

# *Kansas Local Health Department Clinical Services Coding Resource Guide*

*Updated:  
September 2016*

Disclaimer: This manual has been a collaborative effort from numerous health department billers across the state. The information contained is provided only as a suggestion of possible use. Many policies, procedures and codes will vary based on individual departments, services offered, and individual situations. **It is the responsibility of every department to verify information as it pertains to their own individual departments prior to using this information.**



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Center for Public Health Initiatives

# PREFACE

The **Public Health Billing Resource Manual** provides policy & procedural guidance on how to bill 3<sup>rd</sup> party payers for public health programs and services. Developed as a billing resource tool; its purpose is to assist state, district and county public health staff in understanding the insurance coding and billing process.

**Part I-The Policies and Procedures** section focuses on the terms and conditions of billing and reimbursement from 3<sup>rd</sup> party payers. It provides guidance on eligibility & verification, coordination of benefits and billing procedures to avoid delays in reimbursement.

**Part II-The Billing & Coding: Methodologies & Rates** section emphasizes the importance of the clinical components of CPT coding to ensure 3<sup>rd</sup> party payers are charged at the appropriate level of service delivery and reimbursement.

The **Appendices** section includes Related Links, Billing Contact Information, Acronyms, Definitions, and other resources used in mastering the reimbursement process.

Amendments are made Semi-annually in accordance with policy changes in federal and state laws.

**Disclaimer:** Contract Provisions between LHD and 3<sup>rd</sup> Party Private Payers contain confidential and proprietary information that prohibits dissemination, distribution or disclosure of reimbursement rates to any parties other than county Boards of Health and LHD employees.

Currently, KanCare is contracted with the following 3<sup>rd</sup> Party Payers for Immunization Services:

*Sunflower State Health Plan*

*Amerigroup of Kansas*

*United Healthcare Community Plan*

Note: MediKan and Medicare are accepted for other services, i.e., Maternal and Child Health, Family Planning, Adult Health, etc. in most of our county health departments.

*Special thanks* to all of the billers who worked on this manual and those who will contribute to future updates. This work would not have happened without you.

**Any comments or suggestions for updates and changes to this manual can be emailed to the billers listed in section 11.6 or [aaron.davis@wichita.edu](mailto:aaron.davis@wichita.edu).**

# Updates from January 2016 Version

Section	Update Notes
Cover	Title Change
TOC	Updated to reflect changes noted in this table
Section 5.1 KMAP	Phone and website links updates
5.6 KMAP	KMAP details added, along with document retention information from General Benefits Manual
Part II Methodologies and Common LHD Coding	All ICD-9 references removed from tables
6.3 & 6.4 Immunization Services	Several Vaccines added
7.1 Child Health Services	KAN Be Healthy links updated
Section 11 Appendices	<p>Section has been renumbered. New appendices have been added and updated</p> <ul style="list-style-type: none"> <li>• Related Links – broken links have been updated</li> <li>• 11.5 Definitions have been added/adjusted</li> <li>• 11.6 KALHD Billing List Serve &amp; Regional Billing Groups map – contact information has been updated</li> <li>• 11.7 Map updates</li> <li>• 11.10 Claim samples updated and reordered</li> <li>• 11.11 NDC table modified</li> </ul>

# TABLE OF CONTENTS

## **PART I BILLING POLICIES & PROCEDURES**

### **Section 1 Provider Enrollment**

- 1.1 Introduction
- 1.2 Medicaid Enrollment Process
- 1.3 Private Insurance Enrollment Process

### **Section 2 Insurance Eligibility & Verification**

- 2.1 Introduction
- 2.2 Eligibility & Verification

### **Section 3 Coordination of Benefits**

- 3.1 Introduction
- 3.2 Primary & Secondary Payers
- 3.3 Third Party Liability Payments
- 3.4 Third Party Liability Non-covered List (Blanket Denial)

### **Section 4 Claim Submission & Resubmission**

- 4.1 Introduction
- 4.2 Claim Requirements
- 4.3 Filing Time Limits
- 4.4 Appeals Process
- 4.5 Medicaid Denial Issues

### **Section 5 Kansas Medical Assistance Program (KMAP)**

- 5.1 Website Introduction
- 5.2 Eligibility Verification and Prior Authorizations
- 5.3 KanCare Claim Submission & Inquiry
- 5.4 Manuals, Forms and Bulletins
- 5.5 Interactive Tools - KMAP Reference Codes
- 5.6 KMAP Fee-for Service Provide Manual: Record Retention

**PART II    METHODOLOGIES & COMMON LHD CODING****Section 6    Immunization Services**

- 6.1 Methodologies
- 6.2 Vaccine Guidance
- 6.3 Immunizations 18 years of age and younger
- 6.4 Immunizations 19 years of age and older
- 6.5 Medicare Part B
- 6.6 Medicare Part D
- 6.7 Influenza Vaccine Products 2015-2016 Season
- 6.8 International Travel

**Section 7    Child Health Services**

- 7.1 Methodologies
- 7.2 Child Health Visits
- 7.3 Children's Intervention Services (CIS)
- 7.4 Maternal & Infant

**Section 8    Women's Health Services**

- 8.1 Methodologies
- 8.2 Family Planning (FP)

**Section 9    Adult Health / Miscellaneous Services**

- 9.1 Methodologies
- 9.2 Adult Health
- 9.3 Miscellaneous Services

**Section 10    Laboratory Services**

- 10.1 Laboratory Service Codes

**Section 11    Appendices**

- 11.1 Component Requirements for Office & Home Visits
- 11.2 Vaccine route Administration Codes
- 11.3 Related Links
- 11.4 Acronyms
- 11.5 Definitions
- 11.6 KALHD Billing List-Serve & Regional Billing Groups
- 11.7 State LHD Map
- 11.8 Vaccine Guidance (Private, VFC, and CHIP)\*
- 11.9 Common Payer ID's
- 11.10 Claim Samples
- 11.11 NDC Conversion Table

# **PART I**

# **BILLING POLICIES**

# **& PROCEDURES**

# Section 1

## Provider Enrollment

### 1.1 Introduction

Providers must be enrolled as a qualified provider with a 3<sup>rd</sup> party payer before they can submit claims for reimbursement. This section provides guidance on the Enrollment Process.

### 1.2 Medicaid Enrollment Process

A Kansas Medical Assistance Program (KMAP) Provider Agreement must be completed in order to participate in the Kansas Medical Assistance Program (<https://www.kmap-state-ks.us/Public/homepage.asp>).

The State has selected three health plans, or managed care organizations (MCOs), to provide services to Medicaid consumers in the KanCare program. More information about each plan and how to contact them can be found at [http://www.kancare.ks.gov/health\\_plan\\_info.htm](http://www.kancare.ks.gov/health_plan_info.htm). Departments must enter into contracts with each MCO individually.

### 1.3 Private Insurance Enrollment Process

In order to bill most payers, the LHD must be contracted with the payer. It is best to contact each payer and ask how claims will be processed with and without a contract. Also an LHD may contract with a network. This allows the LHD to bill multiple payers under one contract. These are links in the PDF version of this manual.

Payer	Private Insurances	Phone number	Website
BCBS	BCBS	800-432-3587	<a href="http://bcbsks.com/CustomerService/Providers/">http://bcbsks.com/CustomerService/Providers/</a>
Aetna	Aetna Coventry Health Care KS Preferred Health	800-624-0756	<a href="https://www.aetna.com/health-care-professionals.html">https://www.aetna.com/health-care-professionals.html</a>
HPK	Network of insurances	316-652-1327	<a href="http://hpkansas.com/forms/">http://hpkansas.com/forms/</a>
ProviDr's	ProviDr's Care (WPPA)	800-801-9772	<a href="http://providrscare.net/providers/">http://providrscare.net/providers/</a>
WPS	WPS – Medicare B	866-518-3285	<a href="http://www.wpsmedicare.com/j5macpartb/departments/enrollment/">http://www.wpsmedicare.com/j5macpartb/departments/enrollment/</a>
Palmetto GBA	Railroad Medicare	866-899-5227	<a href="http://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Medicare">http://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Medicare</a>

# Section 2

## Insurance Eligibility & Verification

### 2.1 Introduction

The business of Public Health begins with clients seeking services at local county health departments. This Section provides guidance on client intake and the steps required to obtain insurance information for billable services rendered in public health.

### 2.2 Eligibility & Verification

Frontline staff should brief clients on the intake process prior to receiving services. An effective intake process begins with a registration form that gathers vital information on the client's demographics, insurance coverage, and services requested. *New Patients* should complete a form at their first visit. Departments should set a policy to have *Established Patients* complete one at every visit or if they have any changes in their information since their last visit. Verifying and updating this information is critical at every visit.

Important Steps that should be taken with every client at every visit:

- Copy the client's primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and **Exclusions**
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of **Waiver** for non-covered services and payment options

It is to the benefit of the Provider to verify coverage **before** services are rendered. Failure to do so may result in non-payment of non-covered services and difficulties recouping payment from the client after services have been provided. "Active" coverage does not guarantee reimbursement for services listed on the Fee Schedule. Please refer to the client's individual Insurance Plan/Exclusions to identify "Non-Covered" services.

In order to charge clients for non-covered services, a **Waiver for Non-Covered Services** with the following information must be provided to the client:

- Identify the service that is not covered
- Identify covered service that may be available in lieu of the non-covered service
- The cost of the service and payment arrangements
- The client must sign the Waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

Medicaid/KanCare eligibility can be verified at <https://www.kmap-state-ks.us>

**Provider Discretion:** It is a Provider's discretion to accept a Medicaid/KanCare member as a client.

By accepting a Medicaid/KanCare member as a client, the Provider

- 1 Agrees to accept, as payment in full, the amount paid by Medicaid/KanCare for all covered services with the exception of co-pays and payments from 3<sup>rd</sup> party payers.
- 2 Is prohibited from choosing specific procedures for which the Provider will accept Medicaid/KanCare, whereby the Medicaid client would be required to pay for one type of covered service and Medicaid to pay for another service if applicable.

Failure to comply with these procedures will subject the Provider to sanctions, up to and including termination from the Medicaid/KanCare Program.

*Some Departments will use procedures such as:*

When a client is ready to check-out, the paystation collects any copayments, deductibles, and service fees. Payment in full is expected at time of service. If a client is unable to pay, the clinical manager may make payment arrangements. The clinic manager should reinforce the Board of Health's or Health Department's billing policy and resolve the issue with the client through an agreed payment plan.

# Section 3

## Coordination of Benefits

### **3.1 Introduction**

By federal law, Medicaid is the “payer of last resort” in most circumstances. Coordination of Benefits (COB) is the process of determining the primary payer. This section will help define the “payer of last resort” status when submitting claims for payment. To find out more information on COB please refer to General TPL Payment Manual on the KMAP website.

### **3.2 Primary & Secondary Payers**

Third-party liability (TPL) is often referred to as other insurance (OI), other health insurance (OHI), or other insurance coverage (OIC). Other insurance is considered a third-party resource for the beneficiary. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries.

The Kansas Medical Assistance Program (KMAP) is a secondary payer to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

- Children and Youth with Special Health Care Needs (CYSHCN) program
- Kansas Department for Children and Families (DCF), formerly SRS
- Indian Health Services (IHS)
- Crime Victim's Compensation
- Vaccine for Children Program

### **3.3 Third Party Liability Payment**

Details for TPL billing can be found at <https://www.kmap-state-ks.us/Public/providermanuals.asp> under General TPL Payment Manual.

- The Provider's Role
- Billing Requirements
- Other Insurance Pricing
- Billing TPL after Receipt of KMAP Payment
- TPL Payment after Medicaid Payment
- No Response from Other Insurance
- Documentation Requirements
- Blanket Denials and Noncovered Codes

The following tips will assist Providers in reducing payment delays attributed to COB- related problems:

1. Ask All Patients about Secondary Insurance Coverage. Collect and confirm primary and secondary insurance information at each visit.
2. Know What Plans and Payers Need to Pay Claims. Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.
3. Primary & Secondary Payers: The following rules are used to determine the primary and secondary payer: a) The payer covering the patient as a subscriber will be the primary payer. b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.

<b>WHAT IF...the Medicaid Member is also eligible for Medicare?</b>		
<b>SERVICE BY MEDICAID PROGRAM</b>	<b>MEDICARE</b>	<b>MEDICAID</b>
Health Check/Immunization	Does not Cover	Primary Payer
Family Planning	Does not Cover	Primary Payer
Perinatal Case Management/Pregnancy Related Services	Does not Cover	Primary Payer
Dental Services (Health Check, Adult)	Does not Cover	Primary Payer
Adult Services/Immunizations	Primary Payer-Flu, Pneumonia, Hep B; MNT; Preventive Services	Secondary Payer
Nurse Practitioner/Physician Services	Primary Payer	Secondary Payer

<b>WHAT IF...the Medicaid Member is also eligible for other private insurance</b>		
<b>SERVICE BY MEDICAID PROGRAM</b>	<b>PRIVATE INSURANCE</b>	<b>MEDICAID</b>
Health Check/Immunizations	N/A	Primary Payer
Perinatal Case Management/Pregnancy Related	N/A	Primary Payer
Family Planning	COB REQUIRED	
Adult Services/Immunizations	COB REQUIRED	
Nurse Practitioner/Physician Services	COB REQUIRED	
Dental Services (Health Check, Adult)	COB REQUIRED	

**3.4 Third Party Liability Noncovered List (Blanket Denial)**

When a service is not covered by a beneficiary’s primary insurance plan, a blanket denial letter can be requested from the insurance carrier. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan covering the Medicaid beneficiary. The provider can also use a benefits booklet from the other insurance if it shows that the service is not covered. Providers can retain this statement on file to be used as proof of denial for one year. The noncovered status must be reconfirmed and a new letter obtained at the end of one year.

