

North Carolina Health Check Billing Guide



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Effective with date of service July 1, 2011, please replace the April 2010 Special Bulletin II, *Health Check Billing Guide 2010*, with the July 2011 edition of the Health Check Billing Guide. For your convenience key words and phrases have been **bolded**.

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 the *Basic Medicaid Billing Guide*, **Section 6, Prior Approval**, and the prior approval

web page, respectively at the addresses specified below for further information about EPSDT and prior approval requirements.

- <http://www.ncdhhs.gov/dma/provider/library.htm>
- <http://ncdhhs.gov/dma/provider/priorapproval.htm>

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. See "EPSDT Coverage and CAP Waivers" for further detail. ***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 utilization review (UR) vendors review a covered state Medicaid plan services request for prior approval or continuing authorization 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 if the requested service is both a waiver service and a service 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].

- (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] if approved under the auspices of EPSDT.
 - 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 Community Support Services (CSS), a non-covered state Medicaid plan service, for example.
 - d. Other restrictions in the clinical coverage policies, such as the location of the service, prohibition 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].
 - e. 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 the *Basic Medicaid Billing Guide*, **Section 6, Prior Approval**, for further information regarding the provision of out-of-state services.
 - f. 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.
 - g. 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.

- h. 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.
- i. 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).
- j. 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.
- k. Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy as long as the requested service is a service 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].
- l. 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.
- m. 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.
- n. 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. See the section of this manual entitled Medicaid Recipient Due Process (Right to Appeal Prior Approval Decisions).

- o. The recipient has the right to continued Medicaid payment for services currently provided pending 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 a Community Alternatives Program (CAP) 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 if the requested service is a service 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].
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 a CAP program, approval of the waiver services as well as the delivery and cost of the recipient's services must be in compliance with the requirements established by the waiver and this policy. Relative to cost of the services, cost neutrality must be maintained in accordance with waiver requirements. While a recipient may exceed waiver limits, prior approval must be obtained as specified below.
 - a. **CAP for Children (CAP/C) and CAP for Disabled Adults (CAP/DA):** For a service that is both a waiver service and EPSDT service, the recipient may exceed the limit on that individual service, and prior approval is required before the limit is exceeded. If the service is a waiver service only, the limit may not be exceeded. Cost neutrality must be maintained in accordance with waiver requirements.
 - b. **CAP for Persons with Intellectual and Other Developmental Disabilities (CAP/IDD):** Prior approval to exceed \$100,000 per year must be obtained from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). Cost neutrality must be maintained in accordance with waiver requirements.
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".
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 Support Services (CSS), a non-covered or In-Home Care for Children (IHCC). It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP/IDD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.

7. CAP/DA case managers 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 prior approval and due process procedures.

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. Please refer to the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm> to locate the appropriate vendor in the recipient's county/catchment area and/or service type. 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. Please refer to the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm> to locate the appropriate vendor in the recipient's county/catchment area and/or service type. 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/IDD:** Requests for medical, dental services and/or behavioral health services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate DMA vendor for review and approval. Please refer to the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm> to locate the appropriate vendor in the recipient's county/catchment area and/or service type. Plan of care revisions must be submitted in accordance with the policies and procedures published by DMA or the vendor (statewide or LME) reviewing the plan of care request.

NOTE: Do not submit medical and dental requests to the statewide vendor or the LME for review.

- d. All EPSDT and covered state Medicaid plan requests for ***behavioral health services*** must be forwarded to the statewide vendor or the LME responsible for utilization review in the recipient's county/catchment area as indicated in the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm>. 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. Plan of care revisions must be submitted in accordance with the policies and procedures published by DMA or the vendor (statewide or LME) reviewing the plan of care request.
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 and the service under appeal is both a waiver service and a service 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].

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

1. Staff employed by LMEs CANNOT deny requests for services, formally or informally. Requests must be forwarded to appropriate utilization vendor (statewide or LME responsible for utilization review in the recipient's county/catchment area as indicated in the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm>.) if supported by a licensed clinician.
2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or IDD 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 the statewide vendor or the LME responsible for utilization review in the recipient's county/catchment area as indicated in the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm>. If the request needs to be reviewed by DMA clinical staff, the utilization review vendor 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 all behavioral health utilization review vendors.

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 needs to exceed 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 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/>). For those formulas not included on the DMA fee schedule and that have not been assigned Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, submit the request to the Assistant Director, Clinical Policy and Programs as specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age located on DMA's Web site at <http://www.ncdhhs.gov/dma/provider/forms.htm>.
- **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**.
- **Over-the-Counter (OTC) Products**—Over the counter products are covered by N.C. Medicaid in accordance with policy A-2 located at <http://www.ncdhhs.gov/dma/mp/index.htm>. 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, please send the request to Assistant Director, Clinical Policy and Programs.

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*. Requests for non-covered state Medicaid plan services that have been assigned CPT and HCPCS codes should be

submitted to the appropriate vendor. Medical, dental, and behavioral health service requests for non-covered state Medicaid plan services that have **not** been assigned CPT and HCPCS codes and requests for a review when there is no established review process for a requested service should be submitted to the Assistant Director, Clinical Policy and Programs, Division of Medical Assistance 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. 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.

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/>.

ATTACHMENT

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

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
- In-Home Care for Children (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.

Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years Old can be downloaded at

<http://www.ncdhhs.gov/dma/forms/NonCoveredServicesRequest.pdf>

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 1 st 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. The nutritional assessment may include a combination of physical, laboratory, health risk assessment, and dietary determinations that will yield information in assessing the nutritional status of the child or youth. Further assessment or an appropriate management plan with referral and follow-up is indicated when dietary practices suggest risk factors for co-morbidities, dietary inadequacy, obesity, disordered eating practices (pica, eating disorders, or excessive supplementation) or other nutritional problems.

The following resources are offered to assist with preventive counseling and management approaches:

- *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Chapters 4-5 at http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html.
- The Eat Smart Move More “Prescription for Health—5-3-2-1-Almost None” guide at <http://www.eatsmartmovemorenc.com/PediatricObesityTools/PediatricObesityTools.html>.
- “MyPyramid” recommendations at <http://www.mypyramid.gov/>.
- The *Pediatric Obesity Prevention and Treatment Algorithm* (NC Design Team, Contributors, and Reviewers) and related tools are available at <http://www.eatsmartmovemorenc.com/PediatricObesityTools/PediatricObesityTools.html>.

It is also recommended that all female adolescents of childbearing age take a multivitamin with folic acid (<http://jama.ama-assn.org/cgi/content/full/279/18/1430> and <http://www.getfolic.com/>)

- **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).

- **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 gender and age-appropriate growth chart, as indicated. 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.

- **ICD-9-CM Coding for BMI**

The American Academy of Pediatrics has identified childhood obesity as a significant health issue, both for its documented risks to health and well-being during childhood and its implications for health problems as an adult. Helping primary care clinicians and families to prevent and treat childhood obesity and overweight conditions is a priority of the Academy.

Measurement and follow-up of Body Mass Index (BMI) is a core Health Information Data and Information Set (HEDIS) measure for quality of care. In December of 2009, The Agency for Healthcare Research and Quality (AHRQ) included BMI measurement in its set of 24 child health indicators for state Medicaid and CHIP programs. CCNC already measures several of the child health indicators, and will be adding new ones over the coming year. In order to measure rates of documentation of Body Mass Index (BMI) as part of the CCNC Quality Measures and Feedback, providers should include appropriate ICD-9-CM diagnosis codes on claims billed for each Health Check visit. .

