JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

December 14, 2005

Dear Ambulance Provider:

During HIPAA implementation, transportation providers began using the standard electronic claim form to submit claims to Medicaid. Medicaid is continuing to move forward in standardizing the claim forms it accepts. In February 2006, Medicaid will replace the Medicaid Emergency Transportation 131 and Non-Emergency Transportation131-A paper claims with the standard CMS-1500 claim form. Many of you are probably familiar with the CMS-1500 claim form and may be using it to bill other payers.

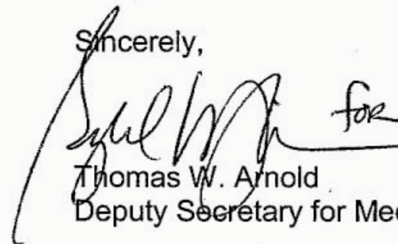
To help you with the transition, the required fields on the Medicaid 131 and 131-A claim forms have been cross walked to the CMS-1500 claim form. The crosswalk is included with this letter along with instructions on completing the claim form extracted from the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, and samples of completed CMS-1500 claims. After the first of the year, you will be sent an updated version of the Florida Medicaid Ambulance Coverage and Limitations Handbook and a complete Florida Medicaid Provider Handbook, CMS-1500.

In January 2006, the Medicaid fiscal agent will be offering training to ambulance providers as part of the monthly CMS-1500 training provided in each area Medicaid office. Information regarding training schedules and locations is available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on the Provider Training link.

Providers who do not already have CMS-1500 claim forms can order them by submitting the claim order form to the Medicaid fiscal agent. The order form is available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then click on Medicaid Forms. Providers may also submit a photocopy the sample order form that is in Appendix C of the Medicaid Provider General Handbook.

Please note: Providers are to continue to submit the Medicaid Transportation 131 and 131-A for claims postmarked through February 10, 2006. All paper claims submitted to the fiscal agent postmarked after February 10, 2006 must be submitted on CMS-1500 claim forms. The change in the paper claim form *will not* affect your electronic claims.

Please contact Glen Davis in the Bureau of Medicaid Services at (850) 922-7305 or your area Medicaid office if you have any questions.


Sincerely,

for

Thomas W. Arnold
Deputy Secretary for Medicaid

Enclosures

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308

Visit AHCA online at
http://ahca.myflorida.com

CROSS WALK OF THE 131 AND 131-A CLAIM FORMS TO THE CMS-1500

Field 1500	Field Title	Notes	Field 131	Field Title	Notes	Field 131A	Field Title	Notes
1.	Medicaid Medicare Indicator							
1a.	Insured's ID number		9.	Medicaid Id Number		9.	Medicaid Id Number	
2.	Patient's Name		8.	Recipient Name		8.	Recipient Name	
3.	Patient's DOB		10.	Date of Birth		10.	Date of Birth	
4.	Insured's Name							
5.	Patient's Address							
6.	Patient's Relationship to Insured							
7.	Insured Address							
8.	Patient Status	No entry required	12	Patient Status Code		12	Patient Status Code	
9.	Other Insured's Name							
9a.	Other Insured's Policy No.							
9b.	Other Insured's DOB							
9c.	Employer's Name or School							
9d.	Insurance Plan Name							
10.	Is Patient's Condition Related to		13	Injury Code		13	Injury Code	
10a.	Employment		13	Injury Code		13	Injury Code	
10b.	Auto Accident		13	Injury Code		13	Injury Code	
10c.	Other Accident		13	Injury Code		13	Injury Code	
11.	Insured Policy No.	No entry required	21	Insurance Policy Number		21	Insurance Policy Number	
11a.	Insured Date of Birth	No entry required						
11b.	Employers Name or School	No entry required						
11c.	Insurance Plan Name	No entry required	22	Insurance Company Name		22	Insurance Company Name	
11d.	Is there another Health Plan	No entry required	20	Other Medical Insurance		20	Other Medical Insurance	
12.	Patient's Signature	No entry required						

CROSS WALK OF THE 131 AND 131-A CLAIM FORMS TO THE CMS-1500

Field 1500	Field Title	Notes	Field 131	Field Title	Notes	Field 131A	Field Title	Notes
13.	Insured or Authorized Person Signature	No entry required						
14.	Date of Current Illness	No entry required	14	Date of Injury		14	Date of Injury	
15.	If Patient had same illness date	No entry required						
16.	Dates Patient is unable to work	No entry required						
17.	Name of Referring physician	No entry required						
17a.	ID Number of Referring physician	No entry required						
18.	Hospital Dates related to current service	No entry required						
19.	Reserved for local use (Keyed Claim Type)							
20.	Outside Lab	No entry required						
21.	Diagnosis or Nature of Illness	No entry required						
22.	Medicaid Resubmission Code	No entry required						
23.	Prior Authorization		4	Prior Authorization Number		4	Prior Authorization Number	Pre Assigned Authorization Number
24.	Service Information	No entry required						
24a.	Dates of Service		30	Date of Service		30	Date of Service	
24b.	Place of Service	No entry required						
24c.	Type of Service	No entry required						
24d.	Procedures, Services		33	Procedure Code	Procedure Code Completed	33	Procedure Code	Procedure Code Completed
24d.	Modifier		34 a / b	Modifier		34 a / b	Modifier	
24e.	Diagnosis	No entry required						
24f.	Charges		36	Usual and Customary Charge		36	Usual and Customary Charge	

CROSS WALK OF THE 131 AND 131-A CLAIM FORMS TO THE CMS-1500

Field 1500	Field Title	Notes	Field 131	Field Title	Notes	Field 131A	Field Title	Notes
24g.	Days or Units							
24h.	EPSDT							
24i.	EMG							
24j.	COB		37.	Paid by Primary Carrier (Line Level)		37.	Paid by Primary Carrier (Line Level)	
24k.	Reserved for local use	Third Party Coverage						
25.	Federal Tax ID	No entry required						
26.	Patient Account No.							
27.	Accept Assignment	No entry required						
28.	Total Charge		38.	Total Charged		38.	Total Charged	
29.	Amount Paid							
30.	Balance Due	No entry required						
31.	Signature of Physician		No Number	Authorized Signature		No Number	Authorized Signature	
32.	Name and Address of Facility							
33.	Physician's Supplier's Billing Name, Address, Zip Code and Provider ID		3/5.	Provider Name, Address and Number		3/5.	Provider Name, Address and Number	

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CHAPTER 1

COMPLETING THE CLAIM FORM

Overview

Introduction

This chapter describes the CMS-1500 paper claim form, the time limits for submission, and how to complete and submit the form for payment to the Florida Medicaid program through the fiscal agent.