The most up-to-date TPL Noncovered List is located on KMAP and can be accessed here: <https://www.kmap-state-ks.us/Public/TPL%20Noncovered.asp>

# Section 4

## Claim Submission / Resubmission

### 4.1 Introduction

The Submission & Resubmission of Claims focuses on the importance of converting clinical services provided to a client into billable claims and submitting them via an Electronic Data Interchange to 3rd party payers for reimbursement. To receive proper payment for services, public health billing staff must collect accurate information required to submit a CMS 1500 insurance form correctly.

### 4.2 Claim Requirements

Providers must take all reasonable measures to determine a 3<sup>rd</sup> Party Payer's liability for covered services prior to filing a Medicaid claim. If a 3<sup>rd</sup> party insurance plan denies or pays insufficiently the applicable reimbursement rate:

- Attach proof of other insurance denial (an RA or letter of EOB from the insurer). Denials requesting additional information from the primary insurance company will not be accepted as proof of denial from the other insurance. If dates of service are over 12 months old, original timely filing must be proven as defined in Section 5100 of the General Billing Fee-for-Service Provider Manual. An original denial is only acceptable for the same service date(s) on the claim.
- When a Medicare supplemental plan (for example Plan 65) is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.
- When a carrier issues a blanket denial letter for a noncovered procedure code, the provider should include a copy of the denial and notate CARC code PR192 on the attachment. Refer to the Blanket Denials and Noncovered Codes portion of Section 3100 for documentation requirements (see section 3.3 of this manual).

For MCOs, failure to file a claim within the contracted timely filing after a service is rendered and/or failure to obtain a required prior approval or precertification will result in a denial of that claim. Obtaining prior approval or precertification does not guarantee payment of a claim.

If a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim.

A 3<sup>rd</sup> Party Payer may deny part or all of a claim for the following reasons: 1) The services are not covered; 2) The client was not eligible on the date of service; 3) The provider failed to obtain prior approval or precertification for the required services; or, 4) The services provided have been determined to be medically unnecessary.

Federal law prohibits State payments for Medicaid services to anyone other than a provider, except in specified circumstances. Expressly prohibited are payments to collection agencies working on a percentage or other basis unrelated to the cost of processing the billing.

### 4.3 Filing Time Limits

Every health insurance company has its own policy on timely filing. Visit each payer site or contact a representative for details and updated information.

<b>Amerigroup</b>	Submission: dependent on contract agreement Appeals/Payment Disputes: contract specific
<b>Sunflower State</b>	Submission: dependent on contract agreement. When Sunflower State is the secondary payer, claims must be received within 365 calendar days from date of the final determination of the primary payer. Resubmission: 180 calendar days from the original date of notification of payment or denial Appeals/Payment Disputes: 180 calendar days from the original date of notification of payment or denial
<b>United Healthcare Community Plan</b>	Submission of claims: dependent on contract agreement. Appeals/Payment Disputes: 30 calendar days of the adjudication date of the EOB.
<b>Medicaid</b>	Submission: 12 months after the date of service. Appeals/Payment Disputes: 24 months after the date of service.
<b>Medicare</b>	Submission: Claims must be received within 1 calendar year from the date of service. Appeals/Reconsiderations: Must be submitted within 6 months of the date on the notice of redetermination letter.
<b>BCBS</b>	Submission: 15 months from date of service. Appeals/Payment Disputes: 120 days from the date of the RA for retrospective review; 60 days from the date of the retrospective review determination for appeals.
<b>AETNA/COVENTRY</b>	Submission: 120 days from date of service. Resubmission: 180 days from date of denial/processing Appeals/Payment Disputes: 180 days of the initial claim decision for reconsiderations; 60 days of previous decision for appeals

### 4.4 Appeals Process

Every health insurance company has a grievance and appeal procedure defined in its policy. You can appeal a 3<sup>rd</sup> party payer's decision to deny a claim or pay less than the amount billed. Please refer to the appropriate payer's website for instructions on to appeal a claim.

The 3<sup>rd</sup> party payer may still deny a claim based on medical necessity despite pre-approval and a correctly coded claim. Appeal requests that do not contain sufficient information will not be processed.

### 4.5 Medicaid Denial Issues

When facing denials, there are multiple reasons that could be causing the issue. The first step in dealing with a denial is to review the denial code and determine what is causing the denial. Review prior claims or reach out for assistance from other billers. If you are still unsure of a correct course of action review the following website:

[http://www.kancare.ks.gov/download/Provider\\_Contacts.pdf](http://www.kancare.ks.gov/download/Provider_Contacts.pdf). This site contains a contact for KDHE. KDHE should be contacted only when all other resources have been exhausted.

# Section 5

## KMAP: Kansas Medical Assistance Program

### **5.1 Website Introduction**

The Kansas Medical Assistance Program (KMAP) website provides users with access to a variety of information such as eligibility verification, claim submission and inquiry, and prior authorizations. Visit <https://www.kmap-state-ks.us/public/homepage.asp> for more information on enrollment. (Not all browsers are compatible with the KMAP website, and most of the current versions cause the site to be difficult to use. Try switching browsers or using an older version if the information is not displayed correctly.)

After logging in to the website, the mailbox view opens. Any recent changes will be listed here. These are official notifications and become part of your provider agreement. Any questions on KMAP specifics or issues in submitting claims can be discussed with a KMAP representative at 1-800-933-6593.

For those unfamiliar with submitting claims through KMAP, the Professional Billing Packet is the best place to start. The most current version can be found here: <https://www.kmap-state-ks.us/Public/Workshop%20Schedule/Workshop%20Materials.asp>

Below is an outline of the more frequently used resources available. These are links in the PDF version of this manual.

### **5.2 Eligibility Verification and Prior Authorizations**

- [Eligibility Verification](#)
- [Prior Authorizations](#)
  - [Submit Prior Authorization Request](#)
  - [Prior Authorization Inquiry](#)
  - [Submit Service Referral](#)
  - [Service Referral Search](#)

### **5.3 KanCare Claim Submission & Inquiry**

- [Claim Submission](#)
  - [Dental](#)
  - [Institutional](#) (Inpatient, Outpatient, Long Term Care and Medicare Cross-over)
  - [Professional](#)
  - [Pharmacy](#)
  - [Right to Appeal](#)
- [Claim Inquiry](#)

## 5.4 **Manuals, Forms and Bulletins**

- [Provider Manuals](#)
- [Forms](#)
- [Bulletins](#)

## 5.5 **Interactive Tools - KMAP Reference Codes**

Pricing & Limitation information for Procedures, Diagnosis, Drugs, and Revenue Codes

- [KMAP Reference Codes](#)
  - [Search by Procedure](#)
  - [Search by NDC](#)
  - [Search by Diagnosis](#)
  - [Coding Modifiers Table](#)
  - [Download Fee Schedules](#)
  - [MS-DRG \(Medicare Severity Diagnosis-Related Group\) to CMS-DRG Crosswalk](#)
  - [HCPCS Reference List](#)
  - [Pharmacy Federal and State Pricing](#)
  - [Fee Schedule for Outpatient Hospitals](#)
- [HCPCS Code Search](#)
- [Provider Services Profile](#): listing of the recent services a beneficiary has received
- [EOB Crosswalks](#)

## 5.6 **KMAP Fee-for Service Provider Manual: General Benefits**

When looking for Medicaid benefit details, the most current version of the “General Benefits” manual should be consulted. This is located in the *Provider Manual* link noted above, with a selection of “General Benefits.” Below is an example of a key components of the 7/6/16 Manual that is regularly questioned.

### **2700. DOCUMENTATION REQUIREMENTS Updated 10/15**

#### **Claim/Record Storage Requirements**

K.S.A. 21-5931 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and lock-in referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Providers who submit claims through computerized systems must maintain these records in a manner which is retrievable.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers:

- To keep such records as necessary to disclose fully the extent of services rendered to beneficiaries
- To furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider

Providing medical records to KDHE-DHCF or its designee is not a billable charge.

# **PART II**

# **METHODOLOGIES & COMMON LHD CODING**

# Section 6

## Immunization Services

### 6.1 Methodologies

The following guidance will allow for successful billing and maximum reimbursement of Immunization Services.

- Information on the Vaccine for Children Program - Eligibility Criteria for vaccines can be found @ <http://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html>
- KIP\_Private\_VFC\_CHIP\_Vaccine\_Flow\_Chart billing guidance can be found @ [http://www.kdheks.gov/immunize/download/KIP\\_Private\\_VFC\\_CHIP\\_Vaccine\\_Flow\\_Chart.pdf](http://www.kdheks.gov/immunize/download/KIP_Private_VFC_CHIP_Vaccine_Flow_Chart.pdf)
- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of CPT® codes for vaccines covered under the Vaccine for Children (VFC) program will not be allowed.
- PACS software requires a charge on each line item being submitted. Providers who bill electronically through the PACS system will need to indicate a charge of \$.01 on the line for the vaccine/toxoid code. The MMIS system will deny the service even though a charge was submitted.
- As of October 29, 2010, administration of Vaccine for Children vaccines is exempt from third-party liability (TPL). When they are billed with an appropriate administrative code, providers do not have to bill the claim to the TPL carrier before Medicaid will process the claim for payment.
- **Modifier 25** should be attached to the E/M service code if vaccines are administered during the same visit.

### 6.2 Vaccine guidance for dual coverage

#### ***If a CHIP (T21) child has both private insurance and T21 what vaccine do you use?***

Use private vaccine and bill the insurance company for the vaccine and administration fee. If CHIP vaccine is used by mistake, bill the private insurance company for the vaccine administration charge only. It is best to determine the child's coverage for immunizations before the service is provided this way you can use the correct vaccine funding source. If the child's private insurance does not cover vaccine, the child is CHIP eligible and CHIP vaccine is used. Be sure to keep this documentation in the child permanent record. This is important to avoid denials of claims and to help your clinic and the CHIP program to be sure the correct payer is billed for immunization services. If you receive a denial from the private insurer and you determined the child had immunization coverage, please contact CHIP customer service 1-800-766-9012 for assistance.

*This explanation was published in the FAQ document from KIP updated 3/4/14.*

***If a child has private insurance and T19 is secondary what vaccine funding source do I use and who is billed?*** Resource is from the 2015 CDC VFC Program Operation Guide page 29.

### *INSURED EXCEPTIONS*

AI/AN with Health Insurance that Covers Immunizations:

AI/AN children are always VFC-eligible. VFC is an entitlement program and participation is not mandatory for an eligible child. For AI/AN children that have full immunization benefits through a primary private insurer, the decision to participate in the VFC program should be made based on what is most cost beneficial to the child and family.

Insured and Medicaid as Secondary Insurance:

Situations occur where children may have private health insurance and Medicaid (T19) as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid (T19).

However, the parent is not required to participate in the VFC program. There are options for the parent and provider. These options are described below:

#### *Option 1*

A provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee. In most healthcare situations, Medicaid is considered the “payer of last resort.” This means that claims must be filed to and rejected by all other insurers before the Medicaid agency will consider payment for the service. This is not true of the VFC vaccine administration fee for Medicaid-eligible children. The Medicaid program must pay the VFC administration fee because immunizations are a component of the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. However, once the claim is submitted to Medicaid, the state Medicaid agency does have the option to seek reimbursement for the administration fee from the primary insurer.

Please note: If the state Medicaid agency rejects a claim for a vaccine administration fee for a child with Medicaid as secondary insurance, stating the claim must first be submitted to the primary insurer for payment, the provider should notify the awardee (KIP). The awardee (KIP) should notify their CDC project officer so that CDC can work with CMS to educate the state Medicaid agency and correct the situation.

Considerations regarding this option:

- This is the easiest way for a provider to use VFC vaccine and bill Medicaid for the administration fee.
- There are no out-of-pocket costs to the parent or guardian for the vaccine or the administration fee.

#### *Option 2*

A provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee. If the primary insurer pays less than the Medicaid amount for the vaccine administration fee, the provider can bill Medicaid for the balance of the vaccine administration fee, up to the amount Medicaid pays for the administration fee. If the primary insurer denies payment of vaccine and the administration fee, the provider may replace the privately purchased vaccine with VFC vaccine and bill Medicaid for the administration fee. The provider must document this replacement on the VFC borrowing form (see Module 4).

Considerations regarding this option:

- The provider may be reimbursed a higher amount if privately purchased vaccine is administered and both the vaccine and the administration fee are billed to the primary insurer.
- The provider should choose from the vaccine inventory that is most cost-effective for the family.
- The parent/guardian of a child with Medicaid as secondary insurance should never be billed for a vaccine or an administration fee.