To promote quality of care, the coding of BMI percentile by appropriate V code will become a routine part of coding for Health Check visits (age 3 years and up) along with the V20.2 code. *CCNC and DMA strongly encourage all primary care providers to begin incorporating the appropriate BMI V codes* into their office processes for well-child care.

The following diagnosis codes should be incorporated into Health Check billing documentation for children, ages 3 to 21 years:

V85.51	<5 percentile	Failure to Thrive
V85.52	5 – 85 percentile	
V85.53	85 – 95 percentile	overweight
V85.54	≥ 95 percentile	obese

- 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/>. There is also a secondary link: www.developmentalscreening.org/screening_tools. Additional information, training, and resources for obtaining validated tools may be found at www.aap.org/sections/dbpeds/practice-screening.asp --From the menu on the left hand side, click on *Screening and Assessment*. This site also has additional information regarding the ABCD initiative.

The two most common tools utilized by North Carolina Medicaid providers are ASQ and PEDs tools. The ASQ-3 (*Ages and Stages Questionnaire*) tool can be found at www.brookepublishing.com or www.agesandstages.com. The PEDs (*Parents' Evaluation of Developmental Status*) tool can be found at www.pedstest.com.

For the M-CHAT screening tool, instructions, and permission, visit www.firstsigns.org/downloads/m-chat.PDF.

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.** The Bright Futures Pocket Guide at http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf provides guidelines for developmental surveillance for each periodic screening assessment.

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.**

A health risk assessment (e.g. Bright Futures Tool Kit/GAPS/HEADSSS) is recommended to be performed on youth ages 11-20. Further screening for developmental, behavioral or mental health issues using evidence-based tools is recommended (e.g. PSC; SDQ; Vanderbilt; PHQ-9; Beck's Depression Inventory-Primary Care Version). The health risk assessment and an evidence-based developmental, behavioral-mental health screening can be billed using CPT 99420 EP (maximum of 2 units/date of service). Additionally providers may bill CPT Codes 99406 EP/ 99407 EP (Smoking & Tobacco Use Cessation Counseling) and CPT 99408 EP/ 99409 EP (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 through 18---United States, 2011*, 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 32 in this guide for additional immunization information.

- **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/how/clinical_care/hearing_screening/#pubs .

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

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 code,
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 recommended for every child before age 1 and required beginning at age 3.** 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 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. For a list of dental providers by county who accept Medicaid, go to: <http://www.ncdhhs.gov/dma/dental/dentalprov.htm>.

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 website at <http://www.ncdhhs.gov/dma/mp/> for billing codes and guidelines.

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS, continued

- **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. Other laboratory tests, as indicated, may be performed and billed as medically indicated (e.g. Pregnancy Testing and Sexually Transmitted Disease Screening for sexually active youth).

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 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 as soon as possible, but no later than three months of age.** 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 website, 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 confirm that the screening was done. An infant without documentation of being screened at birth should have the screening test as soon as possible **but no later than three months of age.**

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. An interferon gamma release assay (blood test, either Quantiferon Gold in-tube® test or T-SPOT TB® test) can be used in place of the tuberculin skin test for children 5 years and older, but the PPD is preferred for children under 5 years of age. 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 (or blood 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.

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 capillary blood). 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 capillary blood). 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.
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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 Childhood Lead Testing and Follow Up Manual* found at:

http://www.deh.enr.state.nc.us/ehs/Children_Health/2009printedversionleadmanual.pdf.

- **Follow-up and Referral**

In a family-centered medical home, the health care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the child are met. To assure continuity of care, if the Health Check screening assessment is not performed in the child's medical home, then the results of the visit and recommendations for follow-up should be shared with the family's permission.

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/EPSTD 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. Support 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://www.fpg.unc.edu/~ncodh/ChildandAdolescentHealth/> and <http://hctransitions.ichp.ufl.edu/>.

Discuss timing for the next Health Check screening assessment appointment and schedule a visit, if appropriate.

IMMUNIZATIONS

Immunization Billing Overview

The North Carolina Immunization Program (NCIP)/Vaccines for Children (VFC) Program provides, at no charge, all recommended vaccines for all children birth through 18 years of age present in North Carolina, who are VFC-eligible, including Medicaid children. 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.

Health Choice recipients are considered *insured*; therefore, they are not eligible for VFC 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 vaccine is administered to this age group, Medicaid will reimburse providers for the vaccine product and the administration fee. 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. Use the *Non-covered State Medicaid Plan Services Request Form* found at <http://www.ncdhhs.gov/dma/provider/forms.htm> to submit the request.

The immunization administration codes currently covered are CPT codes 90471 through 90474. Their descriptors are as follows:

Procedure Code	Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472+ (add-on-code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474+* (add-on-code)	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure

*** Currently, 90474 cannot be billed with 90473 because there are no two oral and/or intranasal vaccines or combination of an oral and intranasal vaccine that would be given to a recipient**

Private Sector Providers and Local Health Departments

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) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 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 90473 with the EP modifier. **Note: CPT code 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. CPT code 90473 cannot 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 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) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 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 or 90473 with the EP modifier. **Note: CPT code 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 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.

Guiding Principles for Billing the Immunization Administration Codes

1. Effective with date of service July 1, 2011, the **ONLY** immunization administration codes covered for Medicaid recipients in the Health Check age range, 0 through 20 years of age, are CPT codes 90471 through 90474.
2. Claims billed with CPT immunization administration codes 90460 and 90461 (effective for dates of service on and after January 1, 2011, for Medicaid recipients through 18 years of age) on and after July 1, 2011, will deny.

3. Append modifier EP to all immunization administration codes billed for Medicaid recipients in the Health Check age range, 0 through 20 years of age.
4. Do NOT append the EP modifier to the vaccine CPT codes.
5. All of the units billed for CPT codes 90471EP, 90472EP, 90473EP, and 90474EP must be billed on **ONE** detail to avoid duplicate audit denials. Currently, 90474EP cannot be billed with 90473EP because there are no two oral/intranasal vaccines that would be given to a recipient. Only one unit of either 90473EP or 90474EP is allowed.
6. CPT vaccine codes for the vaccines administered **must** be reported or billed, as appropriate, even if administration codes are not being billed.
7. **For Medicaid recipients 21 years of age and older (above the Health Check age range), the immunization administration codes have not changed. Bill the series of CPT codes 90471 through 90474 without the EP modifier.**
8. Refer to individual bulletin articles on specific vaccines for additional billing guidelines.
9. Note that some NCIP vaccines may be administered to recipients ages 19 and older, in which case Medicaid will cover the administration fee.

Billing Examples for Claims Regarding Health Check Recipients

1. Billing for a 2-month old infant based on the current immunization schedule, when an oral immunization is included:

Vaccines provided	Administration codes	CPT vaccine codes
DTaP (diphtheria, tetanus, pertussis)	90471	90700
Rotavirus (oral)	90474	90681
Hepatitis B and Haemophilus influenza type b	90472	90748
Inactivated poliovirus	90472	90713
Pneumococcal conjugate vaccine, 13 valent	90472	90670

Coding on the claim:

90471 EP modifier

1 unit

There would be a billed amount.