In This Chapter

This chapter contains:

Topic	Page
Providers Who Bill on the CMS-1500	1-1
Time Limit for Submission of a Claim Form	1-3
Basic Guidelines for Completing a Claim Form	1-7
How to Complete the CMS-1500 Claim Form	1-8
Place of Service Codes (POS)	1-27
Sample of a Completed CMS-1500 Claim Form	1-31
Claims Submission Checklist	1-32
Claims Mailing Checklist	1-32
Where to Send Claim Forms	1-33
Electronic Claims Submission	1-34

Providers Who Bill on the CMS-1500

CMS-1500 Claim Form

The following providers must complete and submit CMS-1500 claim forms to receive Medicaid reimbursement:

- Advanced Registered Nurse Practitioners
- Ambulance, Land and Air
- Ambulatory Surgical Centers
- Assistive Care Providers
- Audiologists
- Birthing Centers
- Child Health Check-Up Providers
- Chiropractors
- Community Mental Health Services Providers
- County Health Departments
- County Health Department Certified Match
- Dentists (as described below)
- Durable Medical Equipment
- Early Intervention Services
- Federally Qualified Health Centers
- Hearing Aid Specialists
- Home Health

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Providers Who Bill on the CMS-1500, continued

CMS-1500 Claim Form, continued

- Independent Laboratories
- Licensed Midwives
- Medicaid Certified School Match
- Medical Foster Care
- Opticians
- Optometrists
- Physicians
- Physician Assistants
- Podiatrists
- Portable X-ray
- Prescribed Pediatric Extended Care
- Registered Nurse First Assistants
- Rural Health Clinics
- Therapists
- Visual Services
- Wheelchair and Stretcher Vans
- Any other provider whose service-specific Coverage and Limitations Handbook requires the CMS-1500 claim form.

Dental Services Billed on the CMS-1500 Claim Form

Dental providers must complete a CMS-1500 claim for the procedure codes listed on the oral and maxillofacial fee schedule.

Dental providers must complete a CMS-1500 claim to obtain reimbursement for CPT procedures that require a modifier.

Dental providers may complete a CMS-1500 claim to receive reimbursement for injectable medication procedure codes that begin with the prefix “J” and for Physician’s Current Procedural Terminology (CPT) procedure codes.

Note: See Chapter 3 of the Dental Services Coverage and Limitations Handbook for an explanation of dental procedure codes and information on which procedures must be billed on the CMS-1500 claim and which procedures are specialty specific.

Dental 111 Claim Form

Dental providers must complete and submit a Dental 111 claim to receive Medicaid reimbursement for all procedure codes beginning with the prefixes “D”. Dental providers may complete a Dental 111 claim to receive reimbursement for injectable medication procedure codes that begin with the prefix “J” and for CPT procedure codes, except those with modifiers.

Note: See Chapter 3 of the Dental Services Coverage and Limitations Handbook for an explanation of dental procedure codes and information for which procedures must be billed on the Dental 111 claim and which procedures are specialty specific.

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Providers Who Bill on the CMS-1500, continued

Billing a Child Health Check-Up on the CMS-1500 Claim Form

Providers who perform Child Health Check-Up screenings must complete and submit a CMS-1500 claim form to receive Medicaid reimbursement for the screening beginning with the implementation of the Health Insurance Portability and Accountability Act (HIPAA) in the Florida Medicaid system.

Providers Who Bill for a Child Health Check-Up

The following providers must complete and submit a CMS-1500 claim form to receive Medicaid reimbursement for Child Health Check-Up screenings:

- Advanced Registered Nurse Practitioners
- Birthing Centers
- Children's Medical Services Clinics
- County Health Departments
- Federally Qualified Health Centers
- HMOs
- Hospitals (outpatient only)
- Licensed Midwives
- Physicians
- Physician Assistants
- Rural Health Clinics
- School Districts

Time Limit for Submission of a Claim Form

Timely Claim Submission

Medicaid providers should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline.

Clean Claim

In order for a claim to be paid, it must be a clean claim. A clean claim is a Medicaid claim that:

- Has been accurately and fully completed according to Medicaid billing guidelines,
- Is accompanied by all necessary documentation, and
- Can be processed and adjudicated by the fiscal agent without obtaining additional information from the provider.

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Time Limit for Submission of a Claim Form, continued

12-Month Filing Limit

A clean claim for services rendered must be received by Medicaid or its fiscal agent no later than 12 months from the date of service.

Out-Of-State Claims

Claims submitted by out-of-state providers must be received by the Medicaid office or its fiscal agent no later than 12 months from the date of service to be considered for payment.

Out-Of-State Exemption

Because of differences in Medicaid billing practices between states, out-of-state providers are exempt from the clean claim requirement. Out-of-state providers must however, comply with all other Florida Medicaid claim filing regulations including adherence to claim filing time limits.

If the original claim was filed within 12 months from the date of service but did not pay and it is now beyond 12 months, the provider must mail the claim to the Medicaid office for the area in which the recipient resides, instead of the fiscal agent.

Note: See Appendix C in the Florida Medicaid Provider General Handbook for the addresses and telephone numbers of the area Medicaid offices.

Date Received Determined

The date stamped on the claim by any Medicaid office or by the Medicaid fiscal agent is the recorded date of receipt for a paper claim. The fiscal agent date stamps the claim the date that it is received in the mailroom.

The date electronically coded on the provider's electronic transmission by the Medicaid fiscal agent is the recorded date of receipt for an electronic claim.

12-Month Begin Date for RPICCs

The initial date for the 12-month filing limit for Regional Perinatal Intensive Care Centers (RPICC) is the date of discharge from the RPICC program.

Third Party Payer or Insurance Claims

Claims for recipients who have Medicare or other insurance must be submitted to a third party payer prior to sending the claim to Medicaid.

Claims for recipients who have third party insurance, other than Medicare, must be received by Medicaid or the Medicaid fiscal agent no later than 12 months from the date or service or six months from the date of the other insurance payment or denial.

The filing limit for Medicare claims crossing over to Medicaid is the greater of 36 months from the date of service or 12 months from Medicare's adjudication date.

Advance Copy

Time Limit for Submission of a Claim Form, continued

Claim Adjustment Requests

All clean claim adjustment requests must be received by the area Medicaid office or its fiscal agent no later than 12 months from the date of the original payment.

Claim Void Requests

The 12-month filing limit does not apply to claim void requests. Claim void requests may be submitted at any time.

Exceptions to the 12-Month Time Limit

Exceptions to the 12-month claim submission time limit may be allowed, if the claim meets one or more of the following conditions:

- New clean claim submitted within six months of the date of the void of original claim payment date,
- Court or hearing decision,
- Delay in recipient eligibility determination by either the Department of Children and Families (DCF) or the Social Security Administration (SSA),
- Medicaid delay in updating eligibility file,
- Court ordered or statutory action, or
- System error on a claim that was originally filed within 12 months from the date of service.

Any claim filed more than 12 months from the date of service that meets an exception must be sent to the area Medicaid office for processing, not to the fiscal agent. Each of these exceptions is discussed below.

Note: See the Archive Void and Adjustment Process in Chapter 3 for information on processing claims that are over two years old.

Note: See Appendix C in the Florida Medicaid Provider General Handbook for the addresses and telephone numbers of the area Medicaid offices.

Original Payment Is Voided

When an original Medicaid claim is voided, the provider may submit a new claim and a written request for assistance to the area Medicaid office no later than six months from the void date.

Note: See Appendix C in the Florida Medicaid Provider General Handbook for a list of the area Medicaid offices addresses and telephone numbers.