**6.3 Immunizations 18 years of age and younger**

Service Description	CPT Code	ICD-10	Age Restriction
<b>Vaccine Administration</b>			
Imm admin, <i>with counseling</i> ; 1 <sup>st</sup> or only component	90460	Z23	0 -18 yrs
Imm admin, <i>with counseling</i> ; ea additional component <b>+ add on code* (not billable to KanCare)</b>	90461	Z23	0 -18 yrs
Immunization admin; 1 vaccine	90471	Z23	
Immunization admin; each additional vaccine <b>+ add on code*</b>	90472	Z23	
Immunization admin, oral, nasal; 1 vaccine	90473	Z23	
Immunization admin, oral, nasal; each additional vaccine <b>+ add on code*</b>	90474	Z23	
<b>Vaccines - Private and VFC</b>			
DTaP, Diphtheria, Tetanus, Pertussis (Daptacel, Tripedia)	90700	Z23	0 – 6yrs
DTaP-Hep B-IPV (Pediatrix)	90723	Z23	
DTaP-HIB-IPV (Pentacel)	90698	Z23	
DTaP-IPV (Kinrix)	90696	Z23	4 yrs – 6 yrs
Hep A, 2-dose, (Havrix,Vaqta)	90633	Z23	1yr – 18 yrs
Hep A, 3-dose, (Havrix)	90634	Z23	1yr – 18 yrs
Hep B, 3-dose (Engerix-B)	90744	Z23	
Hep B-HIB (Comvax)	90748	Z23	
Hep A-Hep B, (Twinrix)	90636	Z23	18 yrs
HIB, Hemophilus b, 3-dose (PedvaxHib)	90647	Z23	
HIB, Hemophilus b, 4-dose, (Acthib,Hiberix)	90648	Z23	
HPV, Human Papilloma Virus, 3-dose (Gardasil)	90649	Z23	9 yrs – 18 yrs
HPV, types 6, 11, 16, 18, 31, 33, 45, 52, 58 (Gardasil)	90651	Z23	
IPV, Polio (IPOL)	90713	Z23	
Meningococcal conjugate (Menactra, Menveo)	90734	Z23	
MMR, Measles, Mumps, Rubella	90707	Z23	
MMRV, Measles, Mumps, Rubella, Varicella (ProQuad)	90710	Z23	
Pneumococcal, 7 valent (Pevnar)	90669	Z23	
Pneumococcal, 13 valent (Pevnar 13)	90670	Z23	
Pneumococcal, 23 valent (Pneumovax 23)	90732	Z23	2 yrs & 18 yrs
Rotavirus, 2-dose, live, oral (Rotarix)	90681	Z23	
Rotavirus, 3-dose, live, oral (RotaTeq)	90680	Z23	
Td, Tetanus, Diphtheria toxoid, preservative free (Tenivac)	90714	Z23	7 yrs & 18 yrs
Tdap, Tetanus, Diphtheria & Pertussis (Boostrix, Adacel)	90715	Z23	7 yrs & 18 yrs
Varicella, live (Varivax)	90716	Z23	

**\*+ add on codes: codes that are always performed in addition to the primary service or procedure & must Never be reported as a stand-alone-code.**

<b>6.4 Immunizations 19 years of age &amp; older</b>			
<b>Service Description</b>	<b>CPT Code</b>	<b>ICD-10</b>	<b>Age Restriction</b>
<b><i>Vaccine Administration</i></b>			
Immunization admin; 1 vaccine	90471	Z23	
Immunization admin; each additional vaccine <b>+ add on code*</b>	90472	Z23	
Immunization admin, oral, nasal; 1 vaccine	90473	Z23	
Immunization admin, oral, nasal; each additional vaccine <b>+ add on code*</b>	90474	Z23	
<b><i>Vaccines</i></b>			
DT, Diphtheria, Tetanus toxoid	90702	Z23	
Hep A 2-dose (Vaqta, Havrix)	90632	Z23	
Hep A-Hep B, adult (Twinrix)	90636	Z23	
Hep B (Recombivax) Pediatric/adolescent dose	90744	Z23	19 years only
Hep B (Engerix-B)	90746	Z23	
Hep B, dialysis or Immunosuppressed	90740	Z23	
HPV, Human Papilloma Virus, 3-dose (Gardasil)	90649	Z23	
IPV, Polio (IPOL)	90713	Z23	
Meningococcal conjugate (Menactra, Menveo)	90734	Z23	
Meningococcal polysaccharide (Menomune)	90733	Z23	
MMR, Measles, Mumps, Rubella	90707	Z23	
MMRV, Measles, Mumps, Rubella, Varicella (ProQuad)	90710	Z23	
Pneumococcal, 7 valent (Prevnar)	90669	Z23	
Pneumococcal, 13 Valent (Prevnar 13)	90670	Z23	
Pneumococcal 23-Valent (Pneumovax 23)	90732	Z23	
Td, Tetanus, Diphtheria toxoid, preservative free (Tenivac)	90714	Z23	
Tdap, Tetanus, Diphtheria & Pertussis (Boostrix, Adacel)	90715	Z23	
Varicella, live (Varivax)	90716	Z23	
Zoster (shingles) live (Zostavax)	90736	Z23	

**\*+ add on codes: codes that are always performed in addition to the primary service or procedure & must Never be reported as a stand-alone-code.**

<b>6.5 Medicare Part B</b>			
Service Description	CPT Code	ICD-10	Age Restriction
<b><i>Vaccine Administration</i></b>			
Immunization; Influenza	G0008	Z23	
Immunization; Pneumococcal	G0009	Z23	
Influenza & Pneumococcal billed together	G0008,G0009	Z23	
<b><i>Vaccines</i></b>			
Pneumococcal, 13 Valent (Pevnar 13)	90670	Z23	
Pneumococcal 23-Valent (Pneumovax 23)	90732	Z23	

<b>6.6 Medicare Part D (TransactRx)</b>			
Service Description	CPT Code	ICD-10	Age Restriction
<b><i>Vaccine Administration</i></b>			
Immunization admin; 1 vaccine	90471	Z23	
Immunization admin; each additional vaccine + add on code*	90472	Z23	
<b><i>Vaccines - commonly billed</i></b>			
Hep A, (Havrix) .5 ml syringe	90633	Z23	1yr - 18 yrs
Hep A, (Havrix) 1ml syringe or vial	90632	Z23	18 yrs +
Hep A, (Vaqta) 1ml vial	90632	Z23	18 yrs +
Hep B, (Engerix-B) 20mcg ml syringe or vial	90746	Z23	18 yrs +
Hep A/HepB, 1ml syringe or vial	90636	Z23	18 yrs +
HPV, types 16,18, (Cervarix) .5ml syringe or vial	90650	Z23	
HPV, types 6,11,16,18 (Gardasil) .5ml syringe or vial	90649	Z23	
Meningitis, (Menactra) .5ml syringe or vial	90734	Z23	
Meningitis, (Menomune) A/C/Y/W-135 .5ml	90733	Z23	
Meningitis, (Menveo) .5ml vial	90734	Z23	
MMR .5ml vial	90707	Z23	
Td, (Tenivac) .5ml syringe or vial	90714	Z23	7 yrs +
Tdap, (Adacel) .5ml syringe or vial	90715	Z23	7 yrs +
Tdap, (Boostrix) .5ml syringe or vial	90715	Z23	7 yrs +
Varicella, (Varivax) .5ml vial	90716	Z23	
Zoster, shingles (Zostavax) .65ml vial	90736	Z23	

\*+ add on codes: codes that are always performed in addition to the primary service or procedure & must Never be reported as a stand-alone-code.

**6.7 Influenza Vaccine Products 2015-2016 Season**

Manufacturer	Trade Name	Supply	CPT	Medicare	ICD-10	Age Group
<b>Vaccine</b>						
Bio CSL, Inc	Afluria (IIV3)	0.5 mL SD syringe	90656	90656	Z23	9 years & older
		5.0 mL MD vial	90658	Q2035	Z23	
GlaxoSmithKline	Fluarix (IIV4)	0.5 mL SD syringe	90686	90686	Z23	3 years & older
ID Biomedical Corp. of Quebec	FluLaval (IIV4)	0.5 mL SD syringe	90686	90686	Z23	3 years & older
		5.0 mL MD vial	90686	90686	Z23	3 years & older
MedImmune	FluMist (LAIV4)	0.2 mL single nasal	90672	90672	Z23	2 through 49 years
NVS Influenza Vaccine (formerly Novartis)	Fluvirin (IIV3)	0.5 mL SD syringe	90656	90656	Z23	4 years & older
		5.0 mL MD vial	90658	Q2037	Z23	4 years & older
	Flucelvax (ccIIV3)	0.5 mL SD syringe	90661	90661	Z23	18 years & older
Protein Sciences Corp.	Flublok (RIV3)	0.5 mL SD vial	90673	90673	Z23	18 years & older
Sanofi Pasteur, Inc.	Fluzone (IIV3)	5.0 mL MD vial	90657	90657	Z23	6 thru 35 months
		5.0 mL MD vial	90658	Q2038	Z23	3 years & older
	Fluzone (IIV4)	0.25 mL SD syringe	90685	90685	Z23	6 thru 35 months
		0.5 mL SD syringe	90686	90686	Z23	3 years & older
		0.5 mL SD vial	90686	90686	Z23	3 years & older
		5.0 mL MD vial	90687	90687	Z23	6 thru 35 months
		5.0 mL MD vial	90688	90688	Z23	3 years & older
	Fluzone High-Dose (IIV3)	0.5 mL SD syringe	90662	90662	Z23	65 years & older
	Fluzone Intradermal (IIV4)	0.1 mL SD micro inj.	90630	90630	Z23	18 thru 64 years
SD = single dose, MD = multi-dose						

**6.8 International Travel (Commonly billed)**

Service Description	CPT Code	ICD-10	Age Restriction
<b>Vaccine</b>			
Typhoid, injection	90691	Z23	
Typhoid, oral	90690	Z23	
Yellow Fever	90717	Z23	
<b>**Additional Vaccines per CDC Recommendations</b>			

# Section 7

## Maternal & Child Health Services

### 7.1 Methodologies

**KAN Be Healthy (KBH)** is a Title XIX program which provides preventive health care and immediate remedial care for the prevention, correction, or early control of abnormal conditions. It is available to beneficiaries who are 20 years of age or under. This program is referred to as Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) at the federal level.

The main source for KBH information is through the state manual. For the current manual, select “KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment from the dropdown here: <https://www.kmap-state-ks.us/Public/providermanuals.asp>.

**KBH Participation/Eligibility:** Beneficiaries who are 20 years of age and under are considered KBH-enrolled participants and are eligible for the KBH program until turning 21 years of age.

KBH screening providers have multiple options to bill for, be reimbursed for, and ensure that the beneficiary’s KBH screens update appropriately. The billing options include:

- An evaluation and management (E&M) preventative medicine CPT code (99381 through 99385 or 99391 through 99395) with modifier EP.
- An E&M office visit CPT code (99202 through 99205 or 99213 through 99215) with modifier EP and wellness diagnosis code (V20 through V20.2, V20.31, V20.32, V70.0 and/or V70.3 through V70.9), (Z00.00, Z00.01, Z00.121, Z00.129, Z00.110, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8, Z02.89, Z02.0, Z02.1, Z02.2, Z02.3 Z02.4, Z02.5, Z02.6, Z02.82, Z0281, Z02.83, Z02.89)
- An E&M preventative medicine CPT code without modifier EP and 12 components billed separately.
- An E&M office visit CPT code with wellness diagnosis, without modifier EP and 12 components billed separately.

Note: There are additional CPT codes that will update one KBH screen only; additional CPT codes update one medical, dental, vision, or hearing KBH screen.

All KBH screenings must include minimum documentation of the following 12 components. These can be billed separately or **modifier EP** can be added to the E&M code.