90472 EP modifier

3 units

There would be a billed amount.

07.01.2011

90474	EP modifier	1 unit	There would be a billed amount.
90700		1 unit	There would be a \$0.00 billed amount.
90681		1 unit	There would be a \$0.00 billed amount.
90748		1 unit	There would be a \$0.00 billed amount.
90713		1 unit	There would be a \$0.00 billed amount.
90670		1 unit	There would be a \$0.00 billed amount.

2. Billing for a 4-year old child when all vaccines are injectable:

Vaccines provided	Administration codes	CPT vaccine codes
DTaP	90471	90700
PCV13	90472	90670
Influenza, split virus, preservative free, 3 years and older	90472	90656

Coding on the claim:

90471	EP modifier	1 unit	There would be a billed amount.
90472	EP modifier	2 units	There would be a billed amount.
90700		1 unit	There would be a \$0.00 billed amount.
90670		1 unit	There would be a \$0.00 billed amount.
90656		1 unit	There would be a \$0.00 billed amount.

3. Billing for a male recipient who is 19 years of age who receives a purchased injectable vaccine.

Vaccines provided	Administration codes	CPT vaccine codes
HPV	90471	90649

Coding on the claim:

90471	EP modifier	1 unit	There would be a billed amount.
90649	EP modifier	1 unit	There would be a billed amount.

Billing of Immunization Administration Codes by Private Sector Providers and Local Health Departments

An immunization administration fee code(s) 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.

Billing of Immunization Administration Codes by Federally Qualified Health Centers or Rural Health Centers

An immunization administration fee code(s) 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. An immunization administration fee code(s) cannot be billed in addition to a core visit code. Report the CPT vaccine code(s) without billing the administration fee.

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.

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 children birth through 18 years of age present in North Carolina, who are VFC-eligible, including Medicaid children. 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.

Health Choice recipients are considered *insured* and are not eligible for the VFC 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, provided at no charge, 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 who are present in North Carolina and who are VFC eligible. **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

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - <i>PedvaxHIB</i> 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	V03.81	Brand name - <i>ActHIB</i> Routine – 2 months to less than 5 years of age High risk – greater than 59 months through 18 years of age Brand name – <i>Hiberix</i> 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	Brand name – Gardasil Females and males 9 years through 18 years of age
90650	Human papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule for intramuscular use	V04.89	Brand name – Cervarix Females 9 years through 18 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
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	V03. 82	Routine: 2 months through 59 months of age High risk: Children 60 months through 18 years age with certain underlying medical conditions
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	V04. 89	Brand name – Rotateq 6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	V04. 89	Brand name – Rotarix 6 weeks through 7 months of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
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
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 pertussis 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 12 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 toxoids (Td) adsorbed,	V06.5	7 years through 18 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
	preservative free, when administered to individuals 7 years or older, for IM use		
90715 *	Tetanus, diphtheria toxoids an acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use	V06.1	7 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
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	V03.89	2 years through 18 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.
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib) for intramuscular use	V06. 8	6 weeks through 15 months of age

***Providers should refer to the Immunization Branch website 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's VFC program office. VFC program telephone numbers for the states bordering North Carolina 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 diagnosis codes should **always** be listed before immunization diagnosis codes. Immunization diagnoses (e.g. V04.81 for influenza) 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.

HEALTH CHECK BILLING REQUIREMENTS, continued

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. 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. 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. 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.**

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 website 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.

HEALTH CHECK BILLING REQUIREMENTS, continued

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.

Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier, and Report/Bill the CPT Code for the Vaccine Product

Providers should refer to the *Immunizations* section beginning on page 27, paying particular attention to the *Guiding Principles for Immunization Administration Codes* section on pages 29 through 30.

Providers may also refer to the claim examples at the end of this guide.

When reporting or billing vaccine administration codes, providers must use the appropriate CPT code(s) with the EP modifier listed in field 24D of the CMS-1500 claim form, or in the appropriate field on the 837P or HP Enterprise Services' Webtool.

Claims must be filed electronically unless they meet one of the ECS-mandated exceptions.

The CPT code for the vaccine product must be reported or billed without the EP modifier appended.

National Drug Codes (NDCs) are **not** required to be billed with CPT codes for vaccine products. NDCs should not be submitted for vaccine CPT codes to prevent denials of those details.

Providers must bill the appropriate number of units on the detail along with the total charge of **all** units billed for that code.

Notes:

In **rare** instances, because of vaccine recalls or because of 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. **Because the NCIP/VFC provides vaccines for Medicaid recipients under 19 years of age, claims for purchased vaccines administered to this age group that are available through VFC will be denied.**

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, provided at no charge, 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 billing guidance on specific vaccines in the General Medicaid bulletin.

If the **EP** modifier is not listed in block 24D for those Health Check age recipients through 20 years of age, the reimbursement rate for the CPT codes 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,	V20.2 Primary Diagnosis

	Preventive CPT Codes and Modifier	Diagnoses Codes
	<p>and 5 years of age EP Modifier is required in block 24D</p> <p>Autism Screening CPT Code: 99420 EP Modifier is required in block 24D</p> <p>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</p> <p>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</p> <p>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</p>	
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 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 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).
- Immunization administration CPT code(s) may be billed if immunizations are provided in addition to a Health Check screening visit. Immunization administration CPT codes 90471, 90472, 90473 and 90474 with the EP modifier may also be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an office or sick visit. When billing immunization administration CPT codes 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 website at: <http://www.ncdhhs.gov/dma/ca/hcc.pdf>.

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.	Vaccines 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	Bill periodic examination with primary diagnosis V20.2 and Interperiodic examinations with primary diagnosis

EOB	Message	Tip
	screening assessment. For information about billing Health Check, please call 1-800-688-6696.	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 immunization procedure codes are billed on the same claim as immunization administration codes. 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 (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	90471 with EP modifier	1 unit	
	OR		
Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	90473 with EP modifier	1 unit	
Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	90472 with EP Modifier OR 90474 with EP modifier	1 or more units 1 unit	

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, nonlyophilized (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),	V07.2	

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
	human, for IM and/or SC SC use (BayRab)		
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 - <i>PedvaxHIB</i> 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	V03.81	Brand name – <i>ActHIB</i> Routine – 2 months to less than 5 years of age; High risk – greater than 59 months through 18 years of age. Brand name – <i>Hiberix</i> 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	Females and males 9 years through 18 years of age
90650	Human papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use	V04.89	Females 9 through 18 years of age
90655 +	Influenza virus vaccine, split virus, preservative free when administered to	V04.81	6 months through 35 months of age

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
	children 6-35 months of age, for IM use		
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 18 years 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 pertussis 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
90703	Tetanus toxoid adsorbed, for IM use	V03.7	

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90704	Mumps virus vaccine live, 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 12 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	V06.1	7 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

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90733	Meningococcal polysaccharide vaccine (any group(s), for SC use	V04.89	
90734 *	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V01.89	2 years through 18 years of age
90740	Hepatitis B vaccine, dialysis or immunocompromised patient dosage (3-dose schedule), for IM use	V05.3	
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	V05.3	20 years of age and older, only in LHDs*
90747	Hepatitis B vaccine dialysis or immunosuppressed patient dosage (4-dose schedule), for IM use	V05.3	
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	V06.8	6 weeks through 15 months of age

*Providers should refer to the Immunization Branch website 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 website at <http://www.ncdhhs.gov/dma/bulletin/>.

