2010
Health Check
Billing Guide

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For your convenience key words and phrases have been **bolded** or highlighted.

In the state of North Carolina, the EPSDT services program is administered under the name Health Check, which is the Medicaid Program for Children.

EPSDT POLICY INSTRUCTIONS

Background

Federal Medicaid law at 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this instruction.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients 21 years of age and over). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient's condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient's conditions. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. Refer to **Section 6, Prior Approval,** for further information about EPSDT and prior approval requirements.

EPSDT Features

Under EPSDT, there is:

1. **No Waiting List for EPSDT Services**

   EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients under 21 years of age.

2. No Monetary Cap on the Total Cost of EPSDT Services*

A child under 21 years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria specified in this policy instruction. If enrolled in a Community Alternatives Program (CAP), then the recipient under 21 years of age may receive **BOTH** waiver and EPSDT services. However, it is important to remember that the conditions set forth in the waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care must not exceed the waiver cost limits specified in the CAP waivers for Children (CAP/C) or Disabled Adults (CAP/DA). Should a recipient enrolled in the CAP waiver for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD) need to exceed the waiver cost limit, prior approval must be obtained from ValueOptions.

***EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. See attached listing.**

3. No Upper Limit on the Number of Hours or Units under EPSDT

For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist, or Other Licensed Clinician

To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes **MAY NOT APPLY** to requests for services for children under 21 years of age.

6. No Co-payment or Other Cost to the Recipient

7. Coverage for Services That Are Never Covered for Recipients over 21 Years of Age

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical and mental illness, or condition [health problem].

8. Coverage for Services Not Listed in the N.C. State Medicaid Plan

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services"

are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.

2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be medical in nature.
4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

IMPORTANT POINTS ABOUT EPSDT COVERAGE

General

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.
3. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child's condition regardless of eligibility for CAP waiver services.
4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.
5. Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.
6. EPSDT operational principles include those specified below.
   a. When state staff or vendors review a covered state Medicaid plan services request for prior approval or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that
      (1) Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.

(2) The decision to approve or deny the request will be based on the recipient's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].

b. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do NOT have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

c. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do NOT apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

d. Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

Out-of-state services are NOT covered if similarly efficacious services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] are available anywhere in the state of North Carolina. Services delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility. Refer to **Section 6, Prior Approval,** for further information regarding the provision of out-of-state services.

e. Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance, requesting a review for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.

f. Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services regarding further detail about information to be submitted.

g. North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

h. Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).

i. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.

j. Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. North Carolina Medicaid will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.

k. Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

l. If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, citation that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

m. The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a re-authorization request.

EPSDT Coverage and CAP Waivers

1. Waiver services are available only to participants in the CAP waiver program and are not a part of the EPSDT benefit unless the waiver service is ALSO an EPSDT service (e.g. durable medical equipment).
2. Any request for services for a CAP recipient under age 21 must be evaluated under BOTH the waiver and EPSDT.
3. Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.
4. ANY child enrolled in a CAP program can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP/C or CAP/DA, the cost of the recipient's care must not exceed the waiver cost limit. Should the recipient be enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD), prior approval must be obtained to exceed the waiver cost limit.
5. A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed by Medicaid. For further information, see "No Waiting List for EPSDT" on page 1 of this instruction.
6. EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP/MR-DD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.

7. Case managers in the Community Alternatives Program for Disabled Adults (CAP/DA) can deny a request for CAP/DA waiver services. If a CAP/DA case manager denies, reduces, or terminates a CAP/DA waiver service, it is handled in accordance with DMA's recipient notices procedure.

   No other case manager can deny a service request supported by a licensed clinician, either formally or informally.

8. When a recipient under 21 years of age is receiving CAP services, case managers must request covered state Medicaid plan services as indicated below. Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.

   a. **CAP/C:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/C consultant at DMA in accordance with the CAP/C policy. A plan of care revision for waiver services must be submitted to the CAP/C consultant as well.

   b. **CAP/DA:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/DA case manager in accordance with the CAP/DA policy. A plan of care revision for waiver services must be submitted to the CAP/DA case manager as well. **All EPSDT requests must be forwarded to the CAP/DA consultant at DMA.**

   c. **CAP/MR-DD:** All EPSDT and covered state Medicaid plan requests for behavioral health services must be forwarded to ValueOptions. This includes requests for children not in a waiver who have a case manager. Requests for medical and dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do **NOT** submit such requests to ValueOptions. Plan of care revisions must be submitted in accordance with the CAP/MR-DD policy.

      EXCEPTION: Behavioral health services requested for individuals residing in the Piedmont Cardinal Health Plan (PCHP) catchment area. See item d below.

   d. All EPSDT and covered state Medicaid plan requests for **behavioral health services** for Medicaid recipients in the Piedmont Cardinal Health Plan (PCHP) catchment area must be forwarded to PCHP. The PCHP catchment area includes Cabarrus, Davidson, Rowan, Stanly, and Union counties. Requests for **medical and dental services** covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do **not** submit such requests to PCHP. Plan of care revisions must be submitted in accordance with the Piedmont Innovations waiver policy.

9. An appeal under CAP must also be considered under EPSDT criteria as well as under CAP provisions if the appeal is for a Medicaid recipient under 21 years of age.

EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services

1. Staff employed by local management entities (LMEs) CANNOT deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.

2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.

3. Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.
4. If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.
5. All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

PROCEDURE FOR REQUESTING EPSDT SERVICES

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. **If prior approval is required** and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary and meets all EPSDT criteria, including to correct or ameliorate a defect, physical or mental illness, or condition [health problem], to the appropriate vendor or DMA staff. When requesting prior approval for a covered service, refer to the *Basic Medicaid Billing Guide,* section 6. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted. See the Provider Documentation section of these instructions for information regarding documentation requirements.

In the event **prior approval is not required** for a service and the recipient exceeds the clinical coverage policy limitations, prior approval from a vendor or DMA staff is required. See the Provider Documentation section of these instructions for information regarding documentation requirements.

Services Formerly Covered by Children's Special Health Services (CSHS)

Previously, requests for pediatric mobility systems, cochlear implants and accessories, ramps, tie-downs, car seats, vests, DME, orthotics and prosthetics, home health supplies, not listed on DME fee schedules for recipients under 21 years of age, oral nutrition, augmentative and alternative communication devices, and over-the counter medications were approved and processed by CSHS. These services have been transferred from CSHS to Medicaid as specified below.

- **Pediatric Mobility Systems**, including non-listed components—Send to HP ENTERPRISE SERVICES using the Certificate of Medical Necessity/Prior Approval (CMN/PA form). Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment,* for details (on DMA's Web site at http://www.ncdhhs.gov/dma/mp/).
- **Cochlear/Auditory Brainstem Implants and Accessories—**Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.

- **Oral Nutrition Formula on DMA Fee Schedules**—Send requests except those for metabolic formula to HP Enterprise Services. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment,* for details (on DMA's Web site at http://www.ncdhhs.gov/dma/mp/).
- **Augmentative and Alternative Communication Devices on DMA Fee Schedules—**Send requests to HP Enterprise Services. Refer to Clinical Policy 5A, *Durable Medical Equipment,* for details (on DMA's Web site at http://www.ncdhhs.gov/dma/mp/).
- **Ramps, Tie Downs, Car Seats, and Vests—**Effective with date of request September 1, 2008, CSHS no longer authorizes payment for ramps, tie-downs, car seats, and vests. These items are not included in the DME covered by Medicaid, nor are they covered under EPSDT services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered **if covered under the waiver**.

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but are coverable** under federal Medicaid law, 1905(r) of the Social Security Act, for recipients under 21 years of age. *See attached listing*. **Medical and dental** service requests for non-covered state Medicaid plan services, and requests for a review when there is no established review process for a requested service, should be submitted to the Division of Medical Assistance, Assistant Director for Clinical Policy and Programs, at the address or facsimile (fax) number specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age. Requests for non-covered state Medicaid plan **mental health services** should be submitted to ValueOptions. The Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age is available on the DMA Web site: http://www.ncdhhs.gov/dma/provider/forms.htm. To decrease delays in reviewing non-covered State Medicaid plan requests, providers are asked to complete this form. A review of a request for a non-covered State Medicaid plan service includes a determination that **ALL** EPSDT criteria specified in these instructions are met.

Requests for the services listed below should be sent to the Assistant Director, Clinical Policy and Programs, DMA and should be submitted on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age as specified at the end of this section and unless otherwise specified.

- **Any other service not listed on the DMA fee schedules for recipients under 21 years of age that appears at 1905(a) of the Social Security Act.**
- **Over-the-Counter (OTC) Medications—**If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS), but the drug does not appear on DMA's approved coverage listing of OTC medications.

Send requests for the services immediately above, any other non-covered state Medicaid plan services that are coverable under 1905(a) of the Social Security Act, or requests for a review when there is no established review process for a requested service on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age and mail or fax to:

Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh NC 27699-2501
FAX: 919-715-7679

PROVIDER DOCUMENTATION

Documentation for either covered or non-covered State Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes:

1. documentation showing that medical necessity and policy criteria are met;
2. documentation to support that all EPSDT criteria are met; and
3. evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

FOR FURTHER INFORMATION ABOUT EPSDT

- Important additional information about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide,* **Sections 2** and **6,** and on the DMA EPSDT provider page. The Web page addresses are specified below.
  Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/basicmed/
  Health Check Billing Guide: http://www.ncdhhs.gov/dma/healthcheck/
  EPSDT Provider Page: http://www.ncdhhs.gov/dma/epsdt/
- DMA and its vendors will conduct ongoing training for employees, agents, and providers on this instruction. Training slides are available on the EPSDT provider page on DMA's Web site at http://www.ncdhhs.gov/dma/epsdt/.

ATTACHMENTS

- Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a) [42 U.S.C. § 1396d(a)]
- Non-Covered State Medicaid Plan Services Request Form for Recipients **under 21 Years of Age**

Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT (**Note:** EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case management services
- TB-related services

- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

Name _____ **MID** _____ **DOB** _____

Non-Covered State Medicaid Plan Services Request Form for Recipients *under* 21 Years Old

This form is available on DMA's Web site at http://www.ncdhhs.gov/dma/provider/forms.htm.

