------------------|--------|------------------|------------------|-----------------------|----------|-----------------------|---------|-----------------------|---------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----------------|----|----|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 TYPE OF BILL | | | | | | | | | | | | | | |
| 8 PATIENT | 9 PATIENT ADDRESS | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM | 7 THROUGH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 BIRTH | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 ACCT STATE | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31 OCCURRENCE CODE | 32 OCCURRENCE DATE | 33 OCCURRENCE CODE | 34 OCCURRENCE DATE | 35 OCCURRENCE CODE | 36 OCCURRENCE DATE | 37 | 38 | 39 CODE | 40 VALUE CODES AMOUNT | 41 CODE | 42 VALUE CODES AMOUNT | 43 CODE | 44 VALUE CODES AMOUNT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 42 PREV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ADJ. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 58 INSURED'S NAME | 59 P.REL. | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 67 | A | B | C | D | E | F | G | H | I | J | K | L | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 69 ADMIT DX | 70 PATIENT REASON DX | 71 ICD CODE | 72 ECI | 73 | 74 | 75 | 76 ATTENDING NPI | 77 OPERATING NPI | 78 OTHER NPI | 79 OTHER | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 00 | | | | | | | | | | | | |
| 80 REMARKS | 81CC a | b | c | d | THE CERTIFICATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FL1: Billing provider (must include ZIP + 4 Code).

New value codes to report covered/non-covered days, co-insurance and lifetime reserve.

FL 50: New two-digit code identifying payer.

FL 56: Billing provider NPI.

FL 57: Qualifier ZZ and billing taxonomy.

FL 76: Attending NPI.

FL 76: Attending taxonomy. Use qualifier ZZ.

FL 78: CA PCP or referring provider NPI.

FL 78: CA override number (if applicable) and 1D qualifier OR PCP taxonomy and ZZ qualifier.

Instructions for the 2006 ADA Claim Form

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the ADA. The ADA instruction manual can be found at www.ada.org. Refer to NPI publications for NPI implementation dates.

ADA Changes Effective March 1, 2007: Revised Claim Transition

- Field 35 (Billing Taxonomy): Enter the billing provider's taxonomy code.
- Field 48 Address: Provider address information must include the ZIP + 4 Code.
- Field 49 (Billing NPI): Enter billing provider's NPI. N.C. Medicaid requests that providers immediately start submitting the NPI and taxonomy in addition to the Medicaid provider number.
- Field 52A (Additional Provider ID): Enter the billing provider's Medicaid number. This number will also be required after NPI implementation for prior approval purposes only.
- Field 54 (NPI): Enter attending provider's NPI. N.C. Medicaid requests that providers immediately start submitting the NPI and taxonomy in addition to the Medicaid provider number.
- Field 56 (Address): Provider address information must include the ZIP + 4 Code.
- Field 56A (Provider Specialty Code): Enter the attending provider's taxonomy.
- Field 58 (Additional Provider ID): Enter attending provider's Medicaid number.

ADA Line-by-Line Instructions

Instructions for the 2006 ADA Form are listed below. Changes are highlighted. Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the ADA. The ADA instruction manual can be found at www.ada.org. Refer to NPI publications for NPI implementation dates.

| Field Number | Field Name | Explanation |
|--------------|------------------------------|--|
| 12 | Name | Enter the recipient's full name (last, first, middle) as it appears on the Medicaid ID card. |
| 13 | Date of Birth | Enter the recipient's date of birth using eight digits (example: July 1, 2006 = 07012006). |
| 14 | Gender | Check the appropriate box: M = Male, F = Female. |
| 15 | Subscriber Information | Enter the recipient's 10-digit identification number listed on the Medicaid card. |
| 23 | Patient ID/Account # | Enter the recipient's medical record number if used by your office. This is optional but will appear on your RA if entered. |
| 24 | Procedure Date | Enter the date the procedure was completed, using eight digits (example: July 1, 2006=07012006). |
| 25 | Area of Oral Cavity | Enter a valid code for procedures that require a quadrant or arch indicator in field 25 or 27. |
| 27 | Tooth Number(s) or Letter(s) | Enter a valid code for procedures that require a tooth number or letter. |
| 28 | Tooth Surface | Enter a valid code for procedures that require a tooth surface. |
| 29 | Procedure Code | Enter the five-digit dental procedure code rendered. Note: All procedure codes must begin with the letter "D." |
| 30 | Description | Enter the description of the procedure. |
| 31 | Fee | Enter your usual fee for the procedure, not the established Medicaid fee. |
| 32 | Other Fee(s) | If applicable, enter the amount of payment received from third-party insurance plan(s). Do not include any payments from Medicare Part B or allowable Medicaid co-payments. |
| 33 | Total Fee | Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid co-payments or third-party insurance payments listed in field 32. The fiscal agent will calculate the maximum amount payable by taking into account any co-payments or third-party payments. |
| 34 | Missing Teeth Information | Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth and show space closure with arrows(←, →). |
| 35. | Remarks | Enter billing provider's taxonomy. |