MEDICAID RECIPIENT DUE PROCESS (RIGHT TO APPEAL A PRIOR APPROVAL DECISION)

Medicaid is an entitlement program, and it is a recipient's constitutional right to appeal a Medicaid decision that denies, reduces, terminates, or suspends a request for Medicaid services. The Medicaid prior approval and recipient hearing processes are described below.

FILING A RECIPIENT HEARING REQUEST FORM: Medicaid recipients or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9. If the recipient decides to appeal Medicaid's decision to deny, terminate, reduce, or suspend the services requested by his/her provider, the recipient must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) by mail or fax within **30 days of the date the notice was mailed**. The mailing address and telephone and fax numbers for OAH are located on the appeal request form. Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.

UNDERSTANDING THE APPEAL PROCESS: If the recipient chooses to appeal, he/she may represent himself/herself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for them. The recipient's case will begin as soon as the completed recipient hearing request form is **received and filed** with the OAH. The recipient will be contacted by OAH or the Mediation Network of North Carolina to discuss his/her case and to be offered an opportunity for mediation in an effort to resolve the appeal. Contact is made by telephone or **trackable mail**. So, it is important for the recipient to accept all **trackable mail** from OAH or the mediation center. **NOTE: New information about the recipient's request that was not provided to Medicaid previously may be submitted at any time during the mediation and appeal processes.**

Mediation is an informal process where the recipient, his/her representatives, and Medicaid have an opportunity to discuss the case with a mediator in hopes that the hearing issues will be resolved. If mediation resolves the case, the hearing will be dismissed, and services will be provided as specified during the mediation process. The recipient and his/her representatives may participate by telephone or in-person. Medicaid representatives will participate by telephone. **Mediation is confidential and legally binding.**

If the recipient does not accept the offer of mediation or the results of mediation, the case will proceed to hearing and will be heard by an administrative law judge with OAH. The recipient will be notified by **trackable mail** of the date, time, and location of the hearing. The administrative law judge will make a decision and will send it to Medicaid for a final agency decision. The petitioner(s) will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision by **trackable mail**. The recipient and provider should not act on the administrative law judge's decision because Medicaid must review the decision and issue the final agency decision. If the recipient does not agree with Medicaid's final agency decision, he/she may ask for a judicial review in superior court. The hearing process must be completed within 90 days of OAH's receipt of the recipient's completed Recipient Hearing Request Form.

IMPLEMENTING THE FINAL AGENCY DECISION: Final agency decisions will notify the recipient of the importance of immediately informing the provider of the decision.

Decisions which uphold the agency action:

A final agency decision which dismisses the recipient's appeal or upholds the Medicaid agency action shall be implemented no later than three business days from the date the decision was mailed to the petitioner(s) identified by OAH at the time the appeal was filed.

Decisions which reverse in part or in full the agency action:

If the Medicaid agency decision or a mediated settlement holds that all or part of the requested services were medically necessary, payment for those services as approved in the final agency decision or settlement will be authorized within three business days for at least 20 prospective calendar days after the date of the decision. A copy of the final agency decision will be mailed by **trackable mail** to the petitioner(s) identified by OAH at the time the appeal was filed. The final agency decision shall include a notification that a new request for prior authorization is required to be received by Medicaid within 15 calendar days of the decision in order to avoid an interruption in services. Upon receipt by Medicaid of a request for service authorization within 15 calendar days from the date of a final agency decision which holds that all or part of the requested services were medically necessary, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior authorization. If the request is denied or reduced, it will be treated as a timely request for reauthorization and maintenance of services pending appeal will apply.

PROVIDING SERVICES DURING THE APPEAL PROCESS (Maintenance of Services): Maintenance of services means that for a **reauthorization or continuing or**

concurrent request that was denied, reduced, or terminated, the recipient is entitled to receive services during the pendency of the appeal **and** as long as he/she remains otherwise Medicaid eligible as described below, unless the recipient gives up this right.

1. If the recipient appeals within **10 days of the date the notice was mailed**, payment authorization for services will continue without a break in service. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.
2. If the recipient appeals more than ten calendar days but within 30 calendar days of the date the notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

Maintenance of services (authorization of payment during the pendency of the appeal) will **not** be authorized if:

1. The recipient appeals more than 30 days after the date the notice was mailed.
2. The recipient's service request was submitted after his/her current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing or concurrent request. Maintenance of services does not apply to initial requests.

CHANGING PROVIDERS DURING THE APPEAL PROCESS: Medicaid recipients have the right to change providers as indicated below.

1. For Medicaid recipients who:
 - a. have appealed an adverse decision, or
 - b. whose provider agency is going out of business, or
 - c. have changed providers for CAP services or
 - d. are changing providers for another service with an authorization period of six months or more,the current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the appropriate utilization vendor and upon submission of written attestation that provision of the service meets Medicaid policy and the recipient's condition meets coverage criteria and acceptance of all associated responsibility; and either written permission of recipient or legal guardian for transfer; or copy of discharge from previous provider.
2. Authorization shall be effective the date the new provider submits a copy of the written attestation.
3. Following the appeal or prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with

the clinical coverage policy requirements and these procedures.

OBTAINING LEGAL ASSISTANCE: For questions regarding legal assistance, please contact Legal Aid of North Carolina at 919-856-2564 or toll-free at 1-866-369-6923. Recipients with disabilities also will be informed they may contact Disability Rights of North Carolina at 1-877-235-4210.

QUESTIONS ABOUT THE MEDICAID PRIOR APPROVAL AND MEDICAID RECIPIENT HEARING PROCESSES: For questions concerning the decision Medicaid makes about the provider's request for service, please contact Medicaid. Questions about the appeal process may be addressed to OAH or the Appeals Unit, Division of Medical Assistance (Medicaid), or you may visit the provider prior approval web page at <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>. Agency contact information appears in the box below.

AGENCY	MAILING ADDRESS	OFFICE NUMBER
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000
Division of Medical Assistance (Medicaid)	Appeals Unit Clinical Policy and Programs 2501 Mail Service Center Raleigh, NC 27699-2501	919-855-4260 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals Unit, Clinical Policy and Programs.