Mail the completed, signed form to the Assistant Director of Clinical Policy and Programs, Division of Medical Assistance, 2501 Mail Service Center, Raleigh, N.C. 27699-2501 or fax it to (919) 715-7679. You may use additional sheets to supply any other information you think would be helpful. **Include evidence-based literature, if available.**

I. **Recipient Information.** This must be completed by a physician, licensed clinician, or other provider.

Name _____

Date of Birth ____/____/____ *(mm/dd/yyyy)* **Medicaid Number** _____

Address _____

_____

_____

II. **Medical Necessity.** All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name		**Provider Name**	
Medicaid Provider #		**Medicaid Provider #**	
Address		**Address**	
Telephone		**Telephone**	
Fax		**Fax**	

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.) _____

_____

_____

What is the recipient's health history? (Include chronic illness.) _____

_____

_____

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.) _____

_____

_____

What treatment has been given for the diagnosis(es) above? [Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).] _____

_____

_____

On the next page, identify the requested procedure, product, or service (if applicable, please include CPT and HCPCS codes). Provide a description of how the requested item will correct or ameliorate the recipient's defect, physical or mental illness, or condition [the problem]. This description *must* include a detailed

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SAMPLE

Name _____ **MID** _____ **DOB** _____

discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment? _____ Yes _____ No

If yes, provide name and protocol # _____

Is the requested product, service, or procedure considered to be safe? _____ Yes _____ No

If no, please explain. _____

Is the requested product, service or procedure effective? _____ Yes _____ No

If no, please explain. _____

Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? _____ Yes _____ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available. _____

What is the expected duration of treatment? _____

Requestor's Signature & Credentials **Date**

DMA-3510

SAMPLE

HEALTH CHECK/EPSDT OVERVIEW

Health Check/EPSDT is important because

1. It provides for early and regular medical, developmental (including physical and mental health development), dental screenings and ongoing surveillance for all Medicaid recipients under the age of 21.
2. It is part of the federal Medicaid EPSDT requirement that provides recipients with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment.
3. Under Health Check/EPSDT, the N.C. Medicaid Program has an explicit obligation to make available a variety of individual and group providers qualified and willing to provide Health Check/EPSDT services.

Health Check screening, diagnostic and treatment services are free of charge to the recipient. Health Check recommends regular medical screening assessments (well-child check-ups) for recipients as indicated in the table below. **The Periodicity Schedule is only a guideline; if a recipient needs to have assessments on a different schedule, the visits are still covered.**

Health Check/EPSDT Periodicity Schedule

Within 1st month	9 or 15 months
2 months	12 months
4 months	18 months
6 months	For children ages 2 through 20, annual visits are recommended

Each **Health Check** screening component is vital for measuring and monitoring over time a child's physical, mental, and developmental growth. Families are encouraged to have their children receive Health Check screening assessments and immunizations on a regular schedule. All Health Check components are required and must be documented in the child's medical record. The components are based on the American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* and may be found at http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1. **The periodicity schedule has been changed to better align Health Check program guidelines with new national standards. Assessments are strongly recommended annually from 2 years of age through 20 years of age.**

It is also the responsibility of each health care provider to assist families in scheduling appointments for timely assessments, to create a quality system for follow-up with families whose children are delinquent for preventive health care check-ups, and to make appropriate referrals and requests for medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment.

Periodic and Interperiodic Health Check Screening Assessments

Periodic Health Check screening assessments require all age-appropriate components including comprehensive health history, measurements, vision and hearing screening/assessment, dental screening, laboratory tests as clinically indicated (including blood lead screening test at 12 and 24 months of age), nutritional assessment, developmental screening/assessment (including physical and mental development), comprehensive unclothed physical assessment, immunizations, anticipatory guidance, and follow-up/referral as indicated. EPSDT requires that medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment is covered.

Refer to the **Periodicity Schedule located on page 14** for the recommended age intervals for periodic screening assessments.

Interperiodic Health Check screening assessments require all age-appropriate components **except developmental, hearing, and vision screenings/risk assessments** and **may be performed outside of the Periodicity Schedule, located on page 14, for reasons including but not limited to:**

- When a child requires a kindergarten or sports physical outside the recommended schedule.
- When a child's previously diagnosed physical, mental, or developmental illnesses or conditions require closer monitoring.
- When further assessment, diagnosis, or treatment is needed due to physical or mental illness.
- Upon referral by a health, developmental, or educational professional based on physical or clinical assessment.

Note: Providers must document in the medical record the reason necessitating an Interperiodic screening assessment. All electronically submitted claims should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment.

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS

A complete Health Check screening assessment consists of the following age-appropriate components:

- **Comprehensive unclothed physical assessment**
  To be performed at every Health Check screening assessment. A complete physical appraisal of the unclothed child/adolescent must be performed to distinguish any observable deviations from normal, expected findings. The assessment will use techniques of inspection, palpation, percussion, and auscultation.

- **Comprehensive health history**
  To be performed at every Health Check screening assessment. At the time of the initial evaluation, this will include a medical history, family history, social history, and review of systems. This information must be updated at subsequent visits.

- **Nutritional assessment**
  To be performed at every Health Check screening assessment.

- **Anticipatory guidance and health education**
  To be performed at every Health Check screening assessment. **The Bright Futures 2008 Pocket Guide provides a quick reference tool for anticipatory guidance topics by age (http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf).**

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

- **Measurements, blood pressure, and other vital signs**
  To be performed as age appropriate and medically necessary at every Health Check screening assessment. Height, weight, head circumference, BMI (Body Mass Index) and BMI percentile must be measured and/or calculated and plotted on a growth chart as age-appropriate. BMI and BMI percentile are required for ages 2 years and above. Weight for length must be assessed for all recipients under 2 years of age. Vital signs should be measured as appropriate and it is recommended that providers reference tables of age appropriate normal vital signs as needed. Blood pressure is required as part of the screening assessment visit beginning at age 3 years old. However, blood pressure measurement in infants and children with specific risk conditions should be considered and performed before 3 years of age.

- **Developmental screening (including physical and mental development)**
  To be performed at Periodic screening assessments at ages 6, 12, and 18 or 24 months, and at 3 years, 4 years, and 5 years of age using a standardized and validated screening tool. A complete list of appropriate screening tools can be found at http://www.dbpeds.org/**.** The American Academy of Pediatrics' policy on Developmental Surveillance and Screening can be found at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/1/405.pdf. **At all other periodic check-ups, developmental surveillance must be done.**

  Providers must perform routine screening for autism spectrum disorders using a validated screening instrument at ages 18 and 24 months. The Modified Checklist for Autism in Toddlers is a validated tool that is readily available at http://www.firstsigns.org/downloads/m-chat.pdf. Guidance for scoring the tool is available at http://www.firstsigns.org/downloads/Downloads_archive/m-chat_scoring.PDF. When the screen is positive, providers should refer children for Early Intervention services and an audiology evaluation. If the child also has a global developmental delay or an intellectual disability, or a suspected genetic or neurologic disorder, providers should consider referral to a developmental and behavioral pediatrician, geneticist or neurologist. **Providers can bill 99420 EP for this developmental screening since this would be done in addition to the ASQ or PEDS.**

  Providers may bill for the Health Risk Assessment (e.g. GAPS/HEADSSS) and Behavioral-Mental Health Screenings (e.g. PSC; SDQ; PHQ-A; Beck's) using **CPT 99420 EP**. . Additionally providers may bill CPT Codes 99406 EP/ 99407 EP (Smoking & Tobacco Use Cessation Counseling) and CPT 99408 / 99409 (Alcohol and Substance Abuse Screening and Brief Intervention / CRAFFT).

- **Immunizations**
  Immunizations must be provided at the time of a Periodic or Interperiodic screening assessment if needed. **It is not appropriate for a Health Check screening assessment to be performed in one location and a child referred to another location or office for immunizations.**

  The *Recommended Immunization Schedules for Persons Aged 0 –-18---United States, 2010,* approved by the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) may be found at http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm.

  Note: Please refer to pages 21 through 35 in this guide for additional immunization information.

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

- **Vision screenings**

  Objective screenings must be performed during **every** Periodic screening assessment beginning at age 3 through age 10 years. Starting at age 11 years, vision screenings must be performed once every three years. Selectively screen vision at other ages based on the provider's assessment of risk, including any academic difficulties. For guidance on vision risk assessment/screening for children and youth, go to AAP Policy Statement on "Eye Examination in Infants, Children and Young Adults by Pediatricians" at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;111/4/902.pdf.

  For children who are uncooperative with a vision screening, providers may ask the parent or legal guardian to bring the child back into the office within a few days for a second attempt at the vision screening. **Children who cannot be tested after repeated attempts must be referred to an ophthalmologist or optometrist for a comprehensive vision examination. The repeated attempts and referral to an ophthalmologist/optometrist must be documented in the medical record.**

  For children who are uncooperative, blind, or have an autism spectrum disorder, providers must:
  1. Document in the patient's medical record the date of service and the reason(s) why the provider was unable to perform the vision screening,
  2. Submit the claim to HP ENTERPRISE SERVICES without the vision CPT code,
  3. HP ENTERPRISE SERVICES will process the claim.

- **Hearing screenings**

  Objective screenings using an otoacoustic auditory emission (OAE) tool or audiometer (auditory sweep) must be performed annually for children ages 4-10.

  At all other ages, selectively screen based on the provider's assessment of risk. Screening must occur if the parent is concerned about the child's hearing, speech or language OR the child is exposed to potentially damaging noise levels, head trauma with loss of consciousness, recurring ear infections, acute/chronic disease that could contribute to hearing loss, ototoxic medications or reports problems including academic difficulties. For further guidance go to http://www.medicalhomeinfo.org/training/materials/April2004Curriculum/SS/Appendices/App%20I%20-%20Hearing%20Assessment.pdf.

  For children who are uncooperative with a hearing screening, providers may ask the parent or legal guardian to bring the child back into the office within a few days for a second attempt at the hearing screening. **Children who cannot be tested after repeated attempts must be referred to an audiologist for a hearing evaluation. The repeated attempts and referral to an audiologist must be documented in the medical record.**

  For children who are uncooperative, deaf, or have an autism spectrum disorder, providers must:
  1. Document in the patient's medical record the date of service and the reason(s) why the provider was unable to perform the hearing screening,
  2. Submit the claim to HP ENTERPRISE SERVICES without the hearing CPT,
  3. HP ENTERPRISE SERVICES will process the claim.