| Field Number | Field Name | Explanation |
|--------------|--|--|
| 38 | Place of Treatment | Enter the appropriate code (below) for the facility where the recipient was treated. Only one place of treatment can be entered per claim. 3 = provider's office (or check box) 1 = inpatient hospital 2 = outpatient hospital F = ambulatory surgical center 4 = rest home or recipient's home 7 = intermediate care facility 8 = skilled nursing facility |
| 48 | Billing Address, City, State, Zip Code | Enter address, including ZIP + 4 Code. |
| 49 | NPI | Enter the billing provider's NPI number of the dentist or practice that is to receive payment. <ul style="list-style-type: none"> If payment is to be made to a group practice, then enter the group NPI number. If payment is to be made to an individual dentist, then enter the individual dentist NPI number. |
| 52A | Additional Provider ID | Enter Medicaid provider number. After NPI implementation, the Medicaid provider number is for prior approval purposes only. |
| 52 | Phone number | Enter the area code and phone number of the billing dentist or practice. |
| 53 | Signed (Treating Dentist) | Signature of provider rendering service. The signature certifies that: "Services for which payment is requested are medically necessary and indicated in the best interest of the recipient's oral health. The provider's signature on Medicaid documents and claims shall be binding and shall certify that all information is accurate and complete." |
| 54 | NPI | Enter the attending provider's NPI number for the individual dentist rendering the service. This number should correspond to the signature in field 53. |
| 56 | Address, City, State, Zip Code | Enter address, including ZIP + 4 Code. |
| 56A | Provider Specialty Code | Enter attending provider's taxonomy. |
| 58 | Additional Provider ID | Enter Medicaid provider number. |

ADA Example Effective March 1, 2007: Revised Claim Transition.
Refer to NPI publications for NPI implementation dates.

ADA Dental Claim

| HEADER INFORMATION | | | | | | | | | | | | |
|--|-------------------------|------------------|----------------------------------|-------------------|--------------------|---|--|---|--|---|--|---------|
| 1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prefauthorization <input type="checkbox"/> EPSDT/Title XIX | | | | | | | | | | | | |
| 2. Predetermination/Prefauthorization Number | | | | | | POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) | | | | | | |
| INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION | | | | | | | | | | | | |
| 3. Company/Plan Name, Address, City, State, Zip Code | | | | | | | | | | | | |
| OTHER COVERAGE | | | | | | 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | |
| 4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11) | | | | | | 13. Date of Birth (MM/DD/CCYY) | | 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F | | 15. Policyholder/Subscriber ID (SSN or ID#) | | |
| 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) | | | | | | 16. Plan/Group Number | | 17. Employer Name | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | |
| 6. Date of Birth (MM/DD/CCYY) | | | | | | 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F | | 8. Policyholder/Subscriber ID (SSN or ID#) | | 18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other | | |
| 9. Plan/Group Number | | | | | | 10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other | | 19. Student Status <input type="checkbox"/> FTB <input type="checkbox"/> PTS | | | | |
| 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code | | | | | | | | | | | | |
| 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | 21. Date of Birth (MM/DD/CCYY) | | | | | | |
| 22. Patient ID/Account # (Assigned by Dentist) | | | | | | 23. Gender <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | |
| RECORD OF SERVICES PROVIDED | | | | | | | | | | | | |
| 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | | | | | | 31. Fee |
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| 10 | | | | | | | | | | | | |
| 32. Other Fee(s) | | | | | | | | | | | | |
| 33. Total Fee | | | | | | | | | | | | |
| 35. Remarks | | | | | | | | | | | | |
| AUTHORIZATIONS | | | | | | | | | | | | |
| 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist/dental practice has a contract/agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out my treatment in connection with this claim. | | | | | | | | | | | | |
| X Patient/Guardian signature | | | | | | Date | | | | | | |
| ANCILLARY CLAIM/TREATMENT INFORMATION | | | | | | | | | | | | |
| 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. | | | | | | 38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other | | | | | | |
| X Subscriber signature | | | | | | Date | | | | | | |
| 39. Number of Enclosures (00 to 99) Redesignate(s) Original(s) | | | | | | 40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) | | | | | | |
| 41. Name, Address, City, State, Zip Code | | | | | | 41. Date Appliance Placed (MM/DD/CCYY) | | | | | | |
| 42. Months of Treatment Remaining | | | | | | 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) | | | | | | |
| 44. Date Prior Placement (MM/DD/CCYY) | | | | | | 45. Treatment Resulting from <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident | | | | | | |
| 46. License Number | | | | | | 47. Auto Accident State | | | | | | |
| BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or claim on behalf of the patient or insured subscriber) | | | | | | | | | | | | |
| 48. Name, Address, City, State, Zip Code | | | | | | | | | | | | |
| ATTENDING LOCATION INFORMATION | | | | | | | | | | | | |
| 49. NPI | | | | | | 50. License Number | | | | | | |
| 51. SSN or TIN | | | | | | 52. Address, City, State, Zip Code | | | | | | |
| 53. Phone | | | | | | 54. NPI | | | | | | |
| 55. Additional Provider ID | | | | | | 56. License Number | | | | | | |
| 57. Additional Provider ID | | | | | | 58. Additional Provider ID | | | | | | |