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

Due Process (Medicaid Recipient Appeals)

<http://ncdhhs.gov/dma/provider/priorapproval.htm>

HP Enterprise Services Provider Services

1-800-688-6696 or 919-851-8888

Health Check Coordinator Contact List

<http://www.ncdhhs.gov/dma/ca/hcc.pdf>

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/2009printedversionleadmanual.pdf

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 Form for Non-Covered Services

<http://www.ncdhhs.gov/dma/provider/forms.htm>

<http://www.ncdhhs.gov/dma/basicmed/>

<http://ncdhhs.gov/dma/provider/priorapproval.htm>

Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2011

<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>

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>

1500

Private Provider
Periodic Examination

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joanna										3. PATIENT'S BIRTH DATE MM DD YY SEX 03 22 11 M F <input checked="" type="checkbox"/>									
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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER				
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
17a. _____					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? <input type="checkbox"/> YES <input type="checkbox"/> 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									
22. MEDICAID RESUBMISSION CODE					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. ERGOT Family Plan					I. ID. QUAL					J. RENDERING PROVIDER ID. #									
1					2					3									
4					5					6									
25. FEDERAL TAX I.D. NUMBER					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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					32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234					33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678									
SIGNED _____ DATE _____					a. NPI					b. ZZ Taxonomy									

NUCC Instruction Manual available at: www.nucc.org

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

1500

Private Provider
Periodic Examination
Developmental Screening

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER 123456789K	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe				3. PATIENT'S BIRTH DATE MM DD YY 01 15 07		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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER		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 DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V20.2		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. ERSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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				32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234				33. BILLING PROVIDER INFO & PH# Dr J P Provider 123 Any St Any City, NC 27523-5678			
SIGNED _____ DATE _____		a. NPI _____		b. ZZ Taxonomy		a. NPI _____		b. ZZ Taxonomy		SIGNED _____ DATE _____	

NUCC Instruction Manual available at: www.nucc.org

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

1500

Private Provider
With Immunizations

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsors SSN) CHAMPVA <input type="checkbox"/> (Member ID) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BULKING <input type="checkbox"/> (ID) OTHER <input type="checkbox"/>												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 02 14 05												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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED'S ADDRESS (No., Street)																							
CITY Fun Town						STATE NC						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) <input type="checkbox"/> YES <input type="checkbox"/> NO												a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)												b. EMPLOYER'S NAME OR SCHOOL NAME																							
c. EMPLOYER'S NAME OR SCHOOL NAME												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO												c. INSURANCE PLAN NAME OR PROGRAM NAME																							
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item # a-d.																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																							
SIGNED _____ DATE _____												SIGNED _____ DATE _____																																			
14. DATE OF CURRENT ILLNESS (Initial symptom) OR INJURY (Accident, OR PREGNANCY)(M/P)						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____ 17b. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																																			
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																			
21. DIAGNOSIS NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24C by Line)												22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO.												23. PATIENT AUTHORIZATION NUMBER																							
1. V06.8												2. _____												3. _____																							
2. _____												4. _____												5. _____																							
24. A. DATE(S) OF SERVICE From To PLACE OF SERVICE EMG												B. PROCEDURES, SERVICES, OR SUPPLIES Explain Unusual Circumstances CPT/HCPCS MODIFIER												C. DIAGNOSIS POINTER																							
1 05 05 11 05 05 11 11 90471 EP 13.71 1 ZZ Taxonomy												2 05 05 11 05 05 11 11 90472 EP 13.71 1 ZZ Taxonomy												3 05 05 11 05 05 11 11 90710 0.00 1 NPI NPI Number																							
4 05 05 11 05 05 11 11 90700 0.00 1 NPI Taxonomy NPI Number												5 _____												6 _____																							
25. FEDERAL TAX I.D. NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
28. TOTAL CHARGE \$ 27.42												29. AMOUNT PAID \$ 27.42												30. BALANCE DUE \$																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION												33. BILLING PROVIDER INFO & PH #																							
Signature on File _____ DATE _____												123 That St That City, NC 27606-1234												Dr J P Provider 123 Any St Any City, NC 27523-5678																							
a. NPI												b. ZZ Taxonomy												a. NPI												b. ZZ Taxonomy											

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0936-0969 FORM CMS-1500 (08/05)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Private Provider Interperiodic Screening Immunizations

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member/Dur) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BENEFIT (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										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 03 28 01					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>														
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																			
CITY Fun Town					STATE NC					CITY					STATE														
ZIP CODE 11111					TELEPHONE (Include Area Code) 655 555-5555										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) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										SEX M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
SIGNED _____ DATE _____										SIGNED _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
19. RESERVED FOR LOCAL USE										17b. NPI										FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO									
1. V70.3										23. PRIOR AUTHORIZATION NUMBER										\$ CHARGES									
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)										E. DIAGNOSIS POINTER										F. \$ CHARGES									
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ 121.46										29. AMOUNT PAID \$										30. BALANCE DUE \$ 121.46									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #									
Signature on File										123 That St That City, NC 27606-1234										Dr J P Provider 123 Any St Any City, NC 27523-5678									
SIGNED _____ DATE _____										a. NPI										b. ZZ Taxonomy									

NUCC Instruction Manual available at: www.nucc.org

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>	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 DD YY SEX 03 02 07 M <input checked="" type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY Fun Town	STATE NC
ZIP CODE 11111	TELEPHONE (Include Area Code) (555) 555-5555
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI _____
19. RESERVED FOR LOCAL USE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)	19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
1. V20.2	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES
2. _____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
3. _____	23. PRIOR AUTHORIZATION NUMBER
4. _____	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) EPT/HPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #
1. 05 02 11 05 02 11 11 99382 EP 80 33 1 R ZZ Taxonomy NPI Number	
2. 05 02 11 05 02 11 11 96110 EP 0 00 1 ZZ Taxonomy NPI Number	
3. 05 02 11 05 02 11 11 99172 EP 0 00 1 ZZ Taxonomy NPI Number	
4. 05 02 11 05 02 11 11 92551 EP 0 00 1 ZZ Taxonomy NPI Number	
5. _____	
6. _____	
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> 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	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234
SIGNED _____ DATE _____	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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Champus Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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 DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 03 02 07			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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)				
CITY Fun Town		STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE				
ZIP CODE 11111		TELEPHONE (Include Area Code) (555) 555-5555				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				
9a. OTHER INSURED'S POLICY OR GROUP NUMBER						9b. AUTO ACCIDENT? (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER				
9c. EMPLOYER'S NAME OR SCHOOL NAME						9d. RESERVED FOR LOCAL USE			11a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
9d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			11b. EMPLOYER'S NAME OR SCHOOL NAME				
11. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			11c. INSURANCE PLAN NAME OR PROGRAM NAME				
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE. MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____		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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V03.82						22. MEDICAID RESUBMISSION CODE		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. ICD-9-CM CODE I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 05 02 11 05 02 11 11 90471 EP 13.71 1 ZZ Taxonomy NPI Number						13.71		1		ZZ		Taxonomy NPI Number	
2 05 02 11 05 02 11 11 90472 EP 27.42 2 ZZ Taxonomy NPI Number						27.42		2		ZZ		Taxonomy NPI Number	
3 05 02 11 05 02 11 11 90713 0.00 1 ZZ Taxonomy NPI Number						0.00		1		ZZ		Taxonomy NPI Number	
4 05 02 11 05 02 11 11 90700 0.00 1 ZZ Taxonomy NPI Number						0.00		1		ZZ		Taxonomy NPI Number	
5 05 02 11 05 02 11 11 90707 0.00 1 ZZ Taxonomy NPI Number						0.00		1		ZZ		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) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 41.13		29. AMOUNT PAID \$ 41.13		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File						32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234			33. BILLING PROVIDER INFO & PH# Dr J P Provider 123 Any St Any City, NC 27523-5678				
SIGNED _____ DATE _____						a. NPI		b. ZZ Taxonomy					