- **Dental screenings**

  An oral screening must be performed at every Health Check screening assessment**. In addition, referral to a dentist is required for every child by the age of 3 years old.** An oral screening performed during a physical assessment is not a substitute for an examination that results from a direct referral to a dentist. The initial dental referral **must** be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. **When any screening indicates a need for dental services at an earlier age (such as baby bottle caries), referrals must be**

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

made for needed dental services and documented in the child's medical record. The periodicity schedule for dental examinations is not governed by the schedule for regular health check-ups.

Note: Although not a requirement of a Health Check screening assessment, providers who perform a Health Check screening assessment and dental varnishing may bill for both services. Refer to **Clinical Coverage Policy # 1A-23, *Physician Fluoride Varnish Services*,** on DMA's Web site at http://www.ncdhhs.gov/dma/mp/ for billing codes and guidelines.

- **Laboratory procedures**
  Laboratory procedures include hemoglobin or hematocrit, newborn metabolic/sickle cell screening, tuberculin skin test, and lead testing.

  Note: Medicaid will not reimburse separately for these routine laboratory tests when performed during a Health Check screening assessment.

  Hemoglobin or Hematocrit
  Hemoglobin or hematocrit **must** be measured once during infancy **(preferably** between the ages of 9 and 12 months) for all children. An assessment of risk for anemia should be performed at other visits and a hemoglobin or hematocrit done, only as appropriate.

  Risk factors for anemia in infants include prematurity, low birth weight, use of low-iron formula, and early introduction of cow's milk. For other children and adolescents, previous diagnosis of iron deficiency anemia, limited access to food, a low iron diet, strict vegetarian diet without receiving an iron supplement, or risk of iron deficiency due to special health care needs may be risk factors for anemia. In adolescent females (ages 11 to 21 years) an annual hemoglobin or hematocrit **must** be performed if any of the following risk factors are present: extensive menstrual or other blood loss, low iron intake, or a previous diagnosis of iron deficiency anemia. **In the absence of risk factors for anemia, hemoglobin or hematocrit screening is no longer recommended as a "routine" screening test for children over one year of age and adolescents.**

  If there is a documented normal result of a hemoglobin or hematocrit performed by another provider within three months prior to the date of the Health Check screening assessment, repeating the hemoglobin or hematocrit is not required as part of the Health Check screening assessment unless the provider believes that this test is needed. **The result and source of the test must be documented in the child's medical record.**

  The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has specific guidelines for hematocrit/hemoglobin testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information. For more information on requirements and time frames, call the local WIC office.

  Newborn Metabolic/Sickle Cell Screening
  North Carolina hospitals are required to screen all newborns for sickle cell disease and a number of other genetic and metabolic conditions prior to discharge from the hospital. **Those results from the State Laboratory of Public Health must be documented in the child's medical record**. This ideally should be a print out of the results from the state lab's website for that child. To link to the State Laboratory of Public Health Web site, go to http://slph.ncpublichealth.com.

  It is important to confirm the newborn metabolic/sickle cell screening has been done as soon as possible. Contact the hospital of birth if the results are not available online within two weeks to

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

confirm that the screening was done. An infant without documentation of being screened at birth should have the screening test as soon as possible.

Resources available to you if a screening test is positive include: Children with Special Health Care Needs Help Line at 1-800-737-3028; genetic centers at the tertiary care centers; and the N.C. Sickle Cell Program (http://www.ncsicklecellprogram.org/SC_Resources.htm).

Tuberculin Test

Reviewing perinatal histories, family and personal medical histories, significant events in life and other components of the social history will identify children and adolescents for whom tuberculosis (TB) testing is indicated. **If none of the screening criteria listed below are present, routine TB screening is not recommended.**

TB testing should be performed as clinically indicated for children and adolescents at increased risk of exposure to tuberculosis, **via Purified Protein Derivative (PPD) intradermal injection/Mantoux method** – not Tine Test. Criteria for screening children and adolescents of all ages for TB, according to the North Carolina Tuberculosis Control Branch, are as follows:

1. Children or adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.
2. Children or adolescents who present for care with the following risk factors should have a **baseline screen:**
   a. Foreign-born individuals from high prevalence areas: Asia, Africa, the Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand and countries in Western Europe.
   b. Children or adolescents who are migrants, seasonal farm workers, homeless or were previously incarcerated.
   c. Children or adolescents who are HIV-infected.
   d. Children or adolescents who inject illicit drugs or use crack cocaine.
   e. Children or adolescents who have traveled outside the United States and who have stayed with family or friends who live in high-incidence areas, for more than one month, cumulatively spent one month or more in a high incidence area.
   f. Children or adolescents who have been exposed to adults at high-risk (those who are homeless, incarcerated, or HIV positive or who have past or present history of substance abuse).

Subsequent TB skin testing is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

The North Carolina Tuberculosis Control Branch (919-733-7286) is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

- **Lead testing**

  Federal regulations state that all Medicaid-enrolled children must have a blood lead test at 12 and 24 months of age. **Providers must document results in the medical records**. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should also perform lead testing when otherwise clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial testing. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

Blood Lead Concentration	Recommended Response
<10 ug/dL	**Rescreen at 24 months of age**
10 through 19 ug/dL	**Confirmation (venous) testing should be conducted within three months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on two consecutive tests (venous or finger stick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered.
20 through 44 ug/dL	**Confirmation (venous) testing should be conducted within 1 week.** If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on two consecutive tests (venous or finger stick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years of age with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	**The child should receive a venous lead test for confirmation as soon as possible**. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Testing

The State Laboratory of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results from specimens of children outside this age group should contact the State Laboratory of Public Health at 919-733-3937.

For additional information about lead testing and follow-up refer to the *North Carolina Lead Screening and Follow Up Manual* found at:
http://www.deh.enr.state.nc.us/ehs/Children_Health/Lead/2008printedversionleadmanual.pdf.

Follow-up and Referral
Children and youth with suspected or identified problems that are not treated in-house must be referred to and receive consultation from an appropriate source. A requirement of Health Check/EPSDT is that children be referred for and receive medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment.

If a communicable disease has been diagnosed as a result of a Health Check Screening Assessment, report the disease using the *Confidential Communicable Disease Report – Part 1* Form at:
http://www.epi.state.nc.us/epi/gcdc/manual/reportforms/Morb_Card.pdf.

Plan for the youth's transition from pediatric to adult health care by encouraging their involvement in health care decision making and by supporting the parent's role in promoting the development of the youth's self-

management skills. Transition resources for families who have youth with special health care needs are available at http://hctransitions.ichp.ufl.edu/.

IMMUNIZATIONS

Immunization Administration CPT Codes with the EP Modifier

The North Carolina Immunization Program (NCIP)/Vaccines for Children (VFC) Program provides, at no charge, all recommended vaccines for all North Carolina VFC-eligible children, including Medicaid children, who are birth through 18 years of age. Vaccines are provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Because of the availability of VFC vaccines for Medicaid children, Medicaid does not reimburse for vaccines available from the NCIP/VFC program. Medicaid does, however, reimburse for the administration of these vaccines.

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. Vaccine procedure codes must always be included on the claim.

Note: The EP modifier must always be appended to the immunization administration CPT procedure code when billing for Medicaid recipients from birth through 20 years of age.

EPSDT PROVISION: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes EPSDT coverage of additional codes/procedures as it relates to immunization administration. Documentation must show how the service product or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Refer to the *Non-covered State Medicaid Plan Services Request Form* on page 12 to submit a request.

Private Sector Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check assessment or an office visit.

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 or 90466 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code, with the total charge for all units reflected on the detail.
- Administration of **one** vaccine that is an **intranasal/oral** immunization is billed with the administration CPT code 90467 with EP modifier or 90473 with the EP modifier. **Note: CPT codes 90467 or 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. Neither code can be billed with another immunization administration code on that date of service. See guidance in next bullet for further clarification. A *second* intranasal/oral immunization cannot be billed at this time.**
- Administration of an intranasal or oral vaccine provided **in addition to** one or more injectable vaccines is billed with CPT code 90468 or 90474 with the EP modifier.
- CPT vaccine codes for the vaccines administered must be reported or billed, as appropriate, even if administration codes are not being billed.

Federally Qualified Health Center or Rural Health Clinic Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check visit.

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 or 90466 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code with the total charge for all units reflected on the detail.
- Administration of **one** vaccine that is an **intranasal/oral** immunization is billed with the administration CPT code 90467 with EP modifier or 90473 with the EP modifier. **Note: CPT codes 90467 or 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. Neither code can be billed with another immunization administration code on that date of service. See guidance in next bullet for further clarification. A *second* intranasal/oral immunization cannot be billed at this time.**
- Administration of an intranasal or oral vaccine provided **in addition** to one or more injectable immunization administrations is billed with CPT code 90468 or 90474 with the EP modifier.
- CPT vaccine codes for the vaccines administered must be reported or billed, as appropriate, even if administration codes are not being billed.
- An immunization administration fee cannot be billed in conjunction with a core visit. Report the CPT vaccine code(s) without billing the administration fee.

Local Health Department Providers

An immunization administration fee may be billed if the immunization(s) is provided in addition to a Health Check assessment on the same date of service. In addition, immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit**.

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) or 90465 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 or 90466 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code with the total charge for all units reflected on the detail.
- Administration of **one** vaccine that is an **intranasal/oral** immunization is billed with the administration CPT code 90467 with EP modifier or 90473 with the EP modifier. **Note: CPT codes 90467 or 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. Neither code can be billed with another immunization administration code on that date of service. See guidance in next bullet for further clarification. A *second* intranasal/oral immunization cannot be billed at this time.**
- Administration of an intranasal or oral immunization vaccine provided **in addition to** one or more injectable immunization administrations is billed with CPT code 90468 or 90474 with the EP modifier.
- CPT vaccine codes for the vaccines administered must be reported or billed, as appropriate, even if the administration codes are not being billed.
- Again, immunization administration codes may be billed in conjunction with the Health Check assessment. Report the CPT vaccine code(s) and the immunization administration codes.

Note: Please refer to the general Medicaid Bulletins at http://www.ncdhhs.gov/dma/bulletin/ for updates on immunizations and administration codes. Refer to the appropriate fee schedule at http://www.ncdhhs.gov/dma/fee/ under *Physician Services CPT/HCPCS* for rate changes for immunizations and administration codes.

Immunization Billing Guidelines For Recipients Birth Through 20

The following guidelines routinely apply to Medicaid recipients under the age of 19 years who are always eligible for state-supplied vaccine. For all Medicaid-covered purchased vaccine administered to Medicaid recipients 19 through 20 years of age who are not eligible for NCIP/VFC products, providers should **bill**, rather than report, the CPT vaccine code. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. Vaccine procedure codes must always be included on the claim.