- Medical history
- Physical growth
- Body systems (cardiovascular/pulmonary gastrointestinal, central nervous system, musculoskeletal, genital/urinary, and integumentary systems)
- Developmental/emotional
- Nutrition
- Health education and anticipatory guidance
- Blood lead screening/testing
- Laboratory (CBC with differential and other as needed)
- Immunizations
- Hearing screen
- Vision screen
- Dental screen

<b>7.2 Child Health Visits</b>		
<b>Service Description</b>	<b>CPT Code</b>	<b>ICD-10</b>
<b><i>Preventive</i></b>		
New Patient: 1 day - 11 months	99381	Z00.121 Z00.129
New Patient: 1 year - 4 years	99382	Z00.121 Z00.129
New Patient: 5 years - 11 years	99383	Z00.121 Z00.129
New Patient: 12 years - 17 years	99384	Z00.121 Z00.129
New Patient: 18 years - 20 years	99385	Z00.00 Z00.01
Established Patient: 1 day - 11 months	99391	Z00.121 Z00.129
Established Patient: 1 year - 4 years	99392	Z00.121 Z00.129
Established Patient: 5 years - 11years	99393	Z00.121 Z00.129
Established Patient: 12 years - 17 years	99394	Z00.121 Z00.129
Established Patient: 18 years - 20 years	99395	Z00.00 Z00.01
<b><i>Evaluation &amp; Management</i></b>		
Nurse Visit	99211	
Nurse Visit/Assessment – <b>KanCare Only</b>	T1001	
New Patient: Problem focused	99201	
New Patient: Expanded problem focused	99202	
New Patient: Detailed	99203	
New Patient: Comprehensive	99204	
Established Patient: Problem focused	99212	
Established Patient: Expanded problem focused	99213	
Established Patient: Detailed	99214	
<b><i>Development/Audiology/Vision Screenings</i></b>		
Developmental screening with interpretation and report	96110	Z00.121, Z00.129 Z00.00, Z00.01
Hearing, pure tone, air only	92551	Z00.121, Z00.129 Z00.00, Z00.01
Hearing, pure tone audiometry; air only	92552	Z00.121, Z00.129 Z00.00, Z00.01
Hearing, pure tone audiometry; air and bone	92553	Z00.121, Z00.129 Z00.00, Z00.01
Hearing, speech threshold	92555	Z00.121, Z00.129 Z00.00, Z00.01
Hearing, speech threshold; with speech recognition	92556	Z00.121, Z00.129 Z00.00, Z00.01
Hearing, comprehensive evaluation & speech recognition (92553,92556)	92557	Z00.121, Z00.129 Z00.00, Z00.01
Tympanometry (impedance testing)	92567	Z00.121, Z00.129 Z00.00, Z00.01
Acoustic reflex testing, threshold	92568	Z00.121, Z00.129 Z00.00, Z00.01
Conditioning play audiometry	92582	Z00.121, Z00.129 Z00.00, Z00.01
Evoked response (EEG) audiometry	92585	Z00.121, Z00.129 Z00.00, Z00.01
Automated Auditory Brainstem Response	92586	Z00.121, Z00.129 Z00.00, Z00.01
Evoked Otoacoustic Emissions; limited	92587	Z00.121, Z00.129 Z00.00, Z00.01
Vision, bilateral	99173	Z00.121, Z00.129 Z00.00, Z00.01
<b><i>Dental Services</i></b>		
Topical Fluoride Varnish	D1206	Z01.20 Z01.21
Topical App of Fluoride	D1208	Z01.20 Z01.21

**7.3 Children's Intervention Services**

Service Description	CPT Code	ICD-10
<b><i>Nutrition Services</i></b>		
Nutrition Assessment; initial assessment, each 15 mins	97802	Z71.3
Nutrition Assessment; re-assessment, each 15 mins	97803	Z71.3

**7.4 Maternal & Infant**

Service Description	CPT Code	ICD-10
<b><i>Nurse Assessment-Mother</i></b>		
Prenatal, 1 visit (maximum of 3)	H1000	Z34.80
Prenatal risk reduction	H1000	Z34.90
Prenatal, total package of 3 visits	H1005	Z34.80
Rhogam	90384	Z41.8
Postpartum	T1001	Z39.2
<b><i>Infant Services-Infant</i></b>		
Newborn - 0-28 days	99502	Z76.2
Infant - over 28 days	T1001	
<b><i>Nutrition Assessment</i></b>		
Prenatal/Postpartum	S9470	
<b><i>Social Work Assessment-Mother only</i></b>		
Prenatal/Postpartum	H1002	
<b><i>Antepartum Care - Qualified Healthcare Professional (APRN, ARNP, PA, MD)</i></b>		
1 - 3 visits, see appropriate E/M code(s)	99211-99215	Z34.80
4 - 6 visits	59425	Z34.80
7 or more visits	59426	Z34.80
<b><i>Diagnosis Codes ICD-10</i></b>		
Abnormal Glucose complicating pregnancy		099.810
Gestational Diabetes		024.419
Gestational Diabetes Mellitus, post-partum		024.439
Iron tablets		099.019
Paperwork (FMLA)		Z02.79
Prenatal Vitamins	84591	Z34.80
Supervision of other high risk pregnancy		009.899
Threatened spontaneous abortion		020.0

# Section 8

## Women's Health Services

### 8.1 Methodologies

**Tobacco Cessation Counseling for Pregnant Women:** Policies and Procedures on counseling visits are located in the Physician Services Manual, Section 903.18.

- ✓ Pregnant women that apply for PE and are in Medicaid FFS status are eligible to receive PCM services and Tobacco Cessation Counseling during the same visit.
- ✓ Codes 99406 or 99407 may be billed along with a distinct E&M service if warranted during the same visit. Counseling may not be used as a basis for the E/M code selection.
- ✓ **Modifier 25** must be added to the E&M service
- ✓ Wellcare will not pay the health departments for prenatal services.
- ✓ The Cessation counseling must be face-to-face in a clinic setting. Only one 12-week (3 months) treatment period allowed per pregnancy; may begin at any trimester. Only one monthly session billed and documented in medical record per treatment period (3 months).
- ✓ For "non-funded WIC" nutritionists who are also qualified as DSPS providers, the counseling visits can be billed (if beyond the two mandatory WIC nutrition counseling visits) in addition to the DSPS Nutritional Counseling service codes.

**340B Pharmaceutical Pricing:** When a covered entity (health department) purchases pharmaceutical products at the 340B price and bills Medicaid/CMOs for the product, the amount billed cannot exceed the entity's actual acquisition cost, plus a dispensing or administration fee as established by the State Medicaid Agency.

**DISCLAIMER:** Not all payers cover dispensing or administrative fees.

<b>8.2 Family Planning</b>		
<b>Service Description</b>	<b>CPT Code</b>	<b>ICD-10</b>
<b><i>Preventive/Periodic Well Women</i></b>		
New Patient: 12 years - 17 years	99384	Z00.121, Z00.129
New Patient: 18 years - 39 years	99385	Z00.00, Z00.01
New Patient: 40 years - 64 years	99386	Z00.00, Z00.01
Established Patient: 12 years - 17 years	99394	Z00.121
Established Patient: 18 years - 39 years	99395	Z00.00, Z00.01
Established Patient: 40 years - 64 years	99396	Z00.00, Z00.01
<b><i>Examinations</i></b>		
Annual Gynecological examination; New Patient	S0610	Z01.411, Z01.419
Annual Gynecological examination; Established Patient	S0612	Z01.411, Z01.419
Annual Gynecological examination; clinical breast exam without pelvic exam	S0613	Z01.411, Z01.419
<b><i>Evaluation &amp; Management</i></b>		
Nurse Visit	99211	
Nurse Visit/Assessment - <b>KanCare Only</b>	T1001	
New Patient: Problem focused	99201	
New Patient: Expanded problem focused	99202	
New Patient: Detailed	99203	
New Patient: Comprehensive	99204	
Established Patient: Problem focused	99212	
Established Patient: Expanded problem focused	99213	
Established Patient: Detailed	99214	
<b><i>Possible ICD-10 Reason for Visit</i></b>		
Anemia		D64.9
Normal Medical/Lab Exam		Z00.00
Abnormal Medical/Lab Exam		Z00.01
Anemia due to blood loss		D50.0
Anemia due to disturbance of hemoglobin synthesis		D50.9
BCP Script		Z30.9
Bacterial Vaginosis (BV)		N76.0
Breast examination screening		Z12.39
Breast lump or mass		N63
Cervicits		N72
Condyloma-TCA		A63.0
Counseling		Z71.9
Currently Pregnant		Z33.1
Depo-Provera contraceptive surveillance		Z30.42
Diabetes Mellitus		E11.9
Employee/school physical		Z02.89
Foreign body		T19.2XXA
Galactorrhea in female		N64.3
Health Maintenance		Z00.8
HPV screening/Pap		Z11.51
IUD surveillance		Z30.431
Lipid screening		Z13.220
Mastitis		N61
Mastodynia		N64.4
Molluscum Contagiosum		B08.1
Nexplanon insertion and/or removal		Z30.8

Service Description	CPT Code	ICD-10
Oral contraceptive surveillance		Z30.41
Pap abnormal		R87.89
Pap screening		Z12.4
Pap screening repeat		Z01.42
Post-operative wound infection		T81.4XXA
Preconception counseling		Z31.69
Screening		Z13.9
Sickle cell anemia		D57.1
STD counseling		Z70.8
STD screening		Z11.3
Symptom related to IUD		T83.9XXA
Thyroid screening		Z13.29
Urinary tract infection		N39.0
Yeast Vaginitis		B37.3
<b>Counseling/Interventions</b>		
Smoking and tobacco counseling; 3 minutes – 10 minutes	99406	
Smoking and tobacco counseling; 11 minutes and up	99407	
<b>Procedures</b>		
Insertion, non-biodegradable drug delivery implant	11981	
Removal, non-biodegradable drug delivery implant	11982	
Removal <i>with</i> reinsertion, non-biodegradable drug delivery implant	11983	Z30.433
Insertion of intrauterine device (IUD)	58300	Z30.430
Removal of intrauterine device (IUD)	58301	Z30.432
Colposcopy of cervix; without biopsy	57452	
Colposcopy of cervix; with biopsy(s) <i>and</i> endocervical curettage	57454	
Colposcopy of cervix; with biopsy(s)	57455	
Colposcopy of cervix; with endocervical curettage	57456	
Colposcopy of cervix; with loop electrode biopsy(s) (LEEP)	57460	
Colposcopy of cervix; with loop electrode conization of cervix (LEEP)	57461	
Conization of cervix; loop electrode excision (LEEP)	57522	
Endometrial sampling (biopsy)	58100	
<b>Possible Diagnosis Codes (ICD-10)</b>		
AGUS		R87.619
ASCUS		R87.610
CIN I		N87.0
CIN II		N87.1
CIN III		D06.9
HGSIL		R87.613
HPV Positive		R87.810
LGSIL		R87.612
<b>Supplies/Pharmacy</b>		
Contraceptive, condom, female	A4268	Z30.49
Contraceptive, condom, male	A4267	Z30.49
Contraceptive, diaphragm	A4266	Z30.8
Contraceptive, oral	S4993	Z30.41
Contraceptive, estonogestrel implant (Implanon/Nexplanon)	J7307	Z30.49
Contraceptive, levonorgestrel releasing intrauterine, 52 mg (Mirena)	J7302	Z30.430
Contraceptive, intrauterine copper (Paragard)	J7300	Z30.430
Contraceptive, medroxyprogesterone acetate injection, 1 mg (Depo)	J1050	Z30.40
Therapeutic, prophylactic or diagnostic injection	96372	

# Section 9

## Adult Health / Miscellaneous Services

### **9.1 Methodologies**

**Diagnostic, Screening & Preventive Services (DSPS):** Is a Medicaid category of services solely for public health providers. County Boards of Health are enrolled as the qualified Medicaid provider.

Health departments agree to provide diagnostic, screening and treatment services in an office, clinic, school-based clinic, home, or other similar physical facility within the boundaries of the State of Kansas.

**Nutritional Counseling (Individual & Group):** Dietitians licensed by the Kansas Board of Examiners may bill for Nutritional Counseling. Medicaid reimburses for new patient nutritional assessment, established patient nutritional, counseling and nutritional group counseling visits.

MediKan/KanCare will pay for one office visit per client, per date of service. If client receives a clinical service (nurse) and a nutritional counseling (dietician) service on the same day, billing should reflect the appropriate level of services provided; higher "enhanced" office visit.

To bill MediKan/KanCare for dispensing TB medicine; providers must perform face-to face, system review services warranting a minimal level office visit.

**Self Pay Services:** Most of our public health departments provide Immunization, Child Health, Women's Health, and Adult Health Services that are covered by our contracted payers. These same services along with other services that are not covered at all may also be provided to patients who have other insurance or are uninsured or underinsured at a set fee. Each County Board of Health sets their own fees for these services and payment may be required at time of service. Listed are a few of the additional services that may be provided at some health departments.

Health departments can bill for any lab that is processed/analyzed in their lab. Health departments can bill for the collection of lab specimens. Some insurance companies will reimburse for lab collection.

Attaching modifier 90 (reference laboratory) to venipuncture (36415) may aid in reimbursement if the outside laboratory that is actually performing the test bills insurance directly for the lab tests. Some insurance companies will deny lab collection as "content of service" to the E/M procedure code.