35: Billing taxonomy.

54: Attending NPI.

56A: Attending Taxonomy.

49: Billing NPI.

52A: Billing Medicaid provider number.

48 & 56: Address including ZIP + 4 Code.

58: Attending Medicaid provider number.

ADA Example: NPI Implementation. Refer to NPI publications for NPI implementation dates.

ADA Dental Claim Form

| HEADER INFORMATION | | | | | | | | | | POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) | | | | | | | | | | | |
|--|-------------------------|------------------|----------------------------------|-------------------|---|-----------------|--|--|--|---|---------|------------------|--|--|--|--|--|--|--|--|--|
| 1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPBDT/Title XIX | | | | | | | | | | 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | | | | | | |
| 2. Predetermination/Preauthorization Number | | | | | | | | | | 13. Date of Birth (MM/DD/CCYY) | | | | | | | | | | | |
| INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION | | | | | | | | | | 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F | | | | | 15. Policyholder/Subscriber ID (SSN or ID#) | | | | | | |
| 3. Company/Plan Name, Address, City, State, Zip Code | | | | | | | | | | 16. Plan/Group Number | | | | | 17. Employer Name | | | | | | |
| OTHER COVERAGE | | | | | | | | | | PATIENT INFORMATION | | | | | | | | | | | |
| 4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11) | | | | | | | | | | 18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other | | | | | | | | | | | |
| 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) | | | | | | | | | | 19. Student Status <input type="checkbox"/> FTB <input type="checkbox"/> PTB | | | | | 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | |
| 6. Date of Birth (MM/DD/CCYY) | | | | | 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F | | 8. Policyholder/Subscriber ID (SSN or ID#) | | | 21. Date of Birth (MM/DD/CCYY) | | | | | 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F | | 23. Patient ID/Account # (Assigned by Dentist) | | | | |
| 9. Plan/Group Number | | | | | 10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other | | | | | 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code | | | | | | | | | | | |
| RECORD OF SERVICES PROVIDED | | | | | | | | | | MISSING | | | | | | | | | | | |
| 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | | | | | 31. Fee | 32. Other Fee(s) | | | | | | | | | |
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| 40. (Place) | | | | | | | | | | 41. (Place) | | | | | | | | | | | |
| 42. (Place) | | | | | | | | | | 43. (Place) | | | | | | | | | | | |
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| 72. (Place) | | | | | | | | | | 73. (Place) | | | | | | | | | | | |
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| 532. (Place) | | | | | | | | | | 533. (Place) | | | | | | | | | | | |
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| 564. (Place) | | | | | | | | | | 565. (Place) | | | | | | | | | | | |
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| 572. (Place) | | | | | | | | | | 573. (Place) | | | | | | | | | | | |
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| QUICK REFERENCE GUIDES FOR CAROLINA ACCESS PROVIDERS |
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Significant changes regarding the placement of Carolina ACCESS information have occurred on both the CMS-1500 and the UB-04 claim forms. Outlined below are specific timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides and referring provider information on the claim. Please make note of these filing requirements.

CMS-1500 (08/05)

Claims Processed with CA PCP Authorization and/or CA Override

Transition Dates: Jan. 1 through May 17, 2007 (Date of Processing)

| <p>Effective April 1, 2007, providers must submit the new CMS-1500 (08/05) claim form. Providers filing on the new CMS-1500 (08/05) claim form must follow the process below for claims received from Jan. 1 through May 17, 2007.</p> | | | | |
|--|---|------------------------------------|--------------------------------------|--|
| <i>Block</i> | <i>Block Name</i> | <i>Required Field Yes / No</i> | <i>Value</i> | <i>Explanation</i> |
| 17 | Name of Referring Provider | No | | |
| 17a (smaller shaded box) | Qualifier | Yes | 1D | Qualifier 1D represents Medicaid provider number. |
| 17a (larger shaded box) | PCP Referral Number or CA Override Number | Yes | Medicaid Provider # or CA Override # | Enter the CA PCP referral number (Medicaid provider number) or the CA override number assigned by EDS. |
| 17b | NPI (National Provider Identifier) | No | NPI Number | The CA referral information is processed from block 17a. |