Vaccine: Injectable(s) Only **Provider Type:** Private Sector Providers		
Service Type	**With Physician Counseling Less than 8 years of age**	**Without Physician Counseling Less than 21 years of age**
Health Check Assessment with Immunization(s)	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one vaccine bill 90471EP x 1. For two or more vaccines bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

Vaccine: Intranasal/Oral Only **Provider Type: Private Sector Providers**		
Service Type	**With Physician Counseling** **Less than 8 years of age**	**Without Physician Counseling** **Less than 21 years of age**
Health Check Assessment with Immunization	For one vaccine, bill 90467EP x 1. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.
Immunization Only	For one vaccine, bill 90467EP x 1. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization	For one vaccine, bill 90467EP x 1. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code. Two or more vaccines – N/A at this time. Immunization diagnosis code is **not** required.

Vaccine: Injectable(s) with Intranasal/Oral **Provider Type: Private Sector Providers**		
Service Type	**With Physician Counseling** **Less than 8 years of age**	**Without Physician Counseling** **Less than 21 years of age**
Health Check Assessment with Immunizations	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units, and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP x 1and 90474EP x 1. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units, and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunizations Only	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units, and 90468EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units, and 90474EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunizations	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units, and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one ORAL/INTRANASAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one ORAL/INTRANASAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units, and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

Vaccine: Injectable(s) Only **Provider Type: FQHC/RHC**		
Service Type	**With Physician Counseling Less than 8 years**	**Without Physician Counseling Less than 21 years**
Health Check Assessment with Immunization(s)	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	N/A	N/A
Core Visit with Immunization(s)	Cannot bill 90465EP or 90466EP. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	Cannot bill 90471EP or 90472EP. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

Vaccine: Intranasal/Oral Only **Provider Type: FQHC/RHC**		
Service Type	**With Physician Counseling** **Less than 8 years**	**Without Physician Counseling** **Less than 21 years**
Health Check Assessment with Immunization	For one vaccine, bill 90467EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code is **not** required.
Immunization Only	For one vaccine, bill 90467EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization	N/A	N/A
Core Visit with Immunization	Cannot bill 90467EP. Report CPT vaccine code for the vaccine given. Immunization diagnosis code is **not** required.	Cannot bill 90473EP. Report CPT vaccine code for the vaccine given. Immunization diagnosis code is **not** required.

Vaccine: Injectable(s) with Intranasal/Oral **Provider Type: FQHC/RHC**		
Service Type	**With Physician Counseling** **Less than 8 years**	**Without Physician Counseling** **Less than 21 years**
Health Check Assessment with Immunizations	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units, and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units, and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunizations Only	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units, and 90468EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units, and 90474EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunizations	N/A	N/A
Core Visit with Immunizations	Cannot bill 90465EP, 90466EP, or 90468EP. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	Cannot bill 90471EP, 90472EP, or 90474EP. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

Vaccine: Injectable(s) Only **Provider Type: Local Health Departments**		
Service Type	**With Physician Counseling** **Less than 8 years of age**	**Without Physician Counseling** **Less than 21 years of age**
Health Check Assessment with Immunization(s)	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunization(s) Only	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunization(s)	For one vaccine, bill 90465EP x 1. For two or more vaccines, bill 90465EP x 1 and 90466EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one vaccine, bill 90471EP x 1. For two or more vaccines, bill 90471EP x 1 and 90472EP x the appropriate number of units. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

Vaccine: Intranasal/Oral Only **Provider Type: Local Health Departments**		
Service Type	**With Physician Counseling** **Less than 8 years of age**	**Without Physician Counseling** **Less than 21 years of age**
Health Check Assessment with Immunization	For one vaccine, bill 90467EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code is **not** required.
Immunization Only	For one vaccine, bill 90467EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code **is** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code **is** required.
Office Visit with Immunization	For one vaccine, bill 90467EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code is **not** required.	For one vaccine, bill 90473EP x 1. Report CPT vaccine code for the vaccine given. Two or more vaccines– N/A at this time. Immunization diagnosis code is **not** required.

Vaccine: Injectable(s) with Intranasal/Oral **Provider Type: Local Health Departments**		
Service Type	**With Physician Counseling** **Less than 8 years of age**	**Without Physician Counseling** **Less than 21 years of age**
Health Check Assessment with Immunizations	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunizations Only	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units and 90468EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units and 90474EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunizations	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP times the appropriate number of units and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

North Carolina Immunization Program/Vaccines for Children Program

The North Carolina Immunization Program (NCIP)/Vaccines for Children (VFC) Program provides, at no charge, all recommended vaccines for all North Carolina VFC-eligible, including Medicaid eligible, children ages birth through 18 years. Vaccines are provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Because of the availability of these vaccines for Medicaid children, Medicaid does not routinely reimburse for vaccines available from the NCIP/VFC program. Medicaid does, however, reimburse for the administration of these vaccines.

In **rare** instances, due to recalls or true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletin.

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. CPT codes for vaccine products must always be included on the claim **(without the EP modifier)**. Remember that some purchased vaccines require the SC modifier. See the specific billing guidance in the General Medicaid bulletin.

The following is a list of NCIP/VFC vaccines provided to children through 18 years of age. **Medicaid recipients are automatically eligible for VFC vaccine, even those who are dually covered by Medicaid and another insurance plan.** All of these vaccines are available to Medicaid children through 18 years of age. Because vaccines have other criteria which must be met, **and vaccine criteria are subject to change,** it is recommended that providers go to the Immunization Branch Web site at http://www.immunizenc.com (select "Providers" and NCIP Coverage Criteria), or call the Immunization Branch at 1-877-873-6247.

The following is a list of NCIP/VFC vaccines:

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for intramuscular (IM) use	V05.3	12 months through 18 years of age
90636*	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for IM use	V06.8	18 years of age and above in local health departments (LHDs), FQHCs, and RHCs
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - *PedvaxHIB* **Routine** – 2 months to less than 5 years of age **High risk** – greater than 59 months through 18 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for IM use ***NOTE : The NCIP will no longer provide these products after May 1, 2010.***	V03.81	Brand name - *ActHIB* **Routine** – 2 months to less than 5 years of age **High risk** – greater than 59 months through 18 years of age Brand name – *Hiberix* Approved for the booster dose in children 15 months through 4 years of age
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular (IM) use	V04.89	9 years through 18 years of age
90655+	Influenza virus vaccine, split virus, preservative free when administered to children 6 - 35 months of age, for IM use	V04.81	6 months through 35 months of age
90656+	Influenza virus vaccine, preservative free, when administered to individuals 3 years and older, for IM use	V04.81	3 years through 18 years of age
90657+	Influenza virus vaccine, split virus, when administered to children 6 to 35 months of age, for IM use	V04.81	6 months through 35 months of age
90658+	Influenza virus vaccine, when administered to individuals 3 years of age and older, for IM use	V04.81	3 years through 18 years of age
90660+	Influenza virus vaccine, live, for intranasal use	V04.81	2 years through 18 years of age.
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use (Prevnar 13)	V03.82	2 months through 59 months of age
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for IM use	V06.3	4 years through 6 years of age, for booster dose only

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use	V06.8	2 months through 4 years of age
90700	Diphtheria , tetanus toxoids, and acellular pertussin vaccine (DTaP), when administered to individuals younger than 7 years, for IM use	V06.1	2 months through 6 years of age
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for IM use	V06.5	2 months through 6 years of age
90707*	Measles, mumps and rubella vaccine (MMR), live, for subcutaneous (SC) use	V06.4	12 months through 18 years of age
90710	Measles, mumps, rubella and varicella vaccine (MMRV), live, for SC use	V06.8	12 months through 6 years of age
90713	Poliovirus vaccine, inactivated (IPV), for SC or IM use	V04.0	2 months through 17 years of age
90714*	Tetanus and diphtheria toxiods (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for IM use	V06.5	7 years through 18 years of age
90715*	Tetanus, diphtheria toxoids an acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use **Note:** Currently, no Tdap product is licensed for individuals under 10 years of age.	V06.1	10 years through 18 years of age
90716	Varicella virus vaccine, live, for SC use	V05.4	12 months through 18 years of age
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for IM use	V06.8	2 months through 6 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for SC or IM use	V03.82	**Only for high risk children 2 years through 18 years of age.**
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V01.84	Routine - 10 years through 18 years of age High risk - 2 years through 9 years of age
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for IM use	V05.3	**Birth through 18 years of age*** **Exception:** If the first dose of Hepatitis B vaccine is administered prior to age 19, NCIP vaccine may be used to complete the series prior to age 20.

***Providers should refer to the Immunization Branch Web site at http://www.immunizenc.com for detailed information regarding vaccines. Certain vaccines are provided for those recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at 1-877-873-6247.**

+Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

N.C. Medicaid providers who are not enrolled in NCIP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-877-873-6247.

Out-of-state providers may obtain VFC vaccines by calling their state VFC program. VFC program telephone numbers for Border States are listed below:

- **Georgia** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-741-7343
- **Virginia** 1-804-864-8055

HEALTH CHECK BILLING REQUIREMENTS

Effective with date of processing October 2, 2009, the N.C. Medicaid Program required all providers to file claims electronically. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Instructions for billing a Health Check screening assessment are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are as follows:

Requirement 1: Identify and Record Diagnosis Code(s)
Place diagnosis code(s) in the correct order in block 21. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Periodic Health Check Screening Assessment – Use V20.2 as the Primary Diagnosis
The primary diagnosis V20.2 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V20.2) and **always** before immunization diagnoses. An immunization diagnosis code is required when one or more immunizations are provided as the only service.

Interperiodic Health Check Screening Assessment – Use V70.3 as the Primary Diagnosis
The primary diagnosis V70.3 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V70.3) and **always** before immunization diagnoses. An immunization diagnosis code is required when one or more immunizations are provided as the only service.

Requirement 2: Identify and Record Preventive Medicine Code and Component Codes
The preventive medicine CPT code with the EP modifier for Health Check screening assessments should be billed as outlined below. In addition to billing the preventive medicine code, developmental screening, vision and hearing CPT codes must be listed based on the Health Check Assessment Components requirements noted on pages 15 through 20.

- A developmental screening CPT code with the EP modifier **must** be listed in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment when age appropriate. No additional reimbursement is allowed for this code. All providers may refer to the claim samples in this guide.