<b>9.2 Adult Health – Preventative/STD/TB/Nutritional Counseling/MISC</b>		
<b>Service Description</b>	<b>CPT Code</b>	<b>Notes</b>
<b><i>Preventative</i></b>		
New Patient: 18 years - 39 years	99385	
New Patient: 40 years - 64 years	99386	
Established Patient: 18 years - 39 years	99395	
Established Patient: 40 years - 64 years	99396	
<b><i>Evaluation &amp; Management</i></b>		
Nurse Visit	99211	
Nurse Visit/Assessment – <b>KanCare Only</b>	T1001	
New Patient: Problem focused	99201	
New Patient: Expanded problem focused	99202	
New Patient: Detailed	99203	
New Patient: Comprehensive	99204	
Established Patient: Problem focused	99212	
Established Patient: Expanded problem focused	99213	
Established Patient: Detailed	99214	
<b><i>Treatment</i></b>		
TCA treatment	E946.4	A63.0
Azithromycin (chlamydia)	J0456	A74.9
Bicillin (syphilis)	E930.32	A53.9
Ceftriaxone (gonorrhea)	J0696	A54.9
Doxycycline (syphilis)	E930.4	A53.9
Metronidazole (trich)	S0030	A59.9
<b><i>Allergy Injections</i></b>		
Allergy injection; single injection	95115	
Allergy injection; 2 or more injections	95117	
<b><i>Nutritional Counseling</i></b>		
Nutrition Assessment individual; Initial assessment, each 15 mins	97802	
Nutrition Assessment individual; re-assessment, each 15 mins	97803	
Nutrition Assessment group; Initial assessment, each 15 mins	97804	
<b><i>Special Evaluations &amp; Management Services</i></b>		
Basic life/Disability evaluation	99450	
Work related/Medical Disability	99456	

**9.3 Miscellaneous Services**

**Fees for these services are set by the local County Boards of Health.**

Blood Pressure, Height, and Weight Checks

Copy of Medical Records

Fax Medical Records

General Lab Services

Health Check Services

International Travel Services

Lice and Scabies Checks

Prepare Immunization & Hearing, Vision, Dental Certificates w/o service

Refugee Screening Services

Childcare Provider Physicals

Sports Physicals w/ Certificate

SSI Services

# Section 10

## Laboratory Services

<b>10.1 Laboratory</b>		
<b>Service Description</b>	<b>CPT Code</b>	<b>ICD-10</b>
<b>Services</b>		
2 Hour Glucose	82950	Z86.32
Blood, occult	82270	
Blood lead	83655	
Blood sugar	82948	
Chlamydia trachomatis; amplified probe technique	87491	
Cholesterol, serum or whole blood	82465	
Complete blood count (CBC)	85025	
Finger/Heal stick	36416	
Gastrin	82941	
Glucagon tolerance test	82946	
Glucose	82947	
Glucose, blood by glucose monitoring device	82962	
Gonadotropin, chorionic (HCG); qualitative	84703	
Gonorrhoeae; amplified probe technique	87591	
Handling, conveyance of specimen to lab	99000	
Hematocrit	85013	
Hemoglobin	85018	Z13.0
Hemoglobin; glycosylated (A1C)	83036	Z13.1
HEP C	86803	Z04.9
HIV-1; antibody	86701	
HIV-2; antibody	86702	
HIV-1 and HIV-2; antibody;	86703	Z11.59, Z04.9
HIV-1; infectious agent	87390	
HPV	87624	Z01.419
Pap Smear	88142	
Rubella; antibody	86762	
Smear; wet mount (eg. KOH prep, Fern Test)	87210	N76.0, N72, B37.3
Smear; Gram or Giemsa stain	87205	
Surgical pathology (biopsy)	88305	
Syphilis test (eg. RPR, VDRL, ART)	86592	Z20.2
TB cell mediated immunity response measurement; gamma	86480	
TB skin Test	86580	Z11.1
Tissue exam by KOH, skin, hair, nails	87220	
Urinalysis; with microscopy	81000	R39.9, Z78.9, R82.90
Urinalysis; automated, with microscopy	81001	
Urinalysis; non-automated, without microscopy	81002	
Urinalysis; automated, without microscopy	81003	
Urine pregnancy test, by visual method	81025	Z32.00, Z32.01(+), Z32.02
Venipuncture	36415	

# Section 11

## Appendices

### **11.1 Component Requirements for Office/Home Visits**

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a recognized health care provider and reported by a specific CPT code(s).

A new patient is one who has not received any professional services from the physician, health care provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

**The Level of Service is based on the following Components:** For **all of the key components**, i.e., history, examination, and medical decision-making, must meet or exceed the stated requirements to qualify for a particular level of office visit.

For **two of the three components**, i.e., history, examination, and medical decision-making, must meet or exceed the state requirements to qualify for a particular level of office visit.

When counseling and/or coordination of care dominates more than 50% of the face-to-face encounter, then **time** shall be considered the controlling factor to qualify for a particular level of office visit.

## Component Requirements for Office Visits

Office or Other Outpatient Services					
<b>Patient:</b> New					
<b>Required Components:</b> 3/3					
Code	99201	99202	99203	99204	99205
<b>Required Key Components</b>					
<b>History and Exam (#1 and #2)</b>					
Problem Focused	x				
Expanded Problem Focused		x			
Detailed			x		
Comprehensive				x	x
<b>Medical Decision Making (#3)</b>					
Straightforward	x	x			
Low			x		
Moderate				x	
High					x
<b>Contributory Factors</b>					
<b>Presenting Problem (Severity) (#1)</b>					
Self-Limited or Minor	x				
Low to Moderate		x			
Moderate			x		
Moderate to High				x	x
<b>Counseling and Coordination of Care (#2 and #3) See E/M Guidelines</b>					
<b>Typical Face-to-Face Time (#4)</b>					
Minutes	10	20	30	45	60

Office or Other Outpatient Services					
<b>Patient:</b> Established					
<b>Required Components:</b> 2/3					
Code	99211	99212	99213	99214	99215
<b>Required Key Components</b>					
<b>History and Exam (#1 and #2)</b>					
Problem Focused	N/A	x			
Expanded Problem Focused			x		
Detailed				x	
Comprehensive					x
<b>Medical Decision Making (#3)</b>					
Straightforward	N/A	x			
Low			x		
Moderate				x	
High					x
<b>Contributory Factors</b>					
<b>Presenting Problem (Severity) (#1)</b>					
Minimal	x				
Self-Limited or Minor		x			
Low to Moderate			x		
Moderate to High				x	x
<b>Counseling and Coordination of Care (#2 and #3) See E/M Guidelines</b>					
<b>Typical Face-to-Face Time (#4)</b>					
Minutes	5	10	15	25	40

## Component Requirements for Home Visits

Home Services					
<b>Patient:</b> New					
<b>Required Components:</b> 3/3					
Code	99341	99342	99343	99344	99345
<b>Required Key Components</b>					
<b>History and Exam (#1 and #2)</b>					
Problem Focused	x				
Expanded Problem Focused		x			
Detailed			x		
Comprehensive				x	x
<b>Medical Decision Making (#3)</b>					
Straightforward	x				
Low		x			
Moderate			x	x	
High					x
<b>Contributory Factors</b>					
<b>Presenting Problem (Severity) (#1)</b>					
Low	x				
Moderate		x			
Moderate to High			x		
High				x	
Unstable/Significant New Problem					x
<b>Counseling and Coordination of Care (#2 and #3) See E/M Guidelines</b>					
<b>Typical Face-to-Face Time (#4)</b>					
Minutes	20	30	45	60	75

Home Services					
<b>Patient:</b> Established					
<b>Required Components:</b> 2/3					
Code	99347	99348	99349	99350	
<b>Required Key Components</b>					
<b>Interval History and Exam (#1 and #2)</b>					
Problem Focused	x				
Expanded Problem Focused		x			
Detailed			x		
Comprehensive				x	
<b>Medical Decision Making (#3)</b>					
Straightforward	x				
Low		x			
Moderate			x		
Moderate to High				x	
<b>Contributory Factors</b>					
<b>Presenting Problem (Severity) (#1)</b>					
Self-Limited or Minor	x				
Low to Moderate		x			
Moderate to High			x		
Moderate to High/Unstable/Significant New Problem				x	
<b>Counseling and Coordination of Care (#2 and #3) See E/M Guidelines</b>					
<b>Typical Face-to-Face Time (#4)</b>					
Minutes	15	25	40	60	

**11.2 Vaccine Route of Administration Codes*****Administration without counseling – All ages***

Route	Injection	Route	Oral / Intranasal
CPT Code	Description	CPT Code	Description
90471	Immunization administration by injection; 1 vaccine (single or combination vaccine/toxoid)	90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
+ 90472	Immunization administration by injection; <i>each additional</i> vaccine (single or combination vaccine/toxoid)	+ 90474	Immunization administration by intranasal or oral route; <i>each additional</i> vaccine (single or combination vaccine/toxoid)

***Administration with counseling – 0 – 18 years of age***

Any Route	
CPT Code	Description
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; 1 or only component or each vaccine or toxoid
+ 90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered

***Medicare Administration Codes***

Route	Injection	Route	Oral / Intranasal
CPT Code	Description	CPT Code	Description
90471	Immunization administration by injection; 1 vaccine (single or combination vaccine/toxoid)	90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
+ 90472	Immunization administration by injection; <i>each additional</i> vaccine (single or combination vaccine/toxoid)	+ 90474	Immunization administration by intranasal or oral route; <i>each additional</i> vaccine (single or combination vaccine/toxoid)
G0008	Influenza vaccine administration		
G0009	Pneumococcal vaccine administration		
G0010	Hep B vaccine administration		

### 11.3 RELATED LINKS

Immunization Schedules: <http://www.cdc.gov/vaccines/schedules/index.html>

Advance Beneficiary of Notice and Instructions: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN\\_Booklet\\_ICN006266.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf)

Aetna office manual for healthcare professionals: <https://www.aetnaeducation.com/ihhtml/application/upload/9511.pdf>

AMA: <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance.page>

Amerigroup of Kansas provider representatives: <https://providers.amerigroup.com/pages/ks.aspx>

Amerigroup Provider Manual: [https://providers.amerigroup.com/ProviderDocuments/KSKS\\_Prov\\_Manual.pdf](https://providers.amerigroup.com/ProviderDocuments/KSKS_Prov_Manual.pdf)

Ask-EDI: <http://www.ask-edi.com/>

Availity Log in: <https://apps.availity.com/availity/>

BCBS Health Department Billing Guidelines: <http://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/BPM.shtml>

Blue Cross and Blue Shield of Kansas, Provider Resources: <http://www.bcbsks.com/CustomerService/Providers/>

Centers for Medicare & Medicaid Services: <http://www.cms.gov/>

Cigna: <http://www.cigna.com/>

Coventry Direct Provider: <https://www.directprovider.com/>

Coventry Provider Representative: <http://chckansas.coventryhealthcare.com/services-and-support/providers/provider-rep-territory/index.htm>

Emdeon: <http://www.emdeon.com/>

KMAP training for LHD (Professional) billers: <https://www.kmap-state-ks.us/Public/Provider.asp>

KMAP Publications: <https://www.kmap-state-ks.us/Public/Publications.asp>

Medicare Enrollment and Claim Submission Guidelines: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf>

Medicare (C-SNAP) login: <https://www.medicareinfo.com/apps/cms/home>

Medicare WPS: <http://www.wpsmedicare.com/index.shtml>

Navinet: <https://navinet.navimedix.com/sign-in?ReturnUrl=/Main.asp>

Optum Health Payment Services:  
<https://myservices.optumhealthpaymentservices.com/registrationSignIn.do>

Payspan: <https://www.payspanhealth.com/nps/login.aspx>

Sunflower Manuals and Guides: <http://www.sunflowerhealthplan.com/for-providers/provider-resources/manuals-guides/>

Sunflower State Health Plan Provider Representative Contacts and Territory Map:  
<http://www.sunflowerhealthplan.com/for-providers/provider-resources/>

Sunflower State Health: <https://provider.sunflowerstatehealth.com/>

TransactRx: <https://www.mytransactrx.com>

United Healthcare Community Plan. Click on United Healthcare Provider Contact List and Physical Health Provider Advocate Map: <http://www.uhcommunityplan.com/health-professionals/ks.html>

United Healthcare Approved Provider Administrative Guide:  
<http://www.uhcommunityplan.com/kansas-03.html>

United Healthcare Online: <https://www.unitedhealthcareonline.com/>

WPC – Washington Publishing Company provides reason and remark code sets used to report payment adjustments in remittance advice transactions and in some coordination-of-benefits transactions: <http://www.wpc-edi.com/reference/>

**11.4 ACRONYMS**

ACA	Affordable Care Act	PEC	Pre-existing Condition
AMA	American Medical Association	PHI	Protected Health Information
BCBS	Blue Cross Blue Shield	POS	Place of Service
CMS	Centers for Medicare & Medicaid Services	PPO	Preferred Provider Organization
COB	Coordination of Benefits	PTAN	Provider Transaction Access Number
COBRA	Consolidated Omnibus Budget Reconciliation Act	QMB	Qualified Medicare Beneficiary
CPT	Current Procedural Terminology	RA	Remittance Advice
DCI	Duplicate Coverage Inquiry	RVU	Relative Value Unit
DME	Durable Medical Equipment	SOF	Signature on File
DOB	Date of Birth	TAR	Treatment Authorization Request
DOS	Date of Service	TIN	Tax Identification Number
DX	Diagnosis, or Diagnosis Code (ICD-10)	TOS	Type of Service
EDI	Electronic Data Interchange	TPA	Third Party Administrator
EFT	Electronic Funds Transfer	TPL	Third Party Liability
EIN	Employer Identification Number	UB	Uniform Billing
E/M	Evaluation & Management	UR	Utilization Review
EMR	Electronic Medical Record		
EOB	Explanation of Benefits		
EOP	Explanation of Payment		
EOMB	Explanation of Medicare Benefits		
EPSDT	Early & Periodic Screening, Diagnostic, & Treatment		
ERA	Electronic Remittance Advice		
ERISA	Employee Retirement Income Security Act of 1974		
FFS	Fee-for-Service		
FI	Fiscal Intermediary		
GHP	Group Health Plan		
HC	Health Check		
HCPCS	Healthcare Common Procedure Coding System		
HIC	Health Insurance Claim		
HIPAA	Health Insurance Portability & Accountability Act		
HMO	Health Maintenance Organization		
HSA	Health Savings Account		
ICD-9	International Classification of Diseases, 9 <sup>th</sup> edition		
ICD-10	International Classification of Diseases, 10 <sup>th</sup> edition		
MAC	Medicare Administrative Contractor		
MCO	Managed Care Organization		
MSP	Medicare Secondary Payer		
N/C	Non-Covered Charge		
NDC	Nation Drug Code		
NEC	Not Elsewhere Classifiable		
NOS	Not Otherwise Classifiable		
NPI	National Provider Identifier		
OIG	Office of Inspector General		
PCP	Primary Care Provider		

## 11.5 DEFINITIONS

**ACA** – Affordable Care Act. Also referred to as “ObamaCare”. A federal law enacted in 2010 intended to increase healthcare coverage and make it more affordable.