NUCC Instruction Manual available at: www.nucc.org

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

1500
HEALTH INSURANCE CLAIM FORM

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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joanna										3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 01/03/01 M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																																	
5. PATIENT'S ADDRESS (AL. Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																	
CITY Fun Town					STATE NC					7. INSURED'S ADDRESS (No., Street)					CITY					STATE																																							
ZIP CODE 11111					TELEPHONE (Include Area Code) (555) 555-5555					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM/DD/YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM/DD/YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V20.2										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/HPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT (Early) Rev I. ID. QUAL J. RENDERING PROVIDER ID. #																																							
1 05 03 11 05 03 11 11 99383 EP 80 33 1 E ZZ Taxonomy										NPI										NPI Number																																							
2 05 03 11 05 03 11 11 99172 EP 0 00 1 ZZ Taxonomy										NPI										NPI Number																																							
3 05 03 11 05 03 11 11 92551 EP 0 00 1 ZZ Taxonomy										NPI										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 gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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										32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234										33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678																																							
SIGNED _____ DATE _____										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

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																																																																																									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small>										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 DD YY 03 11 98					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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																																																																																				
CITY Fun Town					STATE NC					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) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																															
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # 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.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																															
SIGNED _____ DATE _____										SIGNED _____ DATE _____																																																																																									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V20.2										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																																																																															
2. _____										3. _____										4. _____																																																																															
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. FQHC Family Plan										I. ID. QUAL										J. RENDERING PROVIDER ID. #									
05 02 11 05 02 11 11										99394 EP										80.33 1										ZZ Taxonomy																																																																					
05 02 11 05 02 11 11										99172 EP										0.00 1										ZZ Taxonomy																																																																					
05 02 11 05 02 11 11										92551 EP										0.00 1										ZZ Taxonomy NPI Number																																																																					
_____										_____										_____										NPI																																																																					
_____										_____										_____										NPI																																																																					
_____										_____										_____										NPI																																																																					
_____										_____										_____										NPI																																																																					
25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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										32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234										33. BILLING PROVIDER INFO & PH # The JP Provider Clinic 123 Any St Any City, NC 27523-5678																																																																															
SIGNED _____ DATE _____										a. NPI										b. ZZ Taxonomy																																																																															

NUCC Instruction Manual available at: www.nucc.org

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

1500

HEALTH INSURANCE CLAIM FORM

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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BULK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										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 DD YY 07 15 92 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Fun Town STATE NC										7. INSURED'S ADDRESS (No., Street)	
ZIP CODE 11111 TELEPHONE (Include Area Code) (555) 555-5555										CITY _____ STATE _____	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE	
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY _____										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY _____ TO MM DD YY _____	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> 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. _____	
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. # _____										23. PRIOR AUTHORIZATION NUMBER _____	
1										ZZ Taxonomy	
2										NPI NPI Number	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. _____	
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										27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234										28. TOTAL CHARGE \$ 80.33 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ 80.33	
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # The JP Provider Clinic 123 Any St Any City, NC 27523-5678	
a. NPI _____ b. NPI _____										a. NPI _____ b. NPI _____ 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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>												1a. INSURED'S I.D. NUMBER 123456789K <small>(For Program in Item 1)</small>		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe						3. PATIENT'S BIRTH DATE MM DD YY 11 22 09			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street CITY: Fun Town STATE: NC						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY: STATE:					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE			11. INSURED'S POLICY GROUP OR FECA NUMBER			12. INSURED'S DATE OF BIRTH MM DD YY M F					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. EMPLOYER'S NAME OR SCHOOL NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.					
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V03.81						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. EPSTI Form # I. ID. QUAL. J. RENDERING PROVIDER ID. #					
1 05 05 11 05 05 11 11 90471 EP 13.71 1 ZZ Taxonomy NPI Number						2 05 05 11 05 05 11 11 90472 EP 41.13 3 ZZ Taxonomy NPI Number								
3 05 05 11 05 05 11 11 90713 0.00 1 ZZ Taxonomy NPI Number						4 05 05 11 05 05 11 11 90716 0.00 1 ZZ Taxonomy NPI Number								
5 05 05 11 05 05 11 11 90647 0.00 1 ZZ Taxonomy NPI Number						6 05 05 11 05 05 11 11 90700 0.00 1 ZZ Taxonomy NPI Number								
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO			28. TOTAL CHARGE \$ 54.84			29. AMOUNT PAID \$ 54.84		
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						32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234			33. BILLING PROVIDER INFO & PH # The JP Provider Clinic 123 Any St Any City, NC 27523-5678					
SIGNED: _____ DATE: _____						a. NPI b. ZZ Taxonomy			a. NPI b. ZZ Taxonomy					

NUCC Instruction Manual available at: www.nucc.org

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

1500

FQHC/RHC Core Visit with Immunizations

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (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 07 05 09		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street) 123 Fun Street		6. INSURED'S ADDRESS (No., Street)			
7. CITY Fun Town				8. STATE NC		9. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		10. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		11. CITY		12. STATE			
13. ZIP CODE 11111				14. TELEPHONE (Include Area Code) (555) 555-5555		15. EMPLOYED <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		16. ZIP CODE		17. TELEPHONE (Include Area Code)		18. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
19. OTHER INSURED'S POLICY OR GROUP NUMBER						20. EMPLOYER'S NAME OR SCHOOL NAME		21. INSURED'S POLICY GROUP OR FECA NUMBER		22. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		23. EMPLOYER'S NAME OR SCHOOL NAME			
24. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						25. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. INSURANCE PLAN NAME OR PROGRAM NAME		27. EMPLOYER'S NAME OR SCHOOL NAME		28. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.			
29. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						30. RESERVED FOR LOCAL USE		31. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		32. SIGNED _____		33. DATE _____			
14. DATE OF CURRENT ILLNESS (first symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE a. _____ b. NPI _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (relate items 1, 2, 3 or 4 to item 24C by Line) 1. 382.9 2. _____ 3. _____ 4. _____						22. MEDICAID RESUBMISSION CODE		23. ORIGINAL REF. NO.		24. ICD-9-CM ICD-10-CM ICD-9-CM ICD-10-CM					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. MODIFIERS, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		D. DIAGNOSIS POINTER		E. \$ CHARGES		F. C. DAYS OF UNITS		G. ICD-9-CM ICD-10-CM ICD-9-CM ICD-10-CM			
1 05 20 11 05 20 11 11		T 1015		65.00		1		ZZ		Taxonomy		J. RENDERING PROVIDER ID #			
2 05 20 11 05 20 11 11		90700		0.00		1		ZZ		NPI Number		K. TAXONOMY			
3 05 20 11 05 20 11 11		90707		0.00		1		ZZ		NPI Number		L. TAXONOMY			
4 05 20 11 05 20 11 11		90716		0.00		1		ZZ		NPI Number		M. TAXONOMY			
5 _____		_____		_____		_____		_____		_____		_____			
6 _____		_____		_____		_____		_____		_____		_____			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For RHC, see 4242.0) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 65.00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 65.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (Certify that the statements or the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234				33. BILLING PROVIDER INFORMATION # Dr J P Provider 123 Any St Any City, NC 27523-5678							
SIGNED Signature on File DATE				a. NPI		b. ZZ Taxonomy		a. NPI		b. ZZ Taxonomy		c. ZZ Taxonomy			

NUCC Instruction Manual available at: www.nucc.org

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

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Private Provider
Immunizations Only
Purchased Vaccines