- Vision CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment for children ages 3 through 10 and for other children as appropriate based on age or assessment of risk. No additional reimbursement is allowed for these codes. All providers may refer to the sample claims located at the end of this guide.

- Hearing CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment for children ages 4 through 10 and for other children as appropriate based on an assessment of risk. No additional reimbursement is allowed for these codes. All providers may refer to the sample claims in this guide.

Requirement 3: Health Check Modifier – EP
The Health Check CPT codes for periodic and interperiodic screening assessments must have the **EP** modifier listed in block 24D of the CMS-1500 claim form format. Additionally, the vision, hearing, and developmental screening CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form format. **EP is a required modifier for all Health Check claim details (except codes for vaccine products for ages 19 and 20).**

HEALTH CHECK BILLING REQUIREMENTS, continued

Requirement 4: Record Referrals
N.C. Medicaid is HIPAA-compliant and is able to receive standard electronic HIPAA transactions.

Providers billing electronically using the services of a vendor or clearinghouse may reference the National HIPAA Implementation Guide and the North Carolina 837 Professional Claim Transaction Companion Guide for values regarding follow up-visits. The National HIPAA Implementation Guide for the 837 Claim Transaction can be accessed at http://www.wpc-edi.com.

The North Carolina Medicaid 837 Companion Guide can be accessed on the DMA Web site at http://www.ncdhhs.gov/dma/hipaa/837prof.pdf.

Claims submitted via NCECSWeb should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment. List referral code indicator "F" when a referral is made for Family Planning services.

Requirement 5: Next Screening Date
Providers may enter the next screening date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form format.

Provider-Entered Next Screening Date
Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is OUT of range with the periodicity schedule, the system will override the provider's NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

Note: Providers billing electronically are not required to enter a screening date (NSD) for health check screening claims.

Systematically Entered Next Screening Date
Providers have the following choices for block 15 of the CMS-1500 claim form format with a Health Check screening assessment. All of these choices will result in an automatically entered NSD.

- **Leave block 15 blank.**
- **Place all zeros in block 15 (00/00/0000).**
- **Place all ones in block 15 (11/11/1111).**

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

HEALTH CHECK BILLING REQUIREMENTS, continued

Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier

Providers should refer to the tables on pages 23 through 31 in this guide, *Immunization Billing Guidelines for Recipients Birth Through Age 20,* regarding billing immunization administration CPT codes and the EP modifier. Providers may also refer to the claim examples at the end of this guide.

When reporting or billing vaccine administration, providers must use the appropriate CPT code(s) with the EP modifier listed in block 24D of the CMS-1500 claim form format. The CPT code for the vaccine product must be reported or billed without the EP modifier.

- When reporting or billing for one injectable vaccine administration, providers must use CPT code 90471 (one unit) or 90465 (one unit) **with the EP modifier** listed in block 24D. The CPT code for the vaccine product administered must be reported or billed **without the EP modifier appended**.

- When additional injectable vaccine administrations are provided, providers must use CPT code 90472 or 90466 **with the EP modifier** listed in block 24D. Providers must bill the appropriate number of units on the detail along with the total charge of all units billed. The CPT code for each vaccine product administered must be reported or billed **without the EP modifier appended**.

- When reporting or billing for one intranasal/oral vaccine providers must use CPT code 90467 (one unit) or 90473 (one unit) **with the EP modifier** in block 24D for the immunization administration. The CPT vaccine code for the vaccine product administered must be reported or billed **without the EP modifier appended**.

- When reporting or billing for one injectable vaccine and one intranasal/oral vaccine providers must use CPT codes 90465 and 90468 or 90471 and 90474 **with the EP modifier** for the immunization administrations. The CPT vaccine code for each vaccine product administered must be reported or billed **without the EP modifier appended**.

- When reporting or billing for two or more injectable vaccines and one intranasal/oral vaccine providers must use CPT codes 90465, 90466 and 90468 **with the EP modifier** or 90471, 90472 and 90474 with the EP modifier for the immunization administrations. Providers must bill the appropriate number of units on the detail along with the total charge of all units billed. The CPT vaccine code for each vaccine product administered must be reported or billed **without the EP modifier appended.**

Notes:

In **rare** instances, due to recalls or true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletin.

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. CPT codes for vaccine products must always be included on the claim **(without the EP modifier)**. Remember that some purchased vaccines require the SC modifier. Refer to specific billing guidance in the General Medicaid bulletin.

If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 is $0.00.

Health Check Related ICD-9-CM and CPT Codes

The following table lists ICD-9 and CPT codes related to Health Check screening assessments:

	Preventive CPT Codes and Modifier	**Diagnoses Codes**
Periodic Examination	CPT Codes 99381-99385; 99391-99395 EP Modifier is required in block 24D Developmental Screening CPT Code 96110; at 6, 12, 18 or 24 months of age, at age 3, 4, and 5 years of age EP Modifier is required in block 24D Autism Screening CPT Code: 99420 EP Modifier is required in block 24D Health Risk Assessments, CPT Code 99420 (GAPS/HEADSSS) and Behavioral/Mental Health Screening (PSC/SDQ/PSQ-A/Beck's); CPT 99406-99407 for Smoking/Tobacco Use Cessation; and CPT 99408-99409 for Alcohol/Substance Abuse Structured Screening and Brief Intervention (CRAFFT) are currently reimbursed. EP Modifier is required in block 24D Vision CPT Code 99172 or 99173; for children ages 3-10, and then as appropriate based on age and risk. EP Modifier is required in block 24D Hearing CPT Code 92551, 92552, or 92587; for children 4-10 and then as appropriate based on risk. EP Modifier is required in block 24D	V20.2 Primary Diagnosis
Interperiodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D	V70.3 Primary Diagnosis

Preventive Medicine CPT Codes

The following table lists Preventive Medicine CPT codes that must be listed on the CMS-1500 claim form format when filing a claim for a Periodic (V20.2) or an Interperiodic (V70.3) examination. The **EP modifier** must be listed in block 24D of the CMS-1500 claim form format with the appropriate preventive medicine code.

Age	New Patient	Established Patient	Append EP Modifier
Under age 1 year	99381	99391	Yes
1 through 4 years	99382	99392	Yes
5 through 11 years	99383	99393	Yes
12 through 17 years	99384	99394	Yes
18 through 20 years	99385	99395	Yes

TIPS FOR BILLING

All Health Check Providers

- Two Health Check screening assessments on different dates of service cannot be billed on the same claim form.
- CPT codes: 99406 EP, 99407 EP, 99408 EP, 99409 EP can be billed when performed during a periodic Health Check assessment or during an interperiodic Health Check screening assessment for adolescents ages 11 through 20.
- CPT code 99420 EP can be billed when performed during a periodic Health Check screening assessment or during an interperiodic Health Check screening assessment for children ages birth through 20.
- Immunizations and therapeutic injections may be billed on the same date of service and on the same claim.
- A formal, standardized developmental screening tool **must** be used during periodic screening assessments for children ages 6, 12, 18 or 24 months, and 3, 4, and 5 years of age.
- If the required vision and/or hearing screenings cannot be performed during a periodic screening assessment due to a condition such as blindness, deafness, autism, or uncooperative child, providers must:
    - Document in the patient's medical record the date of service and the reason(s) why the provider was unable to perform the vision and/or hearing screening;
    - Submit the claim to HP ENTERPRISE SERVICES without the vision and/or hearing CPT code; and
    - HP ENTERPRISE SERVICES will process the claim.
- Report payments received from third party insurance in block 29 of the CMS-1500 claim form format when preventive services (well child assessments) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit the claim to Medicaid.
- All electronically submitted claims should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment.

Private Sector Health Check Providers Only

- A Health Check screening assessment and an office visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier can be billed with a Health Check screening assessment, office visit or if the vaccine administration is the only service provided that day. When billing in conjunction with an examination code or an office visit code, an immunization diagnosis is **not required** in block 21 of the claim form. When billing an administration code for immunizations as the only service for that day, providers **are required** to use an immunization diagnosis code in block 21 of

the claim form. Always list the CPT vaccine codes when billing these administration codes with the EP modifier. Refer to the claim examples at the end of this guide.

- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for the Health Check screening assessment and the amount billed for immunizations and any other service billed on the same date of service. Thus, it is necessary to check claim status for two separate claims.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers Only

- Providers may bill a core Behavioral Health visit (T1015 HI) and a Health Check screening assessment on the same date of service on separate claims.
- A Health Check screening assessment and a core visit (T1015) cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier can be billed with a Health Check screening assessment or if the vaccine administration is the only service provided that day. When billing in conjunction with an examination code, an immunization diagnosis is **not** required in block 21 of the claim form format. When billing an administration code for immunizations as the only service for that day, an immunization diagnosis code **is** required to be entered in block 21 of the claim form format. An administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list CPT vaccine codes in the appropriate block on the claim form format. Always list CPT vaccine codes when billing any immunization administration code with the EP modifier. Refer to the claim examples at the end of this guide.

Local Health Departments

- Two Health Check screening assessments on different dates of service cannot be billed on the same claim form (format).
- An immunization administration fee may be billed if the immunization(s) is provided in addition to a Health Check screening visit. In addition, immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474 with the EP modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit.** When billing immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474, the EP modifier must be entered. Refer to the claim examples at the end of this guide.
- A formal, standardized developmental screening tool **must** be used during periodic examinations for children ages 6 months, 12 months, 18 or 24 months, and 3, 4, and 5 years of age.

HEALTH CHECK COORDINATION

Health Check Coordination is the responsibility of the 14 Community Care of North Carolina (CCNC) regional networks. Under the direction of the CCNC networks, the Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services.

HCCs provide education and outreach services in 100 North Carolina counties and the Qualla Boundary. HCCs are stationed at certain regional CCNC network sites, local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA Web site at: http://www.ncdhhs.gov/dma/provider/provcontacts.htm.

The role and responsibilities of the HCC include but are not limited to the following:

- Using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- Educating families about the importance of establishing a medical home **that provides ongoing, comprehensive, family-centered, and accessible care** for their children **and youth**
- Assisting families to use the health care services in a consistent and responsible manner
- Assisting with scheduling appointments or securing transportation
- Acting as a local information, referral, and resource person for families
- Providing advocacy services in addressing social, educational or health needs of the recipient
- Initiating follow-up as requested by providers when families need special assistance or fail to bring children in for Health Check or follow-up examinations
- Promoting Health Check and health prevention with other public and private organizations

Physicians, primary care providers (PCPs), and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and helps make preventive health care services more timely and effective.