Court or Hearing Decision

When a recipient is approved for Medicaid as a result of a fair hearing or court decision, there is no time limit for the submission of a claim.

Advance Copy

Time Limit for Submission of a Claim Form, continued

Delay in Recipient Eligibility Determination

An exception may be granted when there is a delay in the determination of an individual's Medicaid eligibility by DCF or SSA. The provider must send in specific documentation to the area Medicaid office no later than 12 months from the date the recipient's eligibility is posted to the Florida Medicaid Management Information System (FMMIS) system. The claim submission must include:

- A clean claim,
- A copy of the recipient's proof of eligibility, and
- Documentation of the reason for late submission.

Medicaid Delay In Updating Eligibility File

If Medicaid delays updating a recipient's eligibility on FMMIS, an exception may be granted. The provider must submit the related clean claims to the area Medicaid office no later than 12 months from the date the recipient's eligibility file was updated.

Court Ordered or Statutory Action

If the Medicaid office takes corrective actions due to a court order or due to final agency action taken under Chapter 120, Florida Statutes, there is no time limit for claim submission.

System Error

If a clean claim is denied due to a system error or any error that is the fault of Medicaid or the fiscal agent, an exception may be granted if the provider submits another clean claim along with documentation of the denial to the area Medicaid office no later than 12 months from the date of the original denial.

Evaluate the Claim

The provider must evaluate any claim that is denied and determine if the claim fits any of the conditions for an exception to the 12-month filing limit.

Submit a New Medicaid Claim Form

The provider must complete and submit a new Medicaid claim form that meets the following criteria:

- The new claim must be a clean claim.
- A signed or initialed legible photocopy of the original claim is acceptable.
- All required attachments that were necessary for processing the original claim must be attached to the exception claim.

Corrections can be made to a photocopy of the claim, but the system will not accept claims with correction fluid, whiteout or highlighted areas.

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Time Limit for Submission of a Claim Form, continued

Supporting Documentation

The provider must send a letter explaining the circumstances of the request for an exception to the time limit, and attach documents that support the exception request. One or more of the following items must be attached:

- A copy of a hearing decision or court order,
- A copy of the recipient's proof of eligibility, or
- A copy of the remittance voucher that indicates the incorrect denial from Medicaid.

Where to Send Requests

All requests for an exception to the 12-month filing time limit must be sent to the area Medicaid office.

Note: See the Florida Medicaid Provider General Handbook for the addresses and telephone numbers of the area Medicaid offices.

Basic Guidelines for Completing a Claim Form

Basic Rules

- There are some basic rules to follow before completing the claim form.

- Make sure the CMS-1500 is the right form to use for the claim.
- Use one claim form for each recipient.
- Enter one procedure code per claim line.
- Enter all information with a typewriter or computer using black type or a pen with black ink. (The fiscal agent can only process claims with black type or ink.)
- Be sure the information on the form is legible.
- Enter information within the allotted spaces.
- Make sure whiteout was not used on the claim form.
- Complete the form using the service-specific Coverage and Limitations Handbook as a reference.
- Follow the instructions found in this handbook for completing the CMS-1500 claim form for Medicaid reimbursement. Instructions that are printed on the claim form do not always reflect Medicaid requirements. Incorrect entries can result in denied Medicaid claims.

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Basic Guidelines for Completing a Claim Form, continued

Before Completing the Form

Before filling out the claim form, answer the following questions:

- Was the recipient eligible for Medicaid on the date of service?
- Has the recipient's eligibility been verified?
- Was MediPass or HMO authorization obtained, if applicable?
- Was the service or item covered by Medicaid?
- Was service authorization obtained, if applicable?
- Was prior authorization obtained, if applicable?
- Has a claim been filed and a response received for all the recipient's other insurance?
- Was the procedure within the service limitations?
- Does this claim require any medical documentation or attachment?

If all of the above information is not available, review the instructions in this handbook. If the response to all of the above, applicable questions is "yes," fill out the claim form following the step-by-step instructions for each item on the form.

Ordering the Claim Forms

To request claim forms, submit a Florida Medicaid Claims Order Form. The Claims Order Form is available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then on Medicaid Forms. Providers may also submit a photocopy of the Florida Medicaid Claims Order Form that is in Appendix C of the Florida Medicaid Provider General Handbook.

How to Complete the CMS-1500 Claim Form

Introduction

This section contains an illustration of the CMS-1500 claim form, step-by-step instructions, and a sample of a completed form.

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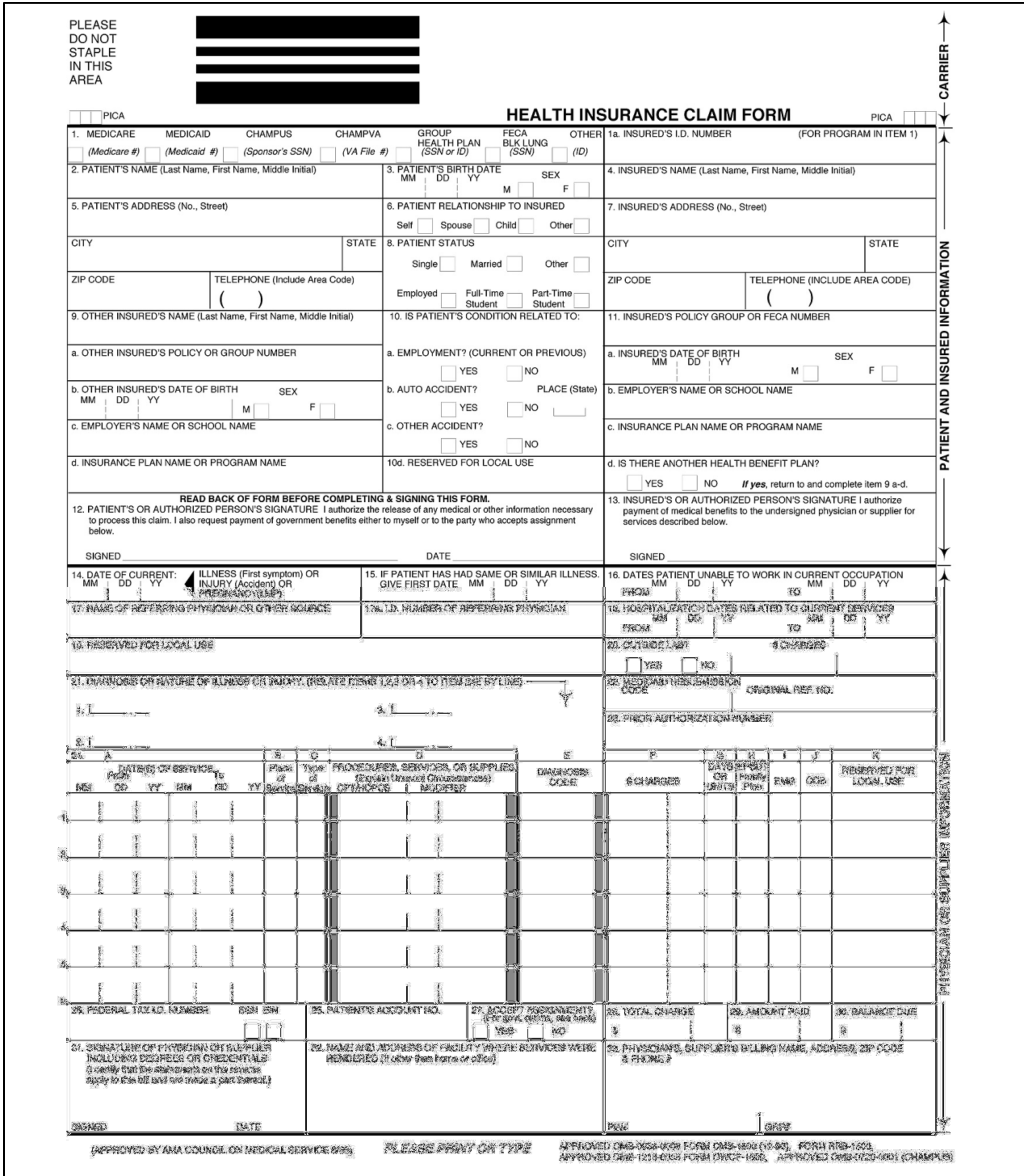
Illustration 1-1. CMS-1500 Claim Form (front)



PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE

1. 2. 3. 4. 5. 6.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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Illustration 1-2. CMS-1500 Claim Form (back)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
1	**Medicare and Medicaid**	For an initial claim submission, enter an "X" in the applicable boxes. If the person is eligible for Medicaid only, just enter an "X" in the Medicaid box. To request an ADJUSTMENT or VOID to the most recently paid Medicaid claim, enter an "A" or "V" in the Medicaid box. Enter the 17-digit Transaction Control Number (TCN) assigned to the paid claim in the upper left corner, between the bar code and the top line of the form. The TCN can be found on the remittance voucher that reported the incorrect payment. For a claim that was adjusted, but still has not paid correctly, use the TCN of the last adjustment that paid. If the TCN does not appear on the top of the claim form and an "A" or "V" is entered in the Medicaid box, the adjustment or void request cannot be processed and will be returned to the provider. Note: See Chapter 3 in this handbook for additional information on adjustments and voids.
1a	**Insured's Medicare and Medicaid Number**	Enter the recipient's ten-digit Medicaid Identification (ID) Number. Do not enter the number on the Medicaid ID card. This is a card control number, not the recipient's Medicaid ID number. Newborn Billing: See Chapter 3 of the Florida Medicaid Provider General Handbook Note: For Medicare crossover claims, enter the Medicare identification number in this item.
2	**Patient's Name**	Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medicaid Identification Card or other proof of eligibility.
3	**Patient's Birth Date**	Enter the recipient's date of birth in month, day, year format. Example: 08/21/97 for August 21, 1997.
	Patient's Sex	Use an "X" to mark the appropriate box, male or female.
4	**Insured's Name**	No entry required unless the recipient is covered by other insurance. If there is other insurance, enter the name of the insured. If the insured and the patient are the same person, enter the word "SAME."

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
5	**Patient's Address**	No entry required.
6	**Patient's Relationship to Insured**	No entry required.
7	**Insured's Address**	No entry required unless the recipient is covered by other insurance.
8	**Patient Status**	No entry required.
9a-d	**Other Health Insurance Coverage**	Enter the requested information if the recipient has other insurance. Do not enter the name of the insurance agency or agent. Enter the word "none" or "not applicable" if there is no other insurance coverage. If the patient has Medicare coverage, bill Medicare first. Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare crossover claims. See Chapter 2 in this handbook for information on billing Medicaid when there is a discount contract.
10a-c	**Is Patient's Condition Related to:**	Enter an "X" in any part(s) that apply and give corresponding information in Item 10a-c.
10d	**Reserved for Local Use**	No entry is required for Medicaid only billing. For Medicare crossover claims, enter the recipient's ten-digit Medicaid ID number.
11a-d	**Insured's Group No.**	No entry required.
12	**Patient's or Authorized Person's Signature**	No entry required.
13	**Insured's or Authorized Person's Signature**	No entry required.
14	**Date of Current Illness, Injury or Pregnancy**	No entry required.
15	**Dates of Same or Similar Illness**	No entry required.
16	**Dates Patient Unable to Work**	No entry required.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
17 and 17a	**Name of Referring Physician and Medicaid Provider ID Number**	For a procedure that requires a MediPass referral, enter the MediPass primary care provider's nine-digit authorization number in field 17a. For a referred procedure, enter the referring physician's name in field 17 and the nine-digit Medicaid provider number in field 17a. An example of a referred procedure may be a consultation. If the referring physician is not a Medicaid provider, enter the name in field 17 and pseudo provider number, 0000001-00, in field 17a. For a procedure that requires service authorization, enter the service authorization number issued to approve the procedure in field 17a. The referring provider and treating provider cannot be the same individual. MediPass primary care providers must leave this field blank for services that they personally render. Leave blank if the procedure was not referred, or did not require approval by a MediPass primary care provider or service authorization.
18	**Hospitalization Dates Related to Current Services**	No entry required.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
19	**Reserved for Local Use Keyed Claim Type**	In the right hand portion of this field, enter the treating provider type that identifies the type of provider that rendered the service. List only one provider type per claim form. The keyed claim types are:

Provider Type	Code
Adult Day Health Care	17
Advanced Registered Nurse Practitioner	30
Ambulance	
Emergency	41
Non-emergency	42
Non-emergency, copay exempt	45
Ambulatory Surgical Center	02
Assistive Care Provider	14
Audiologist	60
Birthing Center	69
Case Management	75
Child Health Check-Up	55
Chiropractic	06
County Health Department	16
County Health Department Certified Match (School Services)	88
Community Mental Health	20
Dentist	35
Durable Medical Equipment	13
Early Intervention Services	81
Family Planning	08
Federally Qualified Health Center	11
Hearing Aid Specialist	19
Home Community Service	80
Home Health	07
Independent Laboratory	09
Licensed Midwife	34
Medicaid Certified School Match	88
Medical Foster Care	15
Optometric	18
Physician	01
Physician Assistant	29
Podiatry	05
Portable X-ray	10
Prescribed Pediatric Extended Care	24
Registered Nurse First Assistant	01
Rural Health Clinic	11
Therapist	12
Visual	63