<input type="checkbox"/> PICA											
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID)	GROUP HEALTH PLAN (SSN or ID)	FECA ELK 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 03/26/92		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY Fun Town			STATE NC	9. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE		
ZIP CODE 11111		TELEPHONE (Include Area Code) (555) 555-5555			Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code)		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				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? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes return to and complete item 0 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.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED _____ DATE _____						SIGNED _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. F. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		19. RESERVED FOR LOCAL USE	
MM DD YY		MM DD YY		FROM MM DD YY TO MM DD YY		FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		21. ICD-9-CM CODE (NATURE OF ILLNESS OR INJURY) (Release Items 1, 2, 3 or 4 to Item 24b by Line)	
17a. _____		17b. NPI _____		17c. _____		17d. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____		23. PRIOR AUTHORIZATION NUMBER _____	
24. A. DATE 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. ERGOT Family Plan	I. D. QUAL	J. RENDERING PROVIDER ID #
1 05 01 11 05 01 11 11		90471	EP				13.71	1	ZZ	Taxonomy	
2 05 01 11 05 01 11 11		90472	EP				13.71	1	ZZ	Taxonomy	
3 05 01 11 05 01 11 11		90649					135.73	1	ZZ	Taxonomy	
4 05 01 11 05 01 11 11		90715					39.49	1	ZZ	Taxonomy	
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER			SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gift, share, joint task) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$ 202.64	29. AMOUNT PAID \$	30. BALANCE DUE \$ 202.64		
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				32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234			33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678				
SIGNED _____ DATE _____				a. NPI			b. ZZ Taxonomy				

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (03/05)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

Private Provider – Split Claim
Periodic Examination

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member/LW) (SSN or IL) (SSN) (IL)</small>										1a. INSURED'S I.D. NUMBER 123456789K <small>(For Program in Item 1)</small>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joanna				3. PATIENT'S BIRTH DATE MM DD YY 02 14 11 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street CITY Fun Town STATE NC				6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE							
ZIP CODE 11111		TELEPHONE (Include Area Code) (555) 555-5555		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE ()		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				b. AUTO ACCIDENT?		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.							
d. INSURANCE PLAN NAME OR PROGRAM NAME				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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V20.2				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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #							
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For split claim, see 1500) <input type="checkbox"/> YES <input type="checkbox"/> 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				32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234				33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678					
SIGNED _____ DATE _____				a. NPI b. SIGNED		a. NPI b. ZZ Taxonomy							

NUCC Instruction Manual available at: www.nucc.org

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

1500

2nd Page of Split Claim
Private Provider
Immunizations

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										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 DD YY 02 14 11 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street CITY Fun Town STATE NC				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.					
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE				17b. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> 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				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. EPSPOT (Family Pay)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 29 11 06 29 11 11				90471 EP			13.71	1	ZZ	Taxonomy	
2 04 29 11 06 29 11 11				90472 EP			13.71	1	ZZ	Taxonomy	
3 04 29 11 06 29 11 11				90474 EP			13.71	1	ZZ	Taxonomy	
4 04 29 11 06 29 11 11				90744			0.00	1	ZZ	Taxonomy	
5 04 29 11 06 29 11 11				90670			0.00	1	ZZ	Taxonomy	
6 04 29 11 04 29 11				90680			0.00	1	ZZ	Taxonomy	
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 41.13		29. AMOUNT PAID \$		30. BALANCE DUE \$ 41.13
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				32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234				33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678			
SIGNED _____ DATE _____				a. NPI		b. ZZ Taxonomy		a. NPI		b. ZZ Taxonomy	

NUCC Instruction Manual available at: www.nucc.org

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

1500

Private Provider
Immunizations Only

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER 123456789K																																																																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe				3. PATIENT'S BIRTH DATE MM DD YY 09 06 06		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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																																																																																					
CITY Fun Town				STATE NC		CITY		STATE		ZIP CODE 11111		TELEPHONE (Include Area Code) (555) 555-5555																																																																																					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																									
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY				b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				c. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																									
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.																																																																																									
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 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? <input type="checkbox"/> YES <input type="checkbox"/> 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																																																																																																	
22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____																																																																																																	
<table border="1"> <thead> <tr> <th rowspan="2">1</th> <th colspan="2">A. DATE(S) OF SERVICE</th> <th rowspan="2">B. PLACE OF SERVICE</th> <th rowspan="2">C. EMG</th> <th rowspan="2">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th rowspan="2">E. DIAGNOSIS POINTER</th> <th rowspan="2">F. \$ CHARGES</th> <th rowspan="2">G. DAYS OR UNITS</th> <th rowspan="2">H. EPSDI (Per Day)</th> <th rowspan="2">I. ID. QUAL</th> <th rowspan="2">J. RENDERING PROVIDER ID. #</th> </tr> <tr> <th>From MM DD YY</th> <th>To MM DD YY</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>03</td> <td>21 11 03</td> <td>21 11 11</td> <td></td> <td>90471 EP</td> <td></td> <td>13.71</td> <td>1</td> <td></td> <td>ZZ</td> <td>Taxonomy</td> </tr> <tr> <td>2</td> <td>03</td> <td>21 11 03</td> <td>21 11 11</td> <td></td> <td>90472 EP</td> <td></td> <td>27.42</td> <td>2</td> <td></td> <td>ZZ</td> <td>Taxonomy</td> </tr> <tr> <td>3</td> <td>03</td> <td>21 11 03</td> <td>21 11 11</td> <td></td> <td>90700</td> <td></td> <td>0.00</td> <td>1</td> <td></td> <td>ZZ</td> <td>Taxonomy</td> </tr> <tr> <td>4</td> <td>03</td> <td>21 11 03</td> <td>21 11 11</td> <td></td> <td>90713</td> <td></td> <td>0.00</td> <td>1</td> <td></td> <td>ZZ</td> <td>Taxonomy</td> </tr> <tr> <td>5</td> <td>03</td> <td>21 11 03</td> <td>21 11 11</td> <td></td> <td>90707</td> <td></td> <td>0.00</td> <td>1</td> <td></td> <td>ZZ</td> <td>Taxonomy</td> </tr> <tr> <td>6</td> <td></td> </tr> </tbody> </table>												1	A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDI (Per Day)	I. ID. QUAL	J. RENDERING PROVIDER ID. #	From MM DD YY	To MM DD YY	1	03	21 11 03	21 11 11		90471 EP		13.71	1		ZZ	Taxonomy	2	03	21 11 03	21 11 11		90472 EP		27.42	2		ZZ	Taxonomy	3	03	21 11 03	21 11 11		90700		0.00	1		ZZ	Taxonomy	4	03	21 11 03	21 11 11		90713		0.00	1		ZZ	Taxonomy	5	03	21 11 03	21 11 11		90707		0.00	1		ZZ	Taxonomy	6											
1	A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDI (Per Day)	I. ID. QUAL	J. RENDERING PROVIDER ID. #																																																																																						
	From MM DD YY	To MM DD YY																																																																																															
1	03	21 11 03	21 11 11		90471 EP		13.71	1		ZZ	Taxonomy																																																																																						
2	03	21 11 03	21 11 11		90472 EP		27.42	2		ZZ	Taxonomy																																																																																						
3	03	21 11 03	21 11 11		90700		0.00	1		ZZ	Taxonomy																																																																																						
4	03	21 11 03	21 11 11		90713		0.00	1		ZZ	Taxonomy																																																																																						
5	03	21 11 03	21 11 11		90707		0.00	1		ZZ	Taxonomy																																																																																						
6																																																																																																	
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO. _____				27. ACCEPT ASSIGNMENT? (Per gov. statute, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 41.13		29. AMOUNT PAID \$ 41.13																																																																																					
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				32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234				33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678																																																																																									
SIGNED _____ DATE _____				a. NPI _____ b. _____				a. NPI NPI b. ZZ Taxonomy																																																																																									