HEALTH CHECK CLAIM DENIALS – EXPLANATION OF BENEFITS (EOB)

EOB	Message	Tip
010	Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.	Verify the recipient's Medicaid identification (MID) number, date of birth (DOB), diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to HP ENTERPRISE SERVICES as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2501 Mail Service Center, Raleigh, NC 27699-2501.
079	This type of service is not payable to your provider type or specialty.	Check your claim for keying errors, make corrections if necessary. Verify the provider type and specialty for your Medicaid provider number by contacting a Health Check Consultant at 919-855-4780.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.	Verify diagnosis code is V20.2 or V70.3 for the Health Check screening assessment according to the billing guidelines on page 36. Correct claim and resubmit.
349	Health Check Screen and related service not allowed same day, same provider, or member of same group.	Resubmit as an adjustment with documentation supporting unrelated services.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient's age. Only recipients age birth through 20 years of age are eligible for Health Check services.
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Immunizations(s) are available at no charge through the NCIP/VFC Program.
1058	The only well child exam billable through the Medicaid program is a Health Check screening assessment. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic examination with primary diagnosis V20.2 and Interperiodic examinations with primary diagnosis V70.3. Check the preventive medicine code entered in block 24D of the claim form and append the EP modifier.
1422	Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check Special Bulletin.	Check the claim to ensure that the immunization procedure code(s) are billed on the same claim as the immunization administration code(s). Make corrections and resubmit as a new day claim.
1769	No additional payment made for vision, hearing and/or developmental screening services.	Payment is included in Health Check reimbursement.
1770	Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	Health Check services must be billed with the primary diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V25.9.

HEALTH CHECK BILLING REFERENCE SHEET

Date of Service _____

Patient's Name	Next Examination Date (optional)
Medicaid ID number	Date of Birth

Health Check Diagnosis Code		
Periodic Health Check screening assessment	Periodic Health Check Screening V20.2	
Interperiodic Health Check screening assessment	Interperiodic Health Check screening assessment V70.3	

Health Check screening assessment Code			
Description	**Preventive Medicine Codes**	**Diagnosis Code**	✓
Regular Periodic Examination- Birth through 20 years	99381-9985; 99391-99395 **With EP Modifier**	V20.2	
Developmental Screening based on age	Development Screening CPT Code 96110 **With EP Modifier**		
Autism Screening based on age	Autism Screening CPT Code: 99420 **With EP Modifier**		
Adolescent Health Risk Assessment and B/MH Screening	CPT 99420 **With EP Modifier**		
Vision Screening based on age	Vision Screening CPT Code 99172 or 99173 **With EP Modifier**		
Hearing Screening based on age	Hearing Screening CPT Code 92551, 92552 or 92587 **With EP Modifier**		
Interperiodic Examination - Birth through 20 years	99381-99385; 99391-99395 **With EP Modifier**	V70.3	

Second Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	E or F - providers billing electronically	

Third Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	E or F - providers billing electronically	

Fourth Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	E or F - providers billing electronically	

Description	**CPT Codes**	**Unit**	
Immunization Administration Fee	90471 **or** 90465 EP Modifier 90467 **or** 90473 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 **or** 90466 EP Modifier 90468 **or** 90474 EP Modifier	Additional immunizations	

IMMUNIZATION BILLING REFERENCE SHEET

Note: Do not bill Medicaid for the cost of a vaccine or immune globulin on this table if the product was provided through the NCIP/VFC program. Only the administration code should be billed.

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous (IV) use	V07.2	
J1460-J1560	Injection, gamma globulin codes, intramuscular (IM) (GamaSTAN SD). Use the code for the amount administered	V07.2	Limited distribution to health departments (LHDs) only, and only during outbreaks.
J1571	Injection, hepatitis B immune globulin (Hepagam B), IM, 0.5 ml	V07.2	
J1573	Injection, hepatitis B immune globulin (Hepagam B), IV, 0.5 ml	V07.2	
90371	Injection, hepatitis B immune globulin (HBIg), human, IM	V07.2	
J1562	Injection, immune Globulin, (Vivaglobin), 100 mg	V07.2	
J1566	Injection, immune globulin, IV, lyophilized (e.g., powder), NOS, 500 mg	V07.2	
J1569	injection, immune globulin, (Gammagard liquid), IC, nonlyophilized (e.g., liquid), 500 mg	V07.2	
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), IV, nonlyophilized (e.g., liquid), 500 mg	V07.2	
J1561	Injection, immune globulin, (Gamunex), IV, nonlyohilized (e.g., liquid), 500 mg non-lyophilized (liquid) (Gamunex)	V07.2	
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg (Atgam)	V07.2	
90375	Rabies immune globulin, (RIg), human, for IM and/or SC SC use (BayRab)	V07.2	
90376	Rabies immune globulin – Heat treated (RIG-HT), IM and/or SC,use (Imogam Rabies)	V07.2	
90379	Respiratory syncytial virus immune globulin (RSV-IgIV), human, for IV use	V07.2	
J2790	Injection, Rho (D) immune globulin, human, full dose, 300 mg,(1500 i.u.) (Rhophylac)	V07.2	
J2788	Injection, Rho (D) immune globulin, human, min dose, 50 mcg (250 i.u.), MiCRhoGAM	V07.2	
J2791	Injection, Rho (D) immune globulin, (human) (Rhophylac) IM or IV, 100 IU HypRho, WINRho SDF)	V07.2	
J2792	Injection, Rho(D) immune globulin, IV, human, solvent detergent, 100 IU	V07.2	
90389	Tetanus immune globulin (TIg), human, for IM use	V07.2	
90396	Varicella-zoster immune globulin, human, for IM use	V07.2	
90585	Bacillus Calmette-Guerin (BCG) for tuberculosis, live for percutaneous use	V03.2	
90632	Hepatitis A vaccine, adult dosage, for IM use	V05.3	19 years of age and above Limited distribution to LHDs only, and only during outbreaks.
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for IM use	V05.3	12 months of age through 18 years of age
90636*	Hepatitis A and B combination (HepA-HepB), adult dosage, for IM use	V06.8	18 years of age and above only in LHDs, FQHCs, and RHCs*

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - *PedvaxHIB* Routine - 2 months to less than 5 years of age High risk, greater than 59 months through 18 years of age.
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for IM use ***Note : The NCIP will no longer provide these products after May 1, 2010***	V03.81	Brand name - *ActHIB* Routine - 2 months to less than 5 years of age; High risk - greater than 59 months through 18 years of age. Brand name – *Hiberix* Approved for the booster dose in children 15 months through 4 years of age
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular (IM) use	V04.89	9 years through 18 years of age
90655+	Influenza virus vaccine, split virus, preservative free when administered to children 6-35 months of age, for IM use	V04.81	6 months through 35 months of age
90656+	Influenza virus vaccine, preservative free, when administered to individuals 3 years and older	V04.81	3 years through 18 years of age
90657+	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for IM use	V04.81	6 months through 35 months of age
90658+	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for IM use	V04.81	3 years through 18 years of age
90660+	Influenza virus vaccine, live, for intranasal use	V04.81	2 years through 18 years of age
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use (Prevnar 13)	V03.82	2 months through 59 months of age
90675	Rabies vaccine for IM use	V04.5	
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for IM use	V06.3	4 years through 6 years of age for the booster dose only
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use	V06.8	2 months through 4 years of age
90700	Diphtheria , tetanus toxoids, and acellular pertussin vaccine (DTap), when administered to individuals younder than 7 years, for IM use	V06.1	2 months through 6 years of age
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for IM use	V06.5	2 months through 6 years of age
90703	Tetanus toxoid adsorbed, for IM use	V03.7	
90704	Mumps virus vaccinelive, for SC use	V04.6	
90705	Measles virus vaccine, live, for SC use	V04.2	
90706	Rubella virus vaccine, live, for SC use	V04.3	
90707*	Measles, mumps, and rubella virus vaccine (MMR), live, for SC use	V06.4	12 months through 18 years of age*

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for SC use	V06.8	12 months through 6 years of age
90713	Polio virus vaccine, inactivated (IPV), for SC or IM use	V04.0	2 months through 17 years of age
90714*	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for IM use	V06.5	7 years through 18 years of age*
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use Note: Currently no Tdap vaccine is licensed for use in persons under the age of 10 years	V06.1	10 years through 18 years of age*
90716	Varicella virus vaccine, live, for SC use	V05.4	12 months through 18 years of age
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (Dtap-Hib), for IM use	V06.8	
90723	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (Dtap-HepB-IPV), for IM use	V06.8	2 months through 6 years of age
90732	Pneumococcal polysaccharide vaccine , 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for SC or IM use	V03.82 or V05.8	Only for high-risk children 2 years through 18 years of age 2 years through 18 years
90733	Meningococcal polysaccharide vaccine (any group(s)), for SC use	V01.84	
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V01.84	**Routine -** 10 years through 18 years of age; **High risk -** 2 years through 9 years of age
90740	Hepatitis B vaccine, dialysis or immunocompromised patient dosage (3-dose schedule), for IM use	585.1-585.9 or diagnosis related to the immuno-compromised state	
90744*	Hepatitis B vaccine pediatric/adolescent dosage (3 dose schedule), for IM use	V05.3	Birth through 18 years of age* **Exception**: If the first dose of Hepatitis B vaccine is administered prior to age 19, NCIP/VFC pediatric vaccine may be used to complete the series prior to age 20*.
90746*	Hepatitis B vaccine, adult dosage, for IM use	V05.8	20 years of age and older, only in LHDs*
90747	Hepatitis B vaccine dialysis or immunosuppressed patient dosage (4-dose schedule), for IM use	585.1-585.9 or diagnosis related to the immuno-compromised state	

***Providers should refer to the Immunization Branch Web site at http://www.immunizenc.com for detailed information regarding vaccines. Certain vaccines are provided for recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at 1-877-873-6247.**

+Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

Note: This list is subject to change. Updates regarding vaccines are published in the general Medicaid bulletins on DMA's Web site at http://www.ncdhhs.gov/dma/bulletin/.