**Accept Assignment** – When a provider accepts as “full-payment” the amount paid on a claim by the insurance company, excluding the coinsurance, deductible or co-pay due from the patient

**Adjusted Claim** – A claim that has been corrected, due to an error during submission or payment, which results in a credit or payment to the provider

**Allowed Amount** – The reimbursement rate that the insurance company will pay for a procedure.

**AMA** - American Medical Association. The AMA is the largest association of Doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world.

**Aging** - One of the medical billing terms referring to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing software's have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments.

**Appeal** - When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance provider’s web site.

**Applied to Deductible** - You typically see these medical billing terms on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.

**Assignment of Benefits** - Insurance payments that are paid to the doctor or hospital for a patient’s treatment.

**Beneficiary** - Person or persons covered by the health insurance plan.

**Blue Cross Blue Shield (BCBS)** - An organization of affiliated insurance companies (approximately 450), independent of the association (and each other), that offer insurance plans within local regions under one or both of the association's brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit BCBS sometimes acts as administrators of Medicare in many states or regions.

**Capitation** - A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patients’ health care services. This payment is not affected by the type or number of services provided.

**Carrier** – The insurance company or “carrier” the patient has a contract with to provide health insurance

**CHAMPUS** - Civilian Health and Medical Program of the Uniformed Services. Recently renamed TRICARE. This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors.

**Charity Care/Sliding Scale** - When medical care is provided at no cost or at reduced cost to a patient that cannot afford to pay.

**Clean Claim** - Medical billing term for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

**Clearinghouse** - This is a service that transmits claims to insurance carriers. Prior to submitting claims the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPPA standards (this is one of the medical billing terms we see a lot more of lately).

**CMS** - Centers for Medicaid and Medicare Services. Federal agency which administers Medicare, Medicaid, HIPPA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration). You'll notice that CMS is the source of a lot of medical billing terms.

**CMS 1500** - Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on a CMS-1500. The form is distinguished by its red ink.

**Coding** - Medical Billing Coding involves taking the doctors notes from a patient visit and translating them into the proper ICD-10 code for diagnosis and CPT codes for treatment.

**COBRA Insurance** - This is health insurance coverage available to an individual and their dependents after becoming unemployed - either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, It's typically more expensive than insurance the cost when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees dismissed for a. COBRA stands for Consolidated Omnibus Budget Reconciliation Act which was passed by Congress in 1986. COBRA coverage typically lasts up to 18 months after becoming unemployed and under certain conditions extend up to 36 months.

**Co-Insurance** - Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example, the insurance carrier pays 80% and the patient pays 20%.

**Contractual Adjustment** - The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company.

**Coordination of Benefits** - When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

**Co-Pay** - Amount paid by patient at each visit as defined by the insured plan.

**CPT Code** - Current Procedural Terminology. This is a 5 digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding diagnosis code. Established by the American Medical Association. This is one of the medical billing terms we use a lot.

**Credentialing** - This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. CAQH credentialing process is a universal system now accepted by insurance company networks.

**Credit Balance** - The balance that's shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example \$50-). It may also be shown in parenthesis; (\$50). The provider may owe the patient a refund.

**Crossover claim** - When claim information is automatically sent from Medicare the secondary insurance such as Medicaid.

**Date of Service (DOS)** - Date that health care services were provided.

**Deductible** - amount patient must pay before insurance coverage begins. For example, a patient could have a \$1000 deductible per year before their health insurance will begin paying. This could take several doctor's visits or prescriptions to reach the deductible.

**Demographics** - Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.

**DOB** - Abbreviation for Date of Birth

**Downcoding** - When the insurance company reduces the code (and corresponding amount) of a claim when there is no documentation to support the level of service submitted by the provider. The insurers' computer processing system converts the code submitted down to the closest code in use which usually reduces the payment.

**Durable Medical Equipment** - Medical Supplies

**Duplicate Coverage Inquiry (DCI)** - Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists.

**Dx** - Abbreviation for diagnosis, or diagnosis code (ICD-10 code).

**Electronic Claim** - Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver.

**Electronic Funds Transfer (EFT)** - An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks.

**E/M** - Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians or other qualified staff to access (or evaluate) patients' treatment needs.

**EMR** - Electronic Medical Records. This is a medical record in digital format of a patient's hospital or provider treatment.

**Enrollee** - Individual covered by health insurance.

**EOB** - Explanation of Benefits. One of the medical billing terms for the statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles.

**ERA** - Electronic Remittance Advice. This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in according to the HIPAA X12N 835 standard.

**ERISA** - Employee Retirement Income Security Act of 1974. This law established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health. Self-insured plans are regulated by this law.

**Fee For Service** - Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays.

**Fee Schedule** - Cost associated with each treatment CPT medical billing codes.

**Financial Responsibility** - The portion of the charges that are the responsibility of the patient or insured.

**Fiscal Intermediary (FI)** - A Medicare representative who processes Medicare claims.

**Formulary** - A list of prescription drug costs which an insurance company will provide reimbursement for.

**Fraud** - When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.

**GHP** - Group Health Plan. A means for one or more employer who provide health benefits or medical care for their employees (or former employees).

**Group Name** - Name of the group or insurance plan that insures the patient.

**Group Number** - Number assigned by insurance company to identify the group under which a patient is insured.

**Guarantor** - A responsible party and/or insured party who is not a patient.

**HCFA** - Health Care Financing Administration. Now known as CMS (see above in Medical Billing Terms).

**HCPCS** - Health Care Financing Administration Common Procedure Coding System. (Pronounced "hick-picks"). A standardized medical coding system used to describe specific items or services provided when delivering health services. May also be referred to as a "procedure code" in the medical billing glossary. The three HCPCS levels are:

- Level I - American Medical Association's Current Procedural Terminology (CPT) codes.
- Level II - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.
- Level III - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

**Health Savings Account** - A tax advantaged medical savings account available to employees who are enrolled in a High-Deductible health plan. This account is to be used for medical expenses only.

**Healthcare Insurance** - Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. May be an individual policy or family policy which covers the beneficiary's family members. May include coverage for disability or accidental death or dismemberment.

**Healthcare Provider** - Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. Not to be confused with insurance providers or the organization that provides insurance coverage.

**Health Care Reform Act** - Health care legislation championed by President Obama in 2010 to provide improved individual health care insurance or national health care insurance for Americans. Also referred to as the Health Care Reform Bill or the Obama Health Care Plan.

**HIC** - Health Insurance Claim. This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims.

**HIPAA** - Health Insurance Portability and Accountability Act. Several federal regulations intended to improve the efficiency and effectiveness of health care. HIPAA has introduced a lot of new medical billing terms into our vocabulary lately.

**HMO** - Health Maintenance Organization. A type of health care plan that places restrictions on treatments.

**ICD-9 Code** - 9<sup>th</sup> revision of the International Classification of Diseases, also known as ICD-9-CM, is a system used to assign 3 to 5 digit codes to patient diagnoses.

**ICD-10 Code** - 10<sup>th</sup> revision of the International Classification of Diseases, also known as ICD-10-CM, is a system used to assign 3 to 7 digit codes to patient diagnoses. Includes additional digits to allow more available codes. ICD-10 was implemented in October 2015.

**Indemnity** - Also referred to as fee-for-service. This is a type of commercial insurance where the patient can use any provider or hospital.

**In-Network (or Participating)** - An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures.

**MAC** - Medicare Administrative Contractor. Contractors who process Medicare claims.

**Managed Care Plan** - Insurance plan requiring patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area.

**Maximum Out of Pocket** - The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses.

**Medical Assistant** - A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physician's assistant, nurse, nurse practitioner, etc.

**Medical Coder** - Analyzes patient charts and assigns the appropriate CPT and ICD-10 codes, and any related CPT modifiers.

**Medical Billing Specialist** - Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice. Knowledgeable in medical billing terminology.

**Medical Necessity** - Medical service or procedure that is performed on for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental.

**Medical Record Number** - A unique number assigned by the provider or health care facility to identify the patient medical record.

**MSP** - Medicare Secondary Payer.

**Medical Savings Account** - Tax exempt account for paying medical expenses administered by a third party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. Sometimes also referred to in medical billing terminology as a Medical Spending Account.

**Medicare** - Insurance provided by federal government for people over 65 or people under 65 with certain restrictions. There are 4 parts:

- **Medicare Part A** - Hospital coverage
- **Medicare Part B** - Physicians visits and outpatient procedures
- Medicare Advantage Plans, sometimes called **Medicare Part C** or MA Plans, are offered by private companies approved by Medicare.
- **Medicare Part D** - Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B.

**Medicare Coinsurance Days** - Medical billing terminology for inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days."

**Medicare Donut Hole** - The gap or difference between the initial limits of insurance and the catastrophic Medicare Part D coverage limits for prescription drugs.

**Medicaid** - Insurance coverage for low income patients. Funded by Federal and state government and administered by states.

**Medigap** - Medicare supplemental health insurance for Medicare beneficiaries which may include payment of Medicare deductibles, co-insurance and balance bills, or other services not covered by Medicare.

**Modifier** - Added to a CPT treatment code to provide additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them.

**N/C** - Non-Covered Charge. A procedure not covered by the patients' health insurance plan.

**NEC** - Not Elsewhere Classifiable. Medical billing terminology used in ICD when information needed to code the term in a more specific category is not available.

**Network Provider** - Health care provider who is contracted with an insurance provider to provide care at a negotiated cost.

**Non-participation (Non-Par)** - When a healthcare provider chooses not to accept Medicare approved payment amounts as payment in full.

**NOS** - Not Otherwise Specified. Used in ICD for unspecified diagnosis.

**NPI Number** - National Provider Identifier. A unique 10 digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES).

**OIG** - Office of Inspector General - Part of department of Health and Human Services. Establish compliance requirements to combat healthcare fraud and abuse. Has guidelines for billing services and individual and small group physician practices.

**Out-of Network (or Non-Participating)** - A provider that does not have a contract with the insurance carrier. Patients usually responsible for a greater portion of the charges or may have to pay all the charges for using an out-of network provider.

**Out-Of-Pocket Maximum** - The maximum amount the patient has to pay under their insurance policy. Anything above this limit is the insurers' obligation. These Out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.

**Outpatient** - Typically treatment in a physician's office, clinic, or day surgery facility lasting less than one day.

**Patient Responsibility** - The amount a patient is responsible for paying that is not covered by the insurance plan.

**PCP** - Primary Care Physician - Usually the physician who provides initial care and coordinates additional care if necessary.

**POS** - Point-of-Service plan. Medical billing terminology for a flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers. When a non-HMO specialist is seen without referral from the Primary Care Physician (self-referral), they have to pay a higher deductible and a percentage of the coinsurance.

**POS (Used on Claims)** - Place of Service. Medical billing terminology used on medical insurance claims - such as the CMS 1500 block 24B. A two digit code which defines where the procedure was performed. For example 71 is for the Health Departments and 12 is for home.

**PPO** - Preferred Provider Organization. Commercial insurance plan where the patient can use any doctor or hospital within the network. Similar to an HMO.

**Practice Management Software** - software used for the daily operations of a provider's office. Typically used for appointment scheduling and billing.

**Preauthorization** - Requirement of insurance plan for primary care doctor to notify the patient insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense.

**Pre-Certification** - Sometimes required by the patients insurance company to determine medical necessity for the services proposed or rendered. This doesn't guarantee the benefits will be paid.

**Predetermination** - Maximum payment insurance will pay towards surgery, consultation, or other medical care - determined before treatment.

**Pre-existing Condition (PEC)** - A medical condition that has been diagnosed or treated within a certain specified period of time just before the patient's effective date of coverage. A Pre-existing condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months).

**Pre-existing Condition Exclusion** - When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective.

**Premium** - The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage.

**Privacy Rule** - The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health Information (PHI). PHI is any information on a patient about the status of their health, treatment, or payments.

**Provider** - Physician or medical care facility (hospital) who provides health care services.

**PTAN** - Provider Transaction Access Number. Also known as the legacy Medicare number.

**Referral** - When one provider (usually a family doctor) refers a patient to another provider (typically a specialist).

**Relative Value Unit** - Measure of value used by Medicare to determine how much to reimbursement for a procedure by using a formula

**Remittance Advice (R/A)** - A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an EOB (Explanation of Benefits).

**Responsible Party** - The person responsible for paying a patient's medical bill. Also referred to as the guarantor.

**Self-Referral** - When a patient sees a specialist without a primary physician referral.

**Self Pay** - Payment made at the time of service by the patient.

**Secondary Insurance Claim** - claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage.

**Secondary Procedure** - When a second CPT procedure is performed during the same physician visit as the primary procedure.

**Security Standard** - Provides guidance for developing and implementing policies and procedures to guard and mitigate compromises to security. The HIPAA security standard is kind of a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI.

**SOF** - Signature on File.

**Specialist** - Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist.

**Subscriber** - Medical billing term to describe the employee for group policies. For individual policies the subscriber describes the policyholder.

**Superbill** - One of the medical billing terms for the form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-10 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.

**Supplemental Insurance** - Additional insurance policy that covers claims for deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare.

**TAR** - Treatment Authorization Request. An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.

**Taxonomy Code** - Specialty standard codes used to indicate a provider's specialty sometimes required to process a claim.