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
19	**Reserved for Local Use Keyed Claim Type** (continued)	Wheelchair and Stretcher Van One-way 42 Round trip 43 One-way, copay exempt 45 Round trip, copay exempt 46
21	**Diagnosis or Nature of Illness or Injury**	Enter the patient's diagnosis code. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). **Child Health Check-Up:** Enter a diagnosis code(s) Codes with an "E" or "M" prefix cannot be used for billing Medicaid. Certain diagnosis codes are identified as emergency diagnosis codes. A copayment is not deducted for services using these diagnosis codes. **Independent Laboratories:** Enter a diagnosis only for limited coverage procedures. Labs must enter the diagnosis code from the referring provider when filing claims for MediPass exempt services, family planning waiver services, and genetic testing. See the Independent Laboratory Services Coverage and Limitations Handbook for the procedure codes and required diagnosis codes. **Ambulance, Wheelchair and Stretcher Vans**: No entry is required.
22	**Medicaid Resubmission Code**	No entry required. See instructions in claim item 1 for submitting voids and adjustments to paid claims.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
23	**Prior Authorization Number**	If the service was prior or post authorized, enter the ten-digit authorization number from the approval letter. Claims for prior and post authorized services are subject to service limits and the 12-month filing limit. **Home Health Visits**: If home health visits were pre-approved, enter the ten-digit authorization number from the approval letter. **Ambulance, Wheelchair and Stretcher Vans**: Although certain services must be prior authorized, there is no required entry in this item. See Chapter 2 in the Florida Medicaid Ambulance Services Coverage and Limitations Handbook for the prior authorization requirements. Note: See Prior Authorizations and the PA01 Form in Chapter 2 of this handbook for further instructions. Note: See the service-specific Coverage and Limitations Handbook or the Florida Medicaid Provider Reimbursement Schedule for service limitations and the services that require prior authorization.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 A	**Date(s) of Service**	Enter the beginning date of service (From Date) in month, day, year format. For example, enter 11/21/05 for November 21, 2005. If the procedure allows consecutive day billing, and is provided for more than one consecutive day, also enter the last date of service (To Date). All services, except those listed below, must be billed with one date of service per claim line. A "To Date" is not necessary. **Ambulances and Wheelchair and Stretcher Vans**: Enter the date of service in the From column. Leave the To column blank.) **Physicians, advanced registered nurse practitioners and physician assistants:** Hospital visits that are rendered on consecutive days during one calendar month can be billed on one line with a "From Date" and a "To Date." **End-Stage Renal Disease Related Services**: Services rendered for a monthly period or for consecutive days within one month may be billed on one line with a "From Date" and a "To Date." **Regional Perinatal Intensive Care Centers (RPICC)**: Enter the admission date in the "From Date" and the date of discharge in the "To Date." The date of discharge is not reimbursed. **Medical Foster Care Providers:** Services rendered in one calendar month may be billed on one line with a "From Date" and a "To Date." Services provided during different months must be billed on separated lines. If there is a break in service provision, begin a new line. If the child's level of care changes, a separate line must be completed for each level of care provided. **Prescribed Pediatric Extended Care (PPEC) Providers**: Services rendered in one calendar week may be billed on one line with a "From Date" and a "To Date." **Assistive Care Services (ACS) Providers:** Enter range of dates when services were provided based on facility documentation. If recipient received ACS on each day of the month without any hospitalization, nursing facility admission, or leave from the facility, then the first date of service will correspond to the first day of the month and the last date of service to the last day of the month. If the recipient received services in the facility, then left the facility for any reason and returned within the same month, use more than one claim line to show the actual billable dates of service.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24A	**Date(s) of Service** (continued)	**Medical Supplies and DME Providers**: The date an item is made available to the recipient is the date of service. Procedure codes that pay a daily reimbursement (A4618, E0202, E0608, E0781, E0791 and E0935) require “From - To” dates of service. The dates must be within the same month. Subsequent months must be billed on new claim lines. For orthotics and prosthetics (“L” procedure codes), the date of service is the date the item is ordered. “L” procedure codes must be billed after the device is fitted. For customized wheelchairs (E1220), the date of service is the date on the letter from the fiscal agent that approves the prior authorization request. The item may not be billed until after the wheelchair has been delivered to the recipient. For rental items: • For the first DME rental claim, the date the item is delivered or made available to the recipient is the date of service. • Subsequent rental claims may be submitted monthly. • For partial month rental payment, see the Durable Medical Equipment Medical Supply Services Coverage and Limitations Handbook. **Prosthetic Eyes**: The date of service is the date the provider ordered the eye. **Hearing aids:** The date of service for all services is the date the device is ordered from the manufacturer. **Independent Laboratory**: The date of service is the date the tests were ordered on the laboratory service form. **Visual Services**: The provider must use the date that the eyeglasses were dispensed as the date of service on the claim when billing for the eyeglasses (frames, lenses, and add-ons). An exception is if the recipient is ineligible for Medicaid when the eyeglasses are dispensed, the provider may use the date the eyeglasses were ordered as the date of service when submitting the claim.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
B	**Place of Service**	Enter the two-digit place of service (POS) code for each procedure performed. **Ambulances and Wheelchair and Stretcher Vans**: No entry required. There is no applicable POS code. Note: See Place of Service Codes in this chapter for the correct place of service codes.
C	**Type of Service**	No entry required.
D	**Procedures, Services or Supplies: CPT HCPCS Codes and Modifiers**	Enter the procedure code from the Procedure Code Fee Schedules in the service-specific Coverage and Limitations Handbook. **Modifiers**: For certain types of service, a modifier must be entered after the procedure code. Refer to service-specific Coverage and Limitations Handbooks for a list of covered codes and special instructions for using modifiers required to uniquely identify some Medicaid services. For services that use modifier 99, when more than two modifiers are needed, enter modifier 99 on the claim line and list the other applicable modifiers on the documentation that is attached to the claim, as described below in By Report. **Entering a pricing modifier and local-code modifier:** If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first modifier field on the claim form, and enter the local-code modifier in the second modifier field. **By Report**: By report procedures are procedures that must be approved or manually priced. They must be submitted on paper claims with relevant reports attached. Procedure codes with 99 modifiers, procedure codes marked "R" on the Procedure Code Fee Schedules, and other procedures specified in the service-specific Coverage and Limitations Handbooks and the Florida Medicaid Provider Reimbursement Schedule are approved and priced by report.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
D (continued)	**Procedures, Services or Supplies: CPT HCPCS Codes and Modifiers**	**Ambulances and Wheelchair and Stretcher Vans**: In the first modifier field, enter both the origin modifier and the destination modifier. The field holds two alpha characters. Do not enter the destination modifier in the second modifier field. The origin and destination modifier codes are as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than P or H
E	Residential, domiciliary, custodial facility (nursing home, not a skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between types of ambulance)
J	Non-hospital based dialysis
N	Skilled nursing facility (SNF)
P	Physician's office, includes HMO non-hospital facility, clinic, etc.
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at the physician's office in route to hospital (includes HMO non-hospital facility, clinic, etc.) Modifier X can be entered only in the second modifier field.