RESOURCE LIST

Children with Special Health Care Needs Helpline
1-800-737-3028

Dental Varnishing
Clinical Coverage Policy #1A-23, *Physician Fluoride Varnish Services*
http://www.ncdhhs.gov/dma/mp/

Developmental Screening standardized and validated screening tools
http://www.dbpeds.org
http://www.brightfutures.aap.org

Developmental Surveillance and Screening
http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/1/405.pdf

DMA Customer Services Center
1-888-245-0179

HP Enterprise Services Provider Services
1-800-688-6696 or 919-851-8888

Health Check Coordinator Contact List
http://www.ncdhhs.gov/dma/provider/provcontacts.htm

National HIPAA Implementation Guide
http://www.wpc-edi.com/hipaa

NC Healthy Start Foundation
http://www.nchealthystart.org/.

North Carolina 837 Professional Claim Transaction Guide
http://www.ncdhhs.gov/dma/hipaa/837prof.pdf

North Carolina Immunization Branch
North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)
http://www.immunizenc.com

North Carolina Lead Screening and Follow Up Manual
http://www.deh.enr.state.nc.us/ehs/Children_Health/index.html

December 2005 Special Bulletin, *Medicaid for Children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Health Check*
http://www.ncdhhs.gov/dma/bulletin/

Basic Medicaid Billing Guide
http://www.ncdhhs.gov/dma/basicmed/

EPSDT Provider Page
http://www.ncdhhs.gov/dma/epsdt/

Physician's Fee Schedule
http://www.ncdhhs.gov/dma/fee/

Policy Instructions: Early and Periodic Screening, Diagnostic and Treatment
http://www.ncdhhs.gov/dma/epsdt/

Prior Approval Process and Request for Non-Covered Services
http://www.ncdhhs.gov/dma/provider/forms.htm
http://www.ncdhhs.gov/dma/basicmed/

Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2010
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5701a8.htm?s_cid=mm5701a8_e

Printable versions of the schedule can be found at:
http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable

Recommendations for Preventive Pediatric Health Care
http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1

2008 Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Third Edition: Bright Futures 3rd Edition Pocket Guide: Bright Futures Tool and Resource Kit
http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf

U.S. Preventive Services Task Force Recommendations
http://www.ahrq.gov/clinic/USpstfix.htm

Private Provider
Periodic Examination
Developmental Screening

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

PHTRAIN (803) - TEENAGER,GIRL (949823938)/Encounter Recording

File Edit Favorites Avatar PH Avatar CWS Help

Patient, Joe 01 15 06 x 123456789K

Page 1 of 1

123 Fun Street

TEENAGER,GIRL (949823938)

Fun Town NC

Encounter Charge Input

11111 555 555-5555

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline
1	Billable (B)	Health Check...	"99385EP-PREV VISIT, ...	ST,S2	ROUTINE CH...	SEBORRHEIC...			NURSE,R...	Rostered Nurse Screener
2	Reportable (R)	Health Check...	99173-VISUAL ACUITY ...		ROUTINE CH...	SEBORRHEIC...			NURSE,R...	Rostered Nurse Screener
3	Reportable (R)	Health Check...	"92552-PURE TONE AU...		ROUTINE CH...	SEBORRHEIC...			NURSE,R...	Rostered Nurse Screener
4	Reportable (R)	Health Check...	87081-CULTURE SCRE...		ROUTINE CH...	SEBORRHEIC...			NURSE,R...	Rostered Nurse Screener

d. INSURANCE PLAN NAME OR PROGRAM NAME — 10d. RESERVED FOR LOCAL USE — 9. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

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

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. V20.2 3. ____ . ____
2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	03	10	05	03	10	11		99392	EP					80.33	1		ZZ / NPI	Taxonomy / NPI Number
2	05	03	10	05	03	10	11		96110	EP					0.00	1		ZZ / NPI	Taxonomy / NPI Number
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
123 That St
That City, NC 27606-1234
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Dr J P Provider
123 Any St
Any City, NC 27523-5678
a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider
Physician Counseling with Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 02 DD 14 YY 04 SEX M [x] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V06.8 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	05	10	05	05	10	11		90465	EP					17 25	1		ZZ NPI	Taxonomy NPI Number
2	05	05	10	05	05	10	11		90466	EP					9 71	1		ZZ NPI	Taxonomy NPI Number
3	05	05	10	05	05	10	11		90710						0 00	1		ZZ NPI	Taxonomy NPI Number
4	05	05	10	05	05	10	11		90700						0 00	1		ZZ NPI	Taxonomy NPI Number
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 26.96

29. AMOUNT PAID $

30. BALANCE DUE $ 26.96

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider
Periodic Examination

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 03 DD 22 YY 10 SEX M [ ] F [x]

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

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

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

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. V20.2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1																		ZZ	Taxonomy
	05	03	10	05	03	10	11		99381	EP					80.33	1		NPI	NPI Number
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider
Interperiodic Screening
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 03 DD 28 YY 00 SEX M [x] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V70.3 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05	05	10	05	05	10	11		99383	EP					80 33	1		ZZ NPI	Taxonomy NPI Number
2 05	05	10	05	05	10	11		90471	EP					17 25	1		ZZ NPI	Taxonomy NPI Number
3 05	05	10	05	05	10	11		90472	EP					19.42	2		ZZ NPI	Taxonomy NPI Number
4 05	05	10	05	05	10	11		90715						0 00	1		ZZ NPI	Taxonomy NPI Number
5 05	05	10	05	05	10	11		90716						0 00	1		ZZ NPI	Taxonomy NPI Number
6 05	05	10	05	05	10	11		90707						0 00	1		ZZ NPI	Taxonomy NPI Number

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 117.00

29. AMOUNT PAID $

30. BALANCE DUE $ 117.00

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider – Split Claim
Periodic Examination
Developmental, Vision, and Hearing Screening
(Block 24H) Referral Indicator "R"
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 03 DD 02 YY 06 SEX M [x] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

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

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

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

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

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

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. V20.2 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	01	10	05	01	10	11		99382	EP					80.33	1	R	ZZ NPI	Taxonomy NPI Number
2	05	01	10	05	01	10	11		96110	EP					0.00	1		ZZ NPI	Taxonomy NPI Number
3	05	01	10	05	01	10	11		99172	EP					0.00	1		ZZ NPI	Taxonomy NPI Number
4	05	01	10	05	01	10	11		92551	EP					0.00	1		ZZ NPI	Taxonomy NPI Number
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

2nd Page of Split Claim
Private Provider
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 03 DD 02 YY 06 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V03.82
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	01	10	05	01	10	11		90465	EP					17 25	1		ZZ NPI	Taxonomy NPI Number
2	05	01	10	05	01	10	11		90466	EP					19 42	2		ZZ NPI	Taxonomy NPI Number
3	05	01	10	05	01	10	11		90713						0 00	1		ZZ NPI	Taxonomy NPI Number
4	05	01	10	05	01	10	11		90700						0 00	1		ZZ NPI	Taxonomy NPI Number
5	05	01	10	05	01	10	11		90707						0 00	1		ZZ NPI	Taxonomy NPI Number
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 36.67

29. AMOUNT PAID $

30. BALANCE DUE $ 36.67

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider
Periodic Examination
Vision & Hearing Screenings
(Block 24H) Referral Indicator "E"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 01 SEX M [ ] F [x]

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

c. OTHER ACCIDENT? YES [ ] NO [ ]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. V20.2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	03	10	05	03	10	11		99383	EP					80.33	1	E	ZZ / NPI	Taxonomy / NPI Number
2	05	03	10	05	03	10	11		99172	EP					0.00	1		ZZ / NPI	Taxonomy / NPI Number
3	05	03	10	05	03	10	11		92551	EP					0.00	1		ZZ / NPI	Taxonomy / NPI Number
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

FQHC/RHC
Periodic Examination
Vision & Hearing Screenings

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 03 DD 11 YY 97 SEX M [x] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V20.2 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	03	10	05	03	10	11		99394	EP					80.33	1		ZZ NPI	Taxonomy NPI Number
2	05	03	10	05	03	10	11		99172	EP					0.00	1		ZZ NPI	Taxonomy NPI Number
3	05	03	10	05	03	10	11		92551	EP					0.00	1		ZZ NPI	Taxonomy NPI Number
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

The JP Provider Clinic
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

FQHC/RHC
Interperiodic Examination
(Block 24H) Referral Indicator "F"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 06 DD 15 YY 91 SEX M [ ] F [x]

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

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

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

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. V70.3 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	15	10	05	15	10	11		99395	EP					80.33	1	F	ZZ NPI	Taxonomy NPI Number
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

The JP Provider Clinic
123 Any St
Any City, NC 27523-5678

a. NPI NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

FQHC/RHC
Immunizations Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 12 DD 25 YY 08 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

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

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

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

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

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

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. V03.81 3. _____
2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	05	10	05	05	10	11		90471	EP				17 25	1		ZZ / NPI	Taxonomy / NPI Number
2	05	05	10	05	05	10	11		90472	EP				29 13	3		ZZ / NPI	Taxonomy / NPI Number
3	05	05	10	05	05	10	11		90713					0 00	1		ZZ / NPI	Taxonomy / NPI Number
4	05	05	10	05	05	10	11		90716					0 00	1		ZZ / NPI	Taxonomy / NPI Number
5	05	05	10	05	05	10	11		90647					0 00	1		ZZ / NPI	Taxonomy / NPI Number
6	05	05	10	05	05	10	11		90700					0 00	1		ZZ / NPI	Taxonomy / NPI Number

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 46 38

29. AMOUNT PAID $

30. BALANCE DUE $ 46 38

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
123 That St
That City, NC 27606-1234
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
The JP Provider Clinic
123 Any St
Any City, NC 27523-5678
a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

FQHC/RHC
Core Visit
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 09 DD 09 YY 08 SEX M [x] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

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

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 382.9 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	20	10	05	20	10	11		T1015						65.00	1		ZZ / NPI	Taxonomy / NPI Number
2	05	20	10	05	20	10	11		90700						0.00	1		ZZ / NPI	Taxonomy / NPI Number
3	05	20	10	05	20	10	11		90707						0.00	1		ZZ / NPI	Taxonomy / NPI Number
4	05	20	10	05	20	10	11		90716						0.00	1		ZZ / NPI	Taxonomy / NPI Number
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 65.00

29. AMOUNT PAID $

30. BALANCE DUE $ 65.00

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
The JP Provider Clinic
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider – Split Claim
Periodic Examination

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 04 DD 30 YY 10 SEX M [ ] F [x]

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

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

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

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. V20.2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06	29	10	06	29	10	11		99391	EP					80.33	1		ZZ NPI	Taxonomy NPI Number
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 80.33