**Term (Termination) Date** - Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible.

**Tertiary Insurance Claim** - Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover.

**Third Party Administrator (TPA)** - An independent corporate entity or person (third party) who administers group benefits, claims and administration for a self-insured company or group.

**TIN** - Tax Identification Number. Also known as Employer Identification Number (EIN).

**TOP** - Triple Option Plan. An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan.

**TOS** - Type of Service. Description of the category of service performed.

**TRICARE** - This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS.

**UB04** - Claim form for hospitals, clinics, or any provider billing for facility fees similar to CMS 1500. Replaces the UB92 form.

**Unbundling** - Submitting several CPT treatment codes when only one code is necessary.

**Untimely Submission** - Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied.

**Upcoding** - An illegal practice of assigning a diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payer.

**UPIN** - Unique Physician Identification Number. 6 digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

**Utilization Limit** - The limits that Medicare sets on how many times certain services can be provided within a year. The patients claim can be denied if the services exceed this limit.

**Utilization Review (UR)** - Review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures.

**V-Codes** - ICD-9-CM coding classification to identify health care for reasons other than injury or illness.

**Workers Comp** - Insurance claim that results from a work related injury or illness.

**Write-off** - Typically reference to the difference between what the physician charges and what the insurance plan contractually allows and the patient is not responsible for. May also be referred to as "not covered" in some glossary of billing terms.

## 11.6 KALHD Billing List-Serve & Regional Billing Groups

### KALHD Billing List-Serve

The list serve that KALHD moderates is a state-wide forum for billers to ask questions and receive assistance from one another. No question is too simple or too complex. Billers on the list-serve range from first time billers to those with more than 20 years of experience. If you are not on the list serve but would like to be, simply send an email with your name, title, and county to [billing@lists.kalhd.org](mailto:billing@lists.kalhd.org) with a request to join.

Please remember when using the list serve, every email and every reply will go to the whole group. Please keep questions and answers direct and to the point. Please do not reply to the whole group with pleasantries or email unrequested answers. This is not meant to be a deterrent in participation, but for you to be considerate of the amount of emails that we all must manage daily.

### Regional Billing Groups

Regional Billing Groups are designed to help billers connect to one another through regular in-person meetings. MCO and payer reps can and should be invited to these meetings as well as other organizations and representatives who might be able to assist billers. These are self-run groups who will only continue if participation remains valid. Check with your regional rep below if you would like to receive invitations to these groups.

#### North Central Region (Billing Biddies)

Contact: Lenora Henderson, Ellsworth County, [lhenders@eaglecom.net](mailto:lhenders@eaglecom.net) or 785-472-4488

#### Northeast Region (Perpetually Perplexed Pros)

Contact(s): Kathy Ortega, Shawnee County, [Kathy.ortega@snco.us](mailto:Kathy.ortega@snco.us) or 785-251-2469; OR Melinda McIntyre, Johnson County, [Melinda.McIntyre@jocogov.org](mailto:Melinda.McIntyre@jocogov.org) or 913-477-8352

#### Northwest Region (Billers Anonymous)

Contact: Kathy Eilert, Gove County, [k.eilert@gchd.onmicrosoft.com](mailto:k.eilert@gchd.onmicrosoft.com) or 785-938-2335

#### South Central Region (Mission Impossible)

Contact: Donna Kaufman, Reno County, [donna.kaufman@renogov.org](mailto:donna.kaufman@renogov.org) or 620-259-8407

#### Southeast Region (Billers 'R' Us)

Contact: No current meetings or contact

#### Southwest Region (KIPHS User Group)

Contact: Michelle Miller, Haskell County, [mmiller@satantahospital.org](mailto:mmiller@satantahospital.org) or 650-675-8191

# 11.7 State LHD Map

Updated Map: <http://www.kdheks.gov/olrh/download/PublicHealthRegionalAttendanceMap.pdf>

## Local Public Health Regional Attendance Map\*

Revised June 2, 2016

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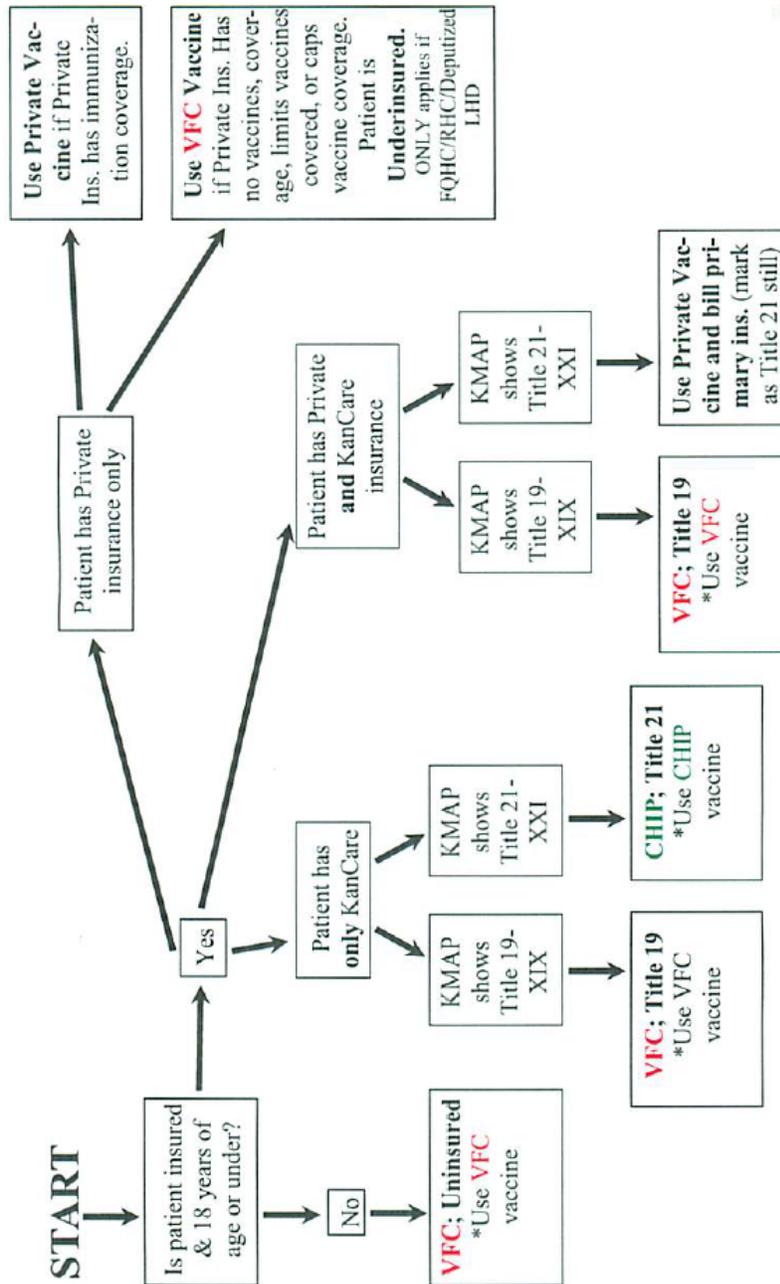
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785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-446-6559	<b>WABANSEE</b> Wabanssee 785-446-6559	<b>LYON</b> Lyon 785-446-6559	<b>OSAGE</b> Osage 785-446-6559	<b>COFFEY</b> Coffey 785-446-6559	<b>WOODSON</b> Woodson 785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-446-6559	<b>WABANSEE</b> Wabanssee 785-446-6559	<b>LYON</b> Lyon 785-446-6559	<b>OSAGE</b> Osage 785-446-6559	<b>COFFEY</b> Coffey 785-446-6559	<b>WOODSON</b> Woodson 785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-446-6559	<b>WABANSEE</b> Wabanssee 785-446-6559	<b>LYON</b> Lyon 785-446-6559	<b>OSAGE</b> Osage 785-446-6559	<b>COFFEY</b> Coffey 785-446-6559	<b>WOODSON</b> Woodson 785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-446-6559	<b>WABANSEE</b> Wabanssee 785-446-6559	<b>LYON</b> Lyon 785-446-6559	<b>OSAGE</b> Osage 785-446-6559	<b>COFFEY</b> Coffey 785-446-6559	<b>WOODSON</b> Woodson 785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-446-6559	<b>WABANSEE</b> Wabanssee 785-446-6559	<b>LYON</b> Lyon 785-446-6559	<b>OSAGE</b> Osage 785-446-6559	<b>COFFEY</b> Coffey 785-446-6559	<b>WOODSON</b> Woodson 785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-446-6559	<b>WABANSEE</b> Wabanssee 785-446-6559	<b>LYON</b> Lyon 785-446-6559	<b>OSAGE</b> Osage 785-446-6559	<b>COFFEY</b> Coffey 785-446-6559	<b>WOODSON</b> Woodson 785-446-6559	<b>WILSON</b> Wilson 785-446-6559	<b>NEOSHO</b> Neosho 785-446-6559	<b>CRAWFORD</b> Crawford 785-446-6559	<b>CHEROKEE</b> Cherokee 785-446-6559	<b>WYANDOTT</b> Wyandott 785-446-6559	<b>JOHNSON</b> Johnson 785-446-6559	<b>DOUGLAS</b> Douglas 785-446-6559	<b>LOUGHEE</b> Lougee 785-446-6559	<b>WYAN</b> Wyan 785-446-6559	<b>DOTTIE</b> Dottie 785-446-6559	<b>SHAWNEE</b> Shawnee 785-4
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11.8 Vaccine Guidance (Private, VFC and CHIP)

**PRIVATE, VFC, and CHIP Vaccine Guidance**



Thank you Thomas CHD for sharing their guidance document which was used to develop this flowchart.

**NOTES:** Blended inventory does not mean can use VFC for CHIP or private. Must use CHIP funded vaccine for CHIP and VFC for VFC. Borrowing only allowed on RARE Emergency basis. Must account for vaccine shipments and doses administered by vaccine funding source (eligibility of child) and use correct funded vaccine.

## 11.9 Common EDI Payer ID's

There are multiple options for EDI in Kansas, including ASK, Availity, KMAP, and individual insurance provider websites. A large collection of EDI payer codes is available from ASK at [http://www.ask-edi.com/edi/edi\\_midwest\\_docs.htm](http://www.ask-edi.com/edi/edi_midwest_docs.htm).

Insurance Company Name	ID	ERA	Notes
WPS (Medicare B)	05202	Y	
Palmetto GBA (Railroad Medicare B)	MR108	Y	(888) 355-9165. EDI enrollment form listed under Payer Enrollment Forms - All or Multiple States. ERA activation can be found within the EDI enrollment form.
Aetna	60054	Y	Customer Service: (888) 632-3862. Pre-Enrollment is required for Electronic Remittance Advice.
Amerigroup RealSolutions	28804	Y	
Amerigroup RealSolutions - KANCARE	27514	N	Coverage: Texas and Kansas. Customer Service: (800) 454-3730
Assurant Health	58730	N	Customer Service: (888) 632-3862
Benefit Management of Kansas	48611		
BlueCross BlueShield of Kansas	47163		Customer Service: (800) 432-3990
BlueCross BlueShield of Nebraska	00076	Y	Customer Service: (888) 592-8961 Pre-Enrollment is required for Electronic Remittance Advice.
Champus	99726		Customer Service: (877) 988-9378. Coverage: KS, NE. Pre-Enrollment is required for Electronic Remittance Advice.
Champva	99726		
Cigna	62308	Y	Customer Service: (800) 468-3510 Pre-Enrollment is required for Electronic Remittance Advice.
Corporate Benefit Services of America	41124	N	Now known as Meritain. Payer ID valid only for claims with a billing submission address of P.O. Box 27267, Minneapolis, MN 55427-0267
Coventry Health Care	25133	Y	Coverage: KS, Customer Service: (301) 581-0600 Pre-Enrollment is required for Electronic Remittance Advice .
Delta Dental of Kansas	CDKS1		
First Health Network	73159	N	
Harrington Health	62061		
Humana	61101	Y	Customer Service: (800) 448-6262 Pre-Enrollment is required for Electronic Remittance Advice.
Medicare of Kansas J5 Part A - UB	05201		
Medicaid of Kansas - J5	05202		
Meritain	41124	N	SEE Corporate Benefit Services of America.
National Telecommunications (NCTA)	52103	N	
Reserve National	73066	N	
Sunflower State Health Plan - KANCARE	68069	Y	Customer Service: (866) 595-8133 ERA enrollment forms will be listed under Centene Corporation.
The Benefit Group	88051	N	
Tricare For Life	TDDIR	Y	
Tricare West Region	99726	Y	Customer Service: (877) 988-9378 Pre-Enrollment is required for Electronic Remittance Advice.
UMR	39026	Y	Customer Service: (877) 233-1800 Pre-Enrollment is required for Electronic Remittance Advice
United Healthcare	87726	Y	Customer Service: (866) 633-2446 Pre-Enrollment is required for Electronic Remittance Advice.
United Healthcare Community Plan of Kansas - KANCARE	96385	Y	Pre-Enrollment is required for Electronic Remittance Advice.