Ambulances and Wheelchair and Stretcher Vans: In the second modifier field, enter the following modifier(s), if applicable:

- Modifier QN when submitting a claim for a negotiated rate; and
- Modifier 76 when the same provider bills the same procedure code and origin and destination modifier for the same recipient on the same date of service.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
E	**Diagnosis Code**	Enter the diagnosis code reference number as shown in Block 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item unless instructed otherwise in the service-specific Coverage and Limitations Handbook. If more than one diagnosis reference is required by the service-specific Coverage and Limitations Handbook, you must use a comma (,) separator between the diagnosis code pointers. When multiple services are performed, enter the primary reference number for each service (either "1", "2", "3", or "4").
F	**Charges**	Enter the usual and customary charge for the procedure performed in dollars and cents format. The decimal must be included. For example: 250.00. **Assistive Care Services Provider:** For each line used, enter the total of the payment rate times the number of days shown on that line.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
G	**Days or Units**	Enter the units of service rendered for each detail line. A unit of service is the number of times a procedure is performed. When only one procedure is performed, enter a "1" in the item. If a procedure code for consecutive days is billed on one claim line using "From - To" dates, enter the appropriate number of units in item 24G. The definition of unit varies by service. Please see the service-specific Coverage and Limitations Handbook for information on how to compute a unit of service. **Anesthesiologists**: Enter the anesthesia time in total minutes. For example, one hour and fifteen minutes should be entered as "75." Do not convert time to units. **Community Mental Health Services**: For intensive therapeutic on site and home and community-based rehabilitative services, one hour equals one unit of service. The total units of service for the day must be entered. **Early Intervention Services**: For early intervention group and individual sessions, 30 minutes equals one unit of service; and for home-visiting sessions, 15 minutes equals one unit of service. The total units of service for the day must be entered. **Home Health Visits, Private Duty Nursing and Personal Care Services:** For home health visits enter the number of visits for the date of service. For private duty nursing and personal care services, enter the number of hours of nursing services or personal care services for the date of service. Round any portion of an hour that exceeds 30 minutes up to the next hour. **Ambulance, Wheelchair and Stretcher Vans:** Enter the number of miles traveled. **Air Ambulances:** If billing procedure codes A0435 or A0436, enter the number of miles as units of service.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
H	**Child Health Check-Up and Family Planning Indicator**	Enter an "E" if the patient was referred for the services as a result of a Child Health Check-Up screening. (Child Health Check-Up was formerly named EPSDT.) If the service is a surgery that was referred as a result of a Child Health Check-Up screening, an "E" in this item will indicate to the system that prior authorization was not required.
	Child Health Check-Up Referral Code Indicator	If the service is a Child Health Check-Up screening, enter the referral code that identifies the health status of the child:

Code	Description
U	**Completed Normal/Not Used** Indicator is used when there are no referrals made.
2	**Abnormal, Treatment Initiated/Under Treatment** Indicator is used when patient is currently under treatment for referred diagnostic or corrective health problem.
T	**Abnormal, Recipient Referred/New Services Requested** Indicator is used for referrals to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic check-up (not including dental referrals).
V	**Patient Refused Referral/Available Not Used** Indicator is used when the patient refused a referral.

CLAIM ITEM	TITLE	ACTION
	Family Planning Indicator	Enter an "F" if the services relate to a pregnancy or if the services were for family planning. If the service requires a copayment, an "F" in this item will indicate that the recipient received a pregnancy-related service or family planning, and the copayment will not be deducted from the provider's reimbursement.
I	**EMG**	Mark a "Y" in this item to indicate an emergency. Authorization from the MediPass primary care provider is not required if a MediPass recipient has an emergency medical condition.
J	**COB**	No entry required except for hospice services. **Hospice:** For all recipients in hospice, enter "H."

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
K	**Reserved for Local Use** **Used for Third Party Insurance and the Treating Provider Number**	**Third Party Coverage**: If payment from a primary insurance carrier is expected or already received, enter the amount in the upper left-hand portion of the item. If no payment was received or if the service was denied, leave the item blank and attach a copy of the explanation of benefits (EOB) from the insurance carrier that indicates the reason for the denial to the claim. **Treating Provider**: When the provider number in item 33 is a group number, enter the individual treating provider's nine-digit Medicaid provider number in the lower right-hand portion of the space. If more than one treating provider in the group rendered services to the same recipient on the same date of service, enter the number for the treating provider who actually rendered the service on the claim line. **Early Intervention Services**: When the provider number in item 33 is a group number, enter the individual treating provider's nine-digit Medicaid provider number in the lower right-hand portion of the space. Services rendered by professional and paraprofessional staff cannot be billed on the same claim form. **Child Health Check-Up:** When the provider number in item 33 is a group number, enter the Child Health Check-Up treating provider's nine-digit Medicaid provider number in the lower right hand portion of the space. HMOs enter their Medicaid provider number.
25	**Federal Tax ID Number**	No entry required.
26	**Patient's Account Number**	The provider may enter a recipient account number so that it will appear on the remittance voucher. Any letter or number combination up to ten digits may be entered.
27	**Accept Assignment**	No entry required.
28	**Total Charge**	Add together all charges in the column under item 24F, and enter the total amount in this item in dollars and cents format, i.e., 250.00.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
29	**Amount Paid**	Enter the amount paid by other health insurance coverage if applicable. This amount must equal the total of the entries in column 24K. The amount must be entered in dollar and cents format, including the decimal. For example: 250.00 Do **not** enter prior Medicaid payments here when filing an adjustment invoice. Do **not** enter Medicare payments here when filing a Medicare and Medicaid crossover claim. Do **not** enter copayment amount in this item.
30	**Balance Due**	No entry required.
31	**Signature of Physician or Supplier and Date**	Sign and date the claim form. If the provider uses a facsimile signature or a signature stamp, the entry must be initialed. The provider is responsible for ensuring that the signature on the claim is that of an authorized individual. The authorized signature certifies that the information entered on the claim is in conformance with the conditions on the back of the claim form and with all federal and state laws and regulations. State laws and regulations include the regulations applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA. Providers are responsible for all claims billed using their Medicaid provider identification numbers. (See Electronic Claims Submissions in this chapter for information on electronic claim certification.) “Signature on file” may be used only if the provider’s billing agent or authorized designee has a written attestation signed by the provider that allows the billing agent or authorized designee to file claims on the provider’s behalf. The attestation must be maintained on file at the billing agent’s or authorized designee’s office. The attestation must be readily available upon request by AHCA.

Advance Copy

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
32	**Name and Address of Facility Where Services Were Rendered**	If services were rendered in recipient's home, no entry is required. Otherwise enter the complete name of hospital, facility or physician's office where services were rendered.
33	**Provider's Name, Address, Zip Code, Telephone Number and Medicaid Provider Number**	Enter the provider's name, address, zip code and telephone number in the upper portion of the item. Enter the nine-digit Medicaid provider number in the lower portion of the item. If the provider is an individual provider, the provider number must be entered after the "PIN#." If the provider is a group provider, the group number must be entered after the "GRP#"; and the individual treating provider number must be entered in item 24K for each claim line billed. The provider number entered in item 33 is the one to which Medicaid payment is made. It is also used to report Medicaid payments to the IRS. Only one provider number can be entered in claim item 33. **Early Intervention Services:** Group providers are assigned two group provider numbers for billing early intervention services: one for services rendered by professional staff and one for services rendered by paraprofessional staff. The provider must bill for services rendered by professional and paraprofessional staff on separate claim forms using the appropriate group provider number. If the provider is enrolled in another program such as therapy services, the provider must use that service-specific provider number for billing those services. The provider's early intervention services provider number can be used only for early intervention services. A provider cannot bill for different types of Medicaid services on the same claim form.