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

Example 1:

Health Check Periodic screening assessment for six-month old child
 Developmental screening
 Immunization

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

Page 1 of 1

INFANT,GIRL (949823937) CNDS/ID Number: 949823937L; Sex: Female

Encounter Charge Input

	Service Status	Program	Service Code	M	Medical Diagnosis	Med Diag 2	Me Dia 3	Me Dia 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Health Check-Hend...	*99381EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	
2	Billable (B)	Health Check-Hend...	90471EP-IMMUNIZATIO...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	1
3	Reportable (R)	Health Check-Hend...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	
4	Reportable (R)	Health Check-Hend...	*90700-DTAP VACCINE, ...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	

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

Page 1 of 1

TEENAGER,GIRL (949823938) CNDS/ID Number: 949823938K; Sex: Female

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis	Me Diag 2	Me Dia 3	Me Dia 4	Practitioner	Discipline	Dur / Un
1	Billable (B)	Health Check-...	*99385EP-PREV VISIT, ...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered Nurs...	
2	Reportable (R)	Health Check-...	99173EP-VISUAL ACUIT...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered Nurs...	
3	Reportable (R)	Health Check-...	*92552EP-PURE TONE ...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered Nurs...	
4	Reportable (R)	Health Check-...	87081-CULTURE SCRE...		690.1 SEBORRH...				NURSE,ROSTER...	Rostered Nurs...	

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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TODDLER,GIRL (949737349) CNDS/ID Number: 949737349K; Sex: Female

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Dural / Unit
					1	2	3	4			
1	Billable (B)	Health Check-Hend...	*99392EP-PREV VISIT, ...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	
2	Reportable (R)	Health Check-Hend...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	
3	Reportable (R)	Health Check-Hend...	99172EP-OCULAR FUN...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	
4	Reportable (R)	Health Check-Hend...	92587EP-EVOKED AUDI...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	

Example 4 –

Health Check Periodic Screening assessment for 2 year old child
 Developmental Screening
 Immunization

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

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JONES,BABY (949823940) CNDS/ID Number: 949823940L; Sex: Male

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Duration / Units
					1	2	3	4			
1	Billable (B)	Health Check-Hend...	*99382EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurs...	
2	Billable (B)	Health Check-Hend...	90471EP-IMMUNIZATIO...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurs...	1
3	Reportable (R)	Health Check-Hend...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurs...	
4	Reportable (R)	Health Check-Hend...	*90707-MMR VACCINE, ...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurs...	

Example – 5

Immunization Administration with vaccine injections only for 15 month old child

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

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TODDLER,JOHN (949823941) CNDS/ID Number: 949823941K; Sex: Male

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Durat / Units
				1		2	3	4			
1	Billable (B)	Immunization-Hend...	90471EP-IMMUNIZATIO...		V06.8 NEED VAC...				NURSE,ROST...	Rostered Nurs...	1
2	Billable (B)	Immunization-Hend...	*90472EP-IMMUNIZATIO...		V06.8 NEED VAC...				NURSE,ROST...	Rostered Nurs...	3
3	Reportable (R)	Immunization-Hend...	*90723-DTAP-HEP B-IP...		V06.8 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
4	Reportable (R)	Immunization-Hend...	*90707-MMR VACCINE, ...		V06.4 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
5	Reportable (R)	Immunization-Hend...	*90716-CHICKEN POX ...		V05.4 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
6	Reportable (R)	Immunization-Hend...	*90648-HIB VACCINE, P...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 6 – Office visit with one vaccine injection for two-year old

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

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TODDLER,PAUL (949834331) CNDS/ID Number: 9498343310; Sex: Male

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Durat / Units
				1		2	3	4			
1	Billable (B)	Child Health-Hende...	99211-OFFICE/OUTPAT...		382.9 UNSP OTI...				PHYSICIAN,FA...	Physician (PHY)	
2	Billable (B)	Child Health-Hende...	90471EP-IMMUNIZATIO...		V04.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
3	Reportable (R)	Health Check-Hend...	90655-FLU VACCINE N...		V04.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 7-

- Immunization Only for eight week old child
- Immunization Administration Fee for Oral Vaccine
- Immunization Administration Fee with vaccine injection

	Service Status	Program	Service Code	Mod	Medical Diagnosis	M Dia 2	M Dia 3	M Dia 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization-Hend...	90471EP-IMMUNIZATIO...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
2	Reportable (R)	Immunization-Hend...	*90647-HIB VACCINE, P...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	
3	Billable (B)	Immunization-Hend...	90474EP-IMMUNE ADMI...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
4	Reportable (R)	Immunization-Hend...	*90680-ROTOVIRUS VA...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 8 –

- Immunizations Only for two-month old child
- Administration for Oral Vaccine
- Administration for Vaccine Injection

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia 2	Me Dia 3	Me Dia 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization-...	90471EP-IMMUNIZATIO...		V05.3 NEED VAC...				NURSE,ROST...	Rostered Nurs...	1
2	Billable (B)	Immunization-...	*90472EP-IMMUNIZATIO...		V06.1 NEED VAC...				NURSE,ROST...	Rostered Nurs...	4
3	Billable (B)	Immunization-...	90474EP-IMMUNE ADMI...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
4	Reportable (R)	Immunization-...	90744-HEPB VACC PE...		V05.3 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
5	Reportable (R)	Immunization-...	*90700-DTAP VACCINE,...		V06.1 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
6	Reportable (R)	Immunization-...	*90648-HIB VACCINE, P...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	
7	Reportable (R)	Immunization-...	90670-PNEUMOC CON...		V03.82 NEED VA...				NURSE,ROST...	Rostered Nurs...	
8	Reportable (R)	Immunization-...	*90713-POLIOVIRUS, IP...		V04.0 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
9	Reportable (R)	Immunization-...	*90680-ROTOVIRUS VA...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 9 –

Office visit at which oral vaccine for two month old child was provided

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

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INFANT,GIRL (949823937) CNDS/ID Number: 949823937L; Sex: Female

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	M Di	Me Diac	Me Diac	Practitioner	Discipline	Duration / Units
					1	2	3	4			
1	Billable (B)	Child Health-Hende...	99211-OFFICE/OUTPAT...		382.9 UNSP OTI...				PHYSICIAN,FA...	Physician (...)	
2	Billable (B)	Health Check-Hend...	90473EP-IMMUNE ADMI...		382.9 UNSP OTI...				NURSE,ROST...	Rostered N...	1
3	Reportable (R)	Health Check-Hend...	*90680-ROTOVIRUS VA...		382.9 UNSP OTI...				NURSE,ROST...	Rostered N...	

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