### 11.10 Claim Examples: Medicare, Flu Shot (High Dose)



WPS GHA  
 Claims Department  
 P.O. Box 7238  
 Madison, WI 53707-7238

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

CARRIER

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (DoD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>SMITH, JERRY L.</b>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>123456789A</b>	
3. PATIENT'S BIRTH DATE (MM DD YY) <b>03 01 1945</b>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>	
5. PATIENT'S ADDRESS (No., Street) <b>123 N. MAIN</b>										7. INSURED'S ADDRESS (No., Street)	
CITY <b>TOPEKA</b>				STATE <b>KS</b>				CITY		STATE	
ZIP CODE <b>66612</b>				TELEPHONE (Include Area Code) <b>(785) 296-0000</b>				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. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME										10a. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										4. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 3, 5a, and 5d.	
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 <b>SIGNATURE ON FILE</b> DATE <b>08/01/2016</b>										SIGNED <b>SIGNATURE ON FILE</b>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER 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										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>321586</b>										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind <b>0</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. <b>Z23</b> B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. END		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES	
1 08 01 16 08 01 16 60		60		90662		A		3000		1 NPI 1234567890	
2 08 01 16 08 01 16 60		60		G0008		A		2000		1 NPI 1234567890	
3		60		NPI		NPI		NPI		NPI	
4		60		NPI		NPI		NPI		NPI	
5		60		NPI		NPI		NPI		NPI	
6		60		NPI		NPI		NPI		NPI	
25. FEDERAL TAX I.D. NUMBER <b>481234567</b> SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>12345</b>		27. ACCEPT ASSIGNMENT? (For gen. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>5000</b>		29. AMOUNT PAID \$ <b>0 00</b>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016				32. SERVICE FACILITY LOCATION INFORMATION LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612				33. BILLING PROVIDER INFO & PH # <b>(785) 291-0000</b> LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612			
SIGNED DATE				a. 1234567890		b.		a. 1234567890		b.	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0898-1197 FORM 1500 (02-12)

# Medicare, Pneumonia Shot (Prevnar 13)



WPS GHA  
 Claims Department  
 P.O. Box 7238  
 Madison, WI 53707-7238

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

CARRIER

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (DoD+D#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>123456789A</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>SMITH, JERRY L.</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>03 01 1945</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) <b>123 N. MAIN</b>		7. INSURED'S ADDRESS (No., Street)	
CITY <b>TOPEKA</b> STATE <b>KS</b>		CITY STATE	
ZIP CODE <b>66612</b> TELEPHONE (Include Area Code) <b>(785) 296-0000</b>		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. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10a. CLAIM CODES (Designated by NUCC)	
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 <b>SIGNATURE ON FILE</b> DATE <b>08/01/2016</b>		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 <b>SIGNATURE ON FILE</b>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>319678</b>		20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind <b>0</b> A. <b>Z23</b> B. C. D. E. F. G. H. I. J. K. L.		22. 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. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. SPEC. Fee/Rate I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 08 01 16 08 01 16 60 90670 A 15200 1 NPI 1234567890		2 08 01 16 08 01 16 60 G0009 A 2000 1 NPI 1234567890	
3		4	
5		6	
25. FEDERAL TAX I.D. NUMBER <b>481234567</b> SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>12345</b>	
27. ACCEPT ASSIGNMENT? (For gen. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ <b>17200</b>	
29. AMOUNT PAID \$ <b>000</b>		30. Revised for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016		32. SERVICE FACILITY LOCATION INFORMATION <b>LOCAL HEALTH DEPARTMENT                  201 N. CENTRAL                  TOPEKA, KS 66612</b>	
33. BILLING PROVIDER INFO & PH # <b>(785) 291-0000</b>		34. BILLING PROVIDER INFO & PH # <b>(785) 291-0000</b>	
SIGNED DATE <b>1234567890</b>		SIGNED DATE <b>1234567890</b>	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

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APPROVED OMB-0838-1197 FORM 1500 (02-12)

# Medicare, Flu Shot (High Dose) and Pneumonia Shot (Pneumovax 23)



WPS GH  
 Claims Department  
 P.O. Box 7238  
 Madison, WI 53707-7238

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (DoD+D#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789A							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JERRY L.						3. PATIENT'S BIRTH DATE 03 01 1945			4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME										
5. PATIENT'S ADDRESS (No., Street) 123 N. MAIN CITY: TOPEKA STATE: KS ZIP CODE: 66612 TELEPHONE (Include Area Code): (785) 296-0000						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" 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) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME 4. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 3, 5a, and 5d.										
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: SIGNATURE ON FILE DATE: 08/01/2016						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: SIGNATURE ON FILE													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL				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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 319677						20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. Z23 B. C. D. E. F. G. H. I. J. K. L. ICD Ind: 0						22. 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. END		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. CPT/HCPCS Fee/Rate		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1		08 01 16		08 01 16		60		90662		A		3000		1		NPI		1234567890	
2		08 01 16		08 01 16		60		90670		A		15200		1		NPI		1234567890	
3		08 01 16		08 01 16		60		G0008		A		2000		1		NPI		1234567890	
4		08 01 16		08 01 16		60		G0009		A		2000		1		NPI		1234567890	
5																NPI			
6																NPI			
25. FEDERAL TAX I.D. NUMBER 481234567				SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 12345				27. ACCEPT ASSIGNMENT? (For gen. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 22200		29. AMOUNT PAID \$ 000		30. Reval for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016						32. SERVICE FACILITY LOCATION INFORMATION LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612						33. BILLING PROVIDER INFO & PH # (785) 291-0000 LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612							
SIGNED						DATE						a. 1234567890		b. 1234567890					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0838-1197 FORM 1500 (02-12)

VFC, Multiple Vaccines



AMERIGROUP  
 PO BOX 65199  
 ATTN: CLAIMS CORRESPONDENCE  
 VIRGINIA BEACH, VA 23466

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (DODDoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789A					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JERRY C.						3. PATIENT'S BIRTH DATE 05 26 2016			4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME								
5. PATIENT'S ADDRESS (No., Street) 123 N. MAIN						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)								
CITY TOPEKA				STATE KS		8. RESERVED FOR NUCC USE			CITY		STATE						
ZIP CODE 66612		TELEPHONE (Include Area Code) (785) 296-0000				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 checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>								
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME								
d. INSURANCE PLAN NAME OR PROGRAM NAME						10a. CLAIM CODES (Designated by NUCC)			4. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 3, 5a, and 5d.								
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 SIGNATURE ON FILE DATE 08/01/2016						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 SIGNATURE ON FILE											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QJAL				15. OTHER DATE MM DD YY QJAL				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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 83																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind 0 A. Z23 B. C. D. E. F. G. H. I. J. K. L.																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE ENG		C. PROCEDURE, SERVICE, OR SUPPLIER CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. SPEC. Fee/Rate		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1		08 01 16 08 01 16 71		90681		A		000		1		1D 100000000A		NPI 1234567890			
2		08 01 16 08 01 16 71		90670		A		000		1		1D 100000000A		NPI 1234567890			
3		08 01 16 08 01 16 71		90744		A		000		1		1D 100000000A		NPI 1234567890			
4		08 01 16 08 01 16 71		90698		A		000		1		1D 100000000A		NPI 1234567890			
5		08 01 16 08 01 16 71		90471		A		2000		1		1D 100000000A		NPI 1234567890			
6		08 01 16 08 01 16 71		90472		A		6000		3		1D 100000000A		NPI 1234567890			
25. FEDERAL TAX I.D. NUMBER 481234567				26. PATIENT'S ACCOUNT NO. 12890		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 8000		29. AMOUNT PAID \$ 000		30. Revised NUCC Use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016						32. SERVICE FACILITY LOCATION INFORMATION LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612						33. BILLING PROVIDER INFO & PH # (785) 291-0000 LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612					
SIGNED DATE				a. 1234567890		b.		a. 1234567890		b.							

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APPROVED OMB-0838-1197 FORM 1500 (02-12)

VFC, Flu Mist and HPV



AMERIGROUP  
 PO BOX 65199  
 ATTN: CLAIMS CORRESPONDENCE  
 VIRGINIA BEACH, VA 23466

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (DoD+D#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789A							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JULIAN R.					3. PATIENT'S BIRTH DATE (MM DD YY) 07 13 2001		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		5. PATIENT'S ADDRESS (No., Street) 123 N. MAIN		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				
CITY TOPEKA			STATE KS			8. RESERVED FOR NUCC USE			CITY			STATE					
ZIP CODE 66612			TELEPHONE (Include Area Code) (785) 296-0000			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 checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10a. CLAIM CODES (Designated by NUCC)			11. INSURED'S POLICY GROUP OR FECA NUMBER			a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. RESERVED FOR NUCC USE			c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			b. OTHER CLAIM ID (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME		
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 SIGNATURE ON FILE DATE 08/01/2016				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 SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 54										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind 0 A. Z23 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. 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. PROCEDURE, SERVICE, OR SUPPLIER (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. SPEC. FEE#		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1		08 01 16 08 01 16 71		90675		A		000		1		1D 100000000A		1234567890			
2		08 01 16 08 01 16 71		90651		A		000		1		1D 100000000A		1234567890			
3		08 01 16 08 01 16 71		90473		A		2000		1		1D 100000000A		1234567890			
4		08 01 16 08 01 16 71		90472		A		2000		1		1D 100000000A		1234567890			
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER 481234567				SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 12789		27. ACCEPT ASSIGNMENT? (For gen. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 4000		29. AMOUNT PAID \$ 000		30. Reval for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016						32. SERVICE FACILITY LOCATION INFORMATION LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612						33. BILLING PROVIDER INFO & PH # (785) 291-0000 LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612					
SIGNED		DATE		a. 1234567890		b.		a. 1234567890		b.							

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APPROVED OMB-0838-1197 FORM 1500 (02-12)

STD and Depo



AMERIGROUP  
 PO BOX 65199  
 ATTN: CLAIMS CORRESPONDENCE  
 VIRGINIA BEACH, VA 23466

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA			
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (DoD+D#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JILL P.		3. PATIENT'S BIRTH DATE (MM DD YY) SEX 09 23 1978 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) 123 N. MAIN		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY TOPEKA STATE KS		8. RESERVED FOR NUCC USE		CITY STATE	
ZIP CODE 66612 TELEPHONE (785) 296-0000		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10a. CLAIM CODES (Designated by NUCC)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10a. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 3, 5a, and 5d.	
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 SIGNATURE ON FILE DATE 08/01/2016		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 SIGNATURE ON FILE		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QJAL 15. OTHER DATE (MM DD YY) QJAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 61 20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/> 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind 0 A. Z11.3 B. Z11.59 C. N76.0 D. Z70.8 E. Z30.40 F. Z30.42 G. H. I. J. K. L. 22. 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 CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. SPEC. Fee/Rate I. ID. QJAL. J. RENDERING PROVIDER ID. # 1 08 01 16 08 01 16 71 99213 A 7500 1 1D 100000000A NPI 1234567890 2 N400009074630 Depo ML150 08 01 16 08 01 16 71 J1050 F 2400 150 1D 100000000A NPI 1234567890 3 4 5 6	
25. FEDERAL TAX I.D. NUMBER 481234567 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 11234		27. ACCEPT ASSIGNMENT? (For gen. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE \$ 9900		29. AMOUNT PAID \$ 0 00		30. Revised for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016		32. SERVICE FACILITY LOCATION INFORMATION LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612		33. BILLING PROVIDER INFO & PH # (785) 291-0000 LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612	
SIGNED DATE 1234567890		SIGNED DATE 1234567890		SIGNED DATE 1234567890	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0838-1197 FORM 1500 (02-12)

Exam and Depo



AMERIGROUP  
 PO BOX 65199  
 ATTN: CLAIMS CORRESPONDENCE  
 VIRGINIA BEACH, VA 23466

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6512

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input checked="" type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (DoD) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JILL P.				3. PATIENT'S BIRTH DATE (MM DD YY) 09 23 1978		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		5. PATIENT'S ADDRESS (No., Street) 123 N. MAIN		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)							
8. RESERVED FOR NUCC USE				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 SIGNATURE ON FILE DATE 08/01/2016		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 SIGNATURE ON FILE							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER 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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 73		20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. Z01.419 B. Z11.3 C. Z71.9 D. Z11.59 E. Z30.42 F. G. H. I. J. K. L.				22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY 08 01 16 08 01 16 B. PLACE OF SERVICE 71 S0610 C. PROCEDURE, SERVICE, OR SUPPLIER (Explain Unusual Circumstances) CPT/HCPCS MODIFIER ML150 J1050 D. DIAGNOSIS POINTER A E		F. \$ CHARGES 12000 2400		G. DAYS OR UNITS 1 150		H. ICD-9-CM 1D 1D		I. QUAL. PROVIDER ID. # 100000000A 100000000A			
25. FEDERAL TAX I.D. NUMBER SSN EIN 481234567 <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 11234		27. ACCEPT ASSIGNMENT? (For gen. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 144 00		29. AMOUNT PAID \$ 0 00		30. Revised for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 08/01/2016		32. SERVICE FACILITY LOCATION INFORMATION LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612		33. BILLING PROVIDER INFO & PH # (785) 291-0000 LOCAL HEALTH DEPARTMENT 201 N. CENTRAL TOPEKA, KS 66612	
SIGNED DATE 1234567890				SIGNED DATE 1234567890		SIGNED DATE 1234567890		SIGNED DATE 1234567890		SIGNED DATE 1234567890		SIGNED DATE 1234567890		SIGNED DATE 1234567890					

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APPROVED OMB-0838-1197 FORM 1500 (02-12)

### 11.11 National Drug Code Conversion Table

A National Drug Code (NDC) has three segments:

- The first segment is 