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Place of Service Codes (POS)

Code	Description
03	**School** A school facility where a recipient receives a Medicaid service. This new place of service is effective with HIPAA implementation.
11	**Office** Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, intermediate care facility (ICF), or mobile van where the health professional routinely provides health examination, diagnosis and treatment of illness or injury on an ambulatory basis.
12	**Patient's Home** Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	**Assisted Living Facility** Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	**Group Home** Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.
21	**Inpatient Hospital** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non surgical) and rehabilitation services, by or under the supervision of physicians, to patients admitted for a variety of medical conditions.
22	**Outpatient Hospital** A portion of a hospital that provides diagnostic, therapeutic (both surgical and non surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Advance Copy

Place of Service Codes (POS), continued

Code	Description
23	**Emergency Room - Hospital** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided on a 24-hour basis.
24	**Ambulatory Surgical Center** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	**Birthing Center** A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.
31	**Skilled Nursing Facility** A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.
32	**Nursing Facility** A facility that primarily provides residents with skilled nursing care and related services for rehabilitation of an injured, disabled, or sick person; or on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	**Custodial Care Facility** A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	**Hospice** A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. Note: This place of service can only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service must be used.

Advance Copy

Place of Service Codes (POS), continued

Code	Description
49	**Independent Clinic** A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
51	**Inpatient Psychiatric Facility** A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. This place of service code is only used for Medicare crossover billing.
53	**Community Mental Health Center** A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	**Intermediate Care Facility for the Developmentally Disabled (IFC-DD)** A facility that primarily provides health-related care and services above the level of custodial care to developmentally disabled individuals, but does not provide the level of care or treatment available in a hospital or a skilled nursing facility.
55	**Residential Substance Abuse Treatment Facility** A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

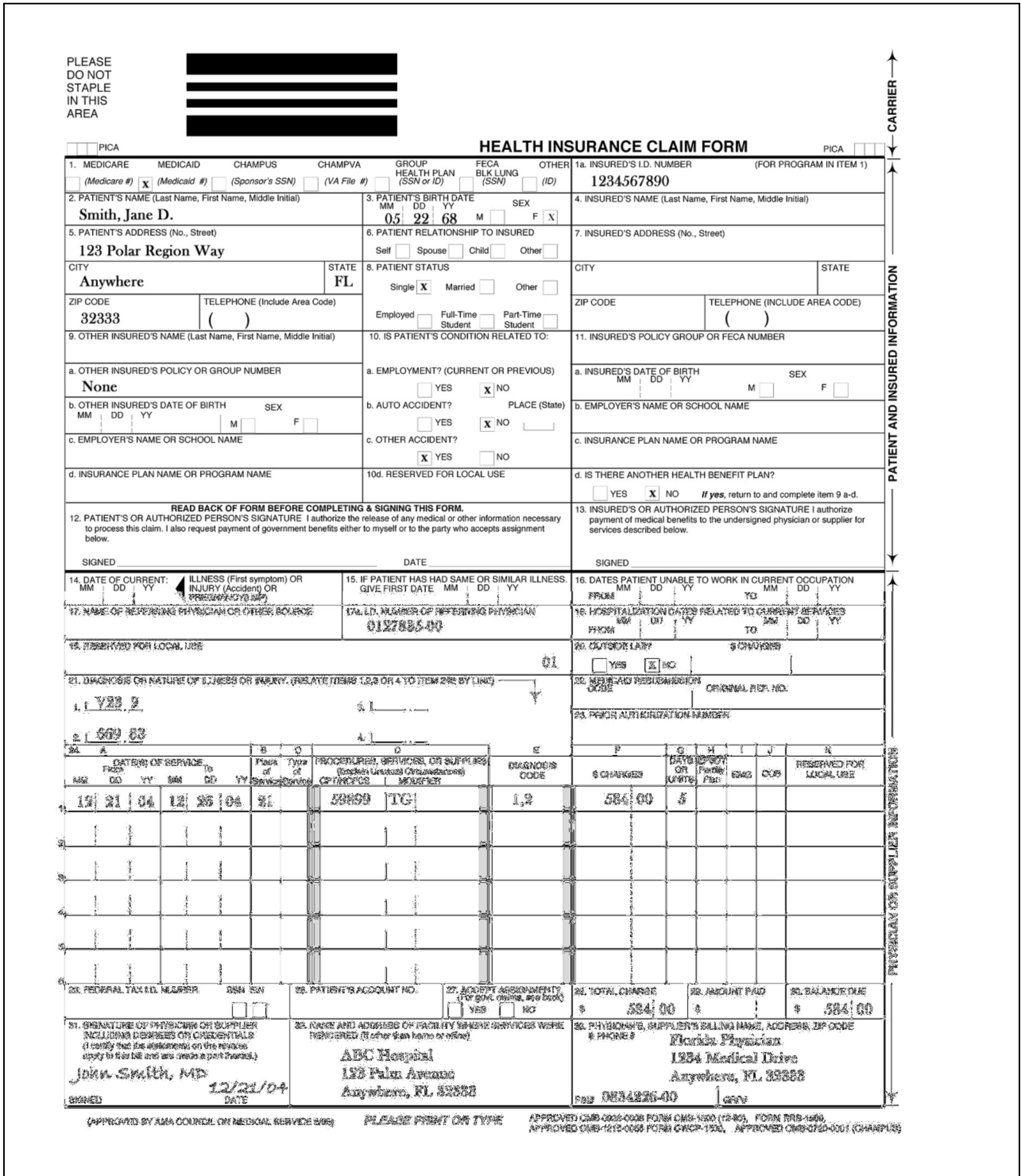
Advance Copy

Place of Service Codes (POS), continued

Code	Description
57	**Non-residential Substance Abuse Treatment Facility** A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
62	**Comprehensive Outpatient Rehabilitation Facility** A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities.
65	**End Stage Renal Disease Treatment Facility** A facility other than a hospital, which provides dialysis treatment, and maintenance or training to patients or caregivers.
71	**State or Local Public Health Clinic** A facility maintained by either state or local health departments that provides ambulatory primary care under the general direction of a physician.
72	**Rural Health Clinic or Federally Qualified Health Center** A certified facility located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician. A certified facility located in a medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	**Independent Laboratory** A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
99	**Other Unlisted Facility** Other service facilities not identified above.

Advance Copy

Illustration 1-3. Sample of a Completed CMS-1500 Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — (Medicare #) [X] (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY: 05 22 68 — SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Polar Region Way

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

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

CITY: Anywhere — STATE: FL

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

CITY — STATE

ZIP CODE: 32333 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: None

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ____ DATE ____

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

SIGNED ____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 0127885-00

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

19. RESERVED FOR LOCAL USE: 01

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.2
2. 669.83
3. ___
4. ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
12 21 04	12 25 04	21		59899	TG	1,2	584 00	5				

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 584 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 584 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Smith, MD — 12/21/04

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

ABC Hospital
123 Palm Avenue
Anywhere, FL 32333

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Florida Physician
1234 Medical Drive
Anywhere, FL 32333

PIN# 0834226-00 — GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Advance Copy

Claims Submission Checklist

Introduction

Use the following checklist before submitting a claim to the Medicaid fiscal agent for reimbursement.