29. AMOUNT PAID $

30. BALANCE DUE $ 80.33

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

2nd Page of Split Claim
Private Provider
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 04 DD 30 YY 10 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

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

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. V05.3 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06	29	10	06	29	10	11		90465	EP					17 25	1		ZZ / NPI	Taxonomy / NPI Number
2	06	29	10	06	29	10	11		90466	EP					19 42	2		ZZ / NPI	Taxonomy / NPI Number
3	06	29	10	06	29	10	11		90680						0 00	1		ZZ / NPI	Taxonomy / NPI Number
4	06	29	10	06	29	10	11		90744						0 00	1		ZZ / NPI	Taxonomy / NPI Number
5	06	29	10	06	29	10	11		90669						0 00	1		ZZ / NPI	Taxonomy / NPI Number
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 36 67

29. AMOUNT PAID $

30. BALANCE DUE $ 36 67

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

Private Provider Immunizations Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K

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

3. PATIENT'S BIRTH DATE MM 09 DD 06 YY 05 SEX M X F ☐

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

5. PATIENT'S ADDRESS (No., Street): 123 Fun Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Fun Town STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

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

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

1. V06.1 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03	21	10	03	21	10	11		90471	EP					17 25	1		ZZ	Taxonomy
																		NPI	NPI Number
2	03	21	10	03	21	10	11		90472	EP					19 42	2		ZZ	Taxonomy
																		NPI	NPI Number
3	03	21	10	03	21	10	11		90700						0 00	1		ZZ	Taxonomy
																		NPI	NPI Number
4	03	21	10	03	21	10	11		90713						0 00	1		ZZ	Taxonomy
																		NPI	NPI Number
5	03	21	10	03	21	10	11		90707						0 00	1		ZZ	Taxonomy
																		NPI	NPI Number
6																			
																		NPI	

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 36.67

29. AMOUNT PAID $

30. BALANCE DUE $ 36.67

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.)

Signature on File

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

123 That St
That City, NC 27606-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Dr J P Provider
123 Any St
Any City, NC 27523-5678

a. NPI NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

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

SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN FOR LOCAL HEALTH DEPARTMENT'S THAT USE THE NEW HEALTH INFORMATION SYSTEM (HIS)

Example #1 - Health Check Periodic Screening assessment for six-month-old child
Developmental Screening
Immunizations Injections

PHTRAIN (803) - INFANT,GIRL (949823937)/Encounter Recording

File Edit Favorites Avatar PH Avatar CWS Avatar MSO Help

Page 1 of 1

INFANT,GIRL (949823937) Date Of Birth: 08/19/2008; Social Security Number: 000-00-0000

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Dia 2	Dia 3	Dia 4	Practitioner	Discipline
1	Billable (B)	Health Check...	"99381EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)
2	Reportable (R)	Health Check...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)
3	Reportable (R)	Health Check...	"90700-DTAP VACCINE,...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)
4	Billable (B)	Health Check...	"90465EP-IMMUNE ADM...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)

Example #2 – Health Check Periodic Screening assessment for 18-year-old
Vision Screening
Hearing Screening
Diagnosis warrants a referral for a follow-up visit, designated with "ST/S2"

PHTRAIN (803) - TEENAGER,GIRL (949823938)/Encounter Recording

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Page 1 of 1

TEENAGER,GIRL (949823938) Date Of Birth: 01/01/1991; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Dia 2	Dia 3	Dia 4	Practitioner	Discipline	Du / U
1	Billable (B)	Health Check-...	"99385EP-...	ST	V20.2 ROUTINE CHILD ...				NURSE,R...	Rostered Nurse Screener (...	
2	Reportable (R)	Health Check-...	99173EP-VI...		V20.2 ROUTINE CHILD ...				NURSE,R...	Rostered Nurse Screener (...	
3	Reportable (R)	Health Check-...	"92552EP-...		V20.2 ROUTINE CHILD ...				NURSE,R...	Rostered Nurse Screener (...	
4	Reportable (R)	Health Check-...	87081-CUL...		690.10 SEBORRHEIC D...				NURSE,R...	Rostered Nurse Screener (...	

Example #3 – Health Check Periodic Screening assessment for 4-year-old child With Developmental Screening, Vision Screening, Hearing Screening

PHTRAIN (803) - TODDLER,GIRL (949737349)/Encounter Recording

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Page 1 of 1

TODDLER,GIRL (949737349) Date Of Birth: 09/01/2004; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline
1	Billable (B)	Health Check-...	"99392EP-PREV VISIT,...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)
2	Reportable (R)	Health Check-...	96110EP-DEVELOPM...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)
3	Reportable (R)	Health Check-...	99172EP-OCULAR FU...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)
4	Reportable (R)	Health Check-...	92587EP-EVOKED AU...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)

Example #4 – Health Check Periodic Screening assessment for 2-year-old child Developmental Screening

PHTRAIN (803) - JONES,BABY (949823940)/Encounter Recording

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Page 1 of 1

JONES,BABY (949823940) Date Of Birth: 02/01/2008; Social Security Number: 000-00-0000

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline
1	Billable (B)	Health Check-...	"99382EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...
2	Reportable (R)	Health Check-...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...
3	Reportable (R)	Health Check-...	"90707-MMR VACCINE, ...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...
4	Billable (B)	Health Check-...	"90465EP-IMMUNE ADM...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...

Example #5 – Immunization Administration Fee with Vaccine Injections ONLY for 15 month old child without physician counseling

PHTRAIN (803) - TODDLER,JOHN (949823941)/Encounter Recording

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Page 1 of 1

TODDLER,JOHN (949823941) Date Of Birth: 11/18/2007; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Mods	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization-...	90471EP-IMMUNIZATIO...		V06.8 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
2	Reportable (R)	Immunization-...	"90723-DTAP-HEP B-IP...		V06.8 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
3	Billable (B)	Immunization-...	"90472EP-IMMUNIZATIO...		V03.81 VACCINE...				NURSE,ROS...	Rostered Nurse Screen...	5
4	Reportable (R)	Immunization-...	"90648-HIB VACCINE, P...		V03.81 VACCINE...				NURSE,ROS...	Rostered Nurse Screen...	
5	Reportable (R)	Immunization-...	"90669-PNEUMOCOCC...		V03.82 VACCINE...				NURSE,ROS...	Rostered Nurse Screen...	
6	Reportable (R)	Immunization-...	"90707-MMR VACCINE, ...		V06.4 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
7	Reportable (R)	Immunization-...	"90716-CHICKEN POX ...		V05.4 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
8	Reportable (R)	Immunization-...	"90633-HEP A VACC, P...		V05.3 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	

Example #6 – Office Visit with One Vaccine Injection for two-year old child

PHTRAIN (803) - TODDLER,PAUL (949834331)/Encounter Recording

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Page 1 of 1

TODDLER,PAUL (949834331) Date Of Birth: 02/26/2007; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Child Health-...	"99211-OFFICE/OUTPA...		382.9 OTITIS ME...				PHYSICIAN,FA...	Physician (PHY)	
2	Billable (B)	Health Check...	90471EP-IMMUNIZATIO...		V04.81 VACCINE...				NURSE,ROST...	Rostered Nurs...	
3	Reportable (R)	Health Check...	90655-FLU VACCINE N...		V04.81 VACCINE...				NURSE,ROST...	Rostered Nurs...	

Example #7 – Immunizations Only for eight-week old child
Immunization Administration Fee for Oral Vaccine w/Physician Counseling
Immunization Administration Fee with Vaccine Injection w/Physician Counseling

PHTRAIN (803) - INFANT,JANE (949824166)/Encounter Recording

File Edit Favorites Avatar PH Avatar CWS Avatar MSO Help

Page 1 of 1

INFANT,JANE (949824166) Date Of Birth: 12/18/2008; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization-Hend...	"90468EP-IMMUNE A...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	1
2	Reportable (R)	Immunization-Hend...	"90680-ROTOVIRUS ...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	
3	Billable (B)	Immunization-Hend...	"90465EP-IMMUNE A...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	
4	Reportable (R)	Immunization-Hend...	90744-HEPB VACC P...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	
5	Billable (B)	Immunization-Hend...	"90466EP-IMMUNE A...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	1
6	Reportable (R)	Immunization-Hend...	"90647-HIB VACCINE...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	

Example #8 – Immunizations Only for two-month old child
Administration Fee for Oral Vaccine without physician counseling
Administration Fee for Vaccine Injection without physician counseling

PHTRAIN (803) - INFANT,JOHNNY (949824169)/Encounter Recording

File Edit Favorites Avatar PH Avatar CWS Help

Page 1 of 1

INFANT,JOHNNY (949824169)

Encounter Charge Input

	Service Status	Program	Service Code	Modi s	Medical Diagnosis 1	Medical Diagnosis 2	Medical Diagnosis 3	Medical Diagnosis 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization...	90474EP-IMMUNE ADM...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
2	Reportable (R)	Immunization...	"90680-ROTOVIRUS VA...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
3	Billable (B)	Immunization...	90471-IMMUNIZATION ...	EP	VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
4	Reportable (R)	Immunization...	90744-HEPB VACC PE...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
5	Billable (B)	Immunization...	"90472EP-IMMUNIZATI...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	4
6	Reportable (R)	Immunization...	"90700-DTAP VACCINE...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
7	Reportable (R)	Immunization...	"90648-HIB VACCINE, ...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
8	Reportable (R)	Immunization...	"90669-PNEUMOCOCC...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
9	Reportable (R)	Immunization...	"90713-POLIOVIRUS, I...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1

Example #9 – Office Visit at which Oral Vaccine for two-month old child was provided without physician counseling

PHTRAIN (803) - BLUEBERRY,CHRISTIE (949824170)/Encounter Recording

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BLUEBERRY,CHRISTIE (949824170) Date Of Birth: 12/19/2008; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modi s	Medical Diagnosis 1	M Dia 2	M Dia 3	M Dia 4	Practitioner	Discipline	Duration / Units	Pla
1	Billable (B)	Child Health-...	"99211-OFFICE/OUTPA...		382.9 OTITIS ME...				PHYSICIAN,FA...	Physician (PHY)		Sta
2	Billable (B)	Health Check-...	90473EP-IMMUNE ADMI...		382.9 OTITIS ME...				NURSE,ROST...	Rostered Nurs...		Sta
3	Reportable (R)	Health Check-...	"90680-ROTOVIRUS VA...		382.9 OTITIS ME...				NURSE,ROST...	Rostered Nurs...		Sta

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