CMS-1500 (08/05)
Claims Processed with CA PCP Authorization
Effective May 18, 2007 (Date of Processing)

| <i>Block</i> | <i>Block Name</i> | <i>Required Field Yes / No</i> | <i>Value</i> | <i>Explanation</i> |
|--------------------------|---------------------------------------|------------------------------------|------------------------------------|---------------------------|
| 17 | Name of Referring Provider | No | | |
| 17a (smaller shaded box) | Qualifier | No | | |
| 17a (larger shaded box) | Taxonomy Number of Referring Provider | No | | |
| 17b | NPI | Yes | CA referring provider's NPI number | This is a required field. |

Note: If any value is entered in field 17a other than ZZ or blank, the claim will deny. If you enter a ZZ qualifier in field 17a you must enter the taxonomy number in field 17a or the claim will deny.

CMS-1500 (08/05)
Claims Processed with CA Override
Effective May 18, 2007 (Date of Processing)

| <i>Block</i> | <i>Block Name</i> | <i>Required Field Yes / No</i> | <i>Value</i> | <i>Explanation</i> |
|--------------------------|----------------------------|------------------------------------|----------------------------|--|
| 17 | Name of Referring Provider | No | | |
| 17a (smaller shaded box) | Qualifier | Yes | 1D | Qualifier 1D represents Medicaid provider number. If any other value is entered, the claim will be denied. |
| 17a (larger shaded box) | CA Override Number | Yes | EDS-issued override number | |
| 17b | NPI | No | | Will not have NPI of referring provider. |

UB-04
Claims Processed with CA PCP Authorization/Referral or CA Override
Transition Dates: March 1 through May 17, 2007 (Date of Processing)

| <p align="center">Effective May 1, 2007, providers must submit the new UB-04 claim form. Providers filing on the new UB-04 claim form must follow the process below for claims received from March 1 through May 17, 2007.</p> | | | | |
|---|---|------------------------------------|---|---|
| <i>Form Locator</i> | <i>Description</i> | <i>Required Field Yes / No</i> | <i>Value</i> | <i>Explanation</i> |
| 78 (blank field 1) | NPI | No | | The CA authorization is processed from field locator 78, blank positions 2 and 3. |
| 78 (blank field 2) | Qualifier | Yes | 1D | Qualifier 1D represents Medicaid provider number. If any other value is entered, the claim will be denied. |
| 78 (blank field 3) | PCP Referral Number or CA Override Number | Yes | Medicaid provider # or EDS-issued CA override # | Enter the current CA PCP number (Medicaid provider #) or the CA override number assigned by EDS. |
| 78 (blank field 4) Last | Last Name of Referring Provider | No | | |
| 78 (blank field 5) First | First Name of Referring Provider | No | | |

UB-04
CA Claims Processed with PCP Authorization/Referral
Effective May 18, 2007 (Date of Processing)

| <i>Form Locator</i> | <i>Description</i> | <i>Required Field Yes / No</i> | <i>Value</i> | <i>Explanation</i> |
|-----------------------------|---------------------------------------|------------------------------------|------------------------------------|---------------------------|
| 78 (blank field 1) | NPI | Yes | CA referring provider's NPI number | This is a required field. |
| 78 (blank field 2) | Qualifier | No | | |
| 78 (blank field 3) | Taxonomy Number of Referring Provider | No | | |
| 78 (blank field 4) Last | Last Name of Referring Provider | No | | |
| 78 (blank field 5) First | First Name of Referring Provider | No | | |

Note: If any value is entered in field 78 (blank field 2) other than ZZ or blank, the claim will be denied. If you enter a ZZ qualifier in field 78 (blank field 2), you must enter the taxonomy number in field 78 (blank field 3) or the claim will be denied.

UB-04
CA Claims Processed with CA Override Number
Effective May 18, 2007 (Date of Processing)

| <i>Form Locator</i> | <i>Description</i> | <i>Required Field Yes / No</i> | <i>Value</i> | <i>Explanation</i> |
|-----------------------------|----------------------------------|------------------------------------|----------------------------|--|
| 78 (blank field 1) | NPI | No | | Will not have NPI number of referring provider. |
| 78 (blank field 2) | Qualifier | Yes | 1D | Qualifier 1D represents Medicaid provider number. If any other value is entered, the claim will be denied. |
| 78 (blank field 3) | CA Override Number | Yes | EDS-issued override number | |
| 78 (blank field 4) Last | Last Name of Referring Provider | No | | . |
| 78 (blank field 5) First | First Name of Referring Provider | No | | |

Mark T. Benton

Mark T. Benton, Senior Deputy Director
and Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier

Cheryll Collier
Executive Director
EDS