Checklist

- ❑ Is the form typed or printed in black ink? If a turnaround document is used, are changes made in black ink?
- ❑ Is the form legible?
- ❑ Were instructions in the handbook followed? Some fields are not self-explanatory or may be used for other purposes.
- ❑ Are the provider name and number entered?
- ❑ Is the claim signed and dated? Unsigned claims will be returned unprocessed.
- ❑ Are attachments required? Claims cannot be paid without the required attachments.
- ❑ Is the MediPass authorization number included in item 17a on the CMS-1500 for services that require the MediPass primary care provider's approval? Is the referring provider identification number included in item 17a for procedure codes requiring a referring provider identification number? Without this number, payment will be denied.
- ❑ Is the Prior Authorization number included in item 23 on the CMS-1500 for services that require prior authorization from Medicaid? Without this number, payment will be denied.

Claims Mailing Checklist

Introduction

The following checklist may be used when mailing claims to the Medicaid fiscal agent for reimbursement.

Checklist

- ❑ Enclose only one claim type, i.e., clean CMS-1500, adjustment CMS-1500, or void CMS-1500 per envelope. Claims and adjustment requests should be sent separately, because they are processed separately at the Medicaid fiscal agent.
- ❑ The claims envelope should be addressed to the correct P.O. box and corresponding nine-digit zip code for each claim type being mailed. Typewritten or machine-printed addresses speed up post office processing.
- ❑ Claims mailed in a large envelope or "flat" need to be marked "First Class" and paid for as first class postage. If first class is not specified, the post office will send large envelopes as third class mail. This will delay delivery of claims to the Medicaid fiscal agent.

Advance Copy

Where to Send Claim Forms

CLAIM TYPE	ADDRESS
Original CMS-1500 **Resubmitted CMS-1500**	CMS-1500 Claims P.O. Box 7072 Tallahassee, Florida 32314-7072
CMS-1500 Crossover	CMS-1500 Crossover Claims P.O. Box 7074 Tallahassee, Florida 32314-7074
Adjustments and Voids	Adjustments and Voids P.O. Box 7080 Tallahassee, Florida 32314-7080
Exceptions to Filing Time Limits	Area Medicaid Office (See Appendix C in the Florida Medicaid Provider General Handbook for the address.)
Prior Authorization Request	Prior Authorizations P.O. Box 7090 Tallahassee, Florida 32314-7090
Newborn Claims	Newborn Claims P.O. Box 7092 Tallahassee, Florida 32314-7092
RPICC Claims **(Regional Perinatal Intensive Care Centers)**	RPICC Claims P.O. Box 7084 Tallahassee, Florida 32314-7084

Advance Copy

Electronic Claim Submission

Introduction

Submitting Medicaid claims via electronic media offers the advantage of speed and accuracy in processing. Providers may submit electronic claims themselves or choose a billing agent that offers electronic claim submission services. Billing agents must enroll as Medicaid providers.

Benefits

The benefits of electronic claims submission include:

- Increase speed of claims payments, seven days in some cases.
- Correct data entry errors immediately, avoiding mailing time and costs.
- Eliminate the cost and inconvenience of claims paperwork.
- Reduce office space required for storing claim forms, envelopes, etc.
- Decrease mailing costs.
- Decrease clerical labor costs.
- Automate the office for a more efficient operation.

Free Software

The Medicaid fiscal agent will provide free PC-based software, called WINASAP2003, to enable providers to submit claims electronically on personal computers (PC) in their offices.

Providers can transmit the claims via telephone lines directly to the fiscal agent.

The WINASAP2003 software, user manual and technical support is available free of charge to Florida Medicaid providers.

Note: For more information about obtaining the WINASAP2003 software, call the fiscal agent Provider Inquiry at 800-289-7799.

Format Specifications

If you have a practice management system, use a billing agent, claims clearinghouse, or code your own submission software, the fiscal agent has specifications available detailing electronic formats and communications requirements.

How to Participate in Electronic Claims Submission

The fiscal agent's field representatives will assist providers with installing WINASAP2003 software as well as assist with initial testing and instructions for ongoing claims submission. To schedule an appointment with a field representative or for any non-software questions, call the fiscal agent Provider Inquiry at 800-289-7799.

Advance Copy

Electronic Claim Submission, continued

Technical Support

The Electronic Data Interchange (EDI) Support Unit assists providers who have questions about electronic claims submission. The fiscal agent's EDI Technical Support is available to all providers Monday through Friday from 8:00 a.m. to 7:00 p.m. EST at 800-829-0218.

EDI Support will:

- Provide information on available services.
- Assist in enrolling users for electronic claims submission and report retrieval.
- Process test transmissions.
- Provide technical assistance on transmission difficulties.

Note: Information on EDI is available on the fiscal agent's Website at http://floridamedicaid.acs-inc.com.

Claim Certification

Because an electronic claim cannot be submitted with a signature, the provider's endorsed signature on the back of the remittance check issued by the Medicaid fiscal agent takes the place of a signature on a paper claim form. It acknowledges the submission of the claim and the receipt of the payment for the claim. It certifies that the claim is in compliance with the conditions stated on the back of the paper claim form, and with all federal and state laws.
Any provider who utilizes the electronic funds transfer system is certifying with each use of the electronic funds transfer system that the claim(s) for which the provider is being paid is in compliance with the provisions found on the back of the paper claim form and with all federal and state laws.

SAMPLE GROUND AMBULANCE CLAIM

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pindansky, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 09 19 54 — SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Free Willy Lane

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

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

CITY: Gorgonzola — STATE: FL

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

CITY: — STATE:

ZIP CODE: 32308 — TELEPHONE (Include Area Code): ( )

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

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

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

b. AUTO ACCIDENT? [X] YES [ ] NO — PLACE (State): FL

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ____ DATE ____

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

SIGNED ____

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 41

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __ 3. ___ . __

2. ___ . __ 4. ___ . __

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 01 06				A0427	SH		220 00	35		Y		
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 220 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Smith 3/5/06

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

AAA Ambulance Service
123 Main Street
Gorgonzola, FL 32308

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

AAA Ambulance Services
123 Main Street
Gorgonzola, FL 32308

PIN# 123456700 GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

SAMPLE AIR AMBULANCE CLAIM

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pindansky, Joan

3. PATIENT'S BIRTH DATE MM DD YY: 09 19 54 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Free Willy Lane

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

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

CITY: Gorgonzola STATE: FL

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

CITY STATE

ZIP CODE: 32308 TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ________ DATE ________

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

SIGNED ________

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 41

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __ 3. ___ . __

2. ___ . __ 4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1	03 01 06				A0431	SH		4600 00	35		Y		
2	03 01 06				A0436	SH		140 00	35		Y		
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 4740 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Smith *3/5/06*

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Aero Ambulance
123 Skyway Drive
Gorgonzola, FL 32308

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Aero Ambulance
123 Skyway Drive
Gorgonzola, FL 32308

PIN# 123456700 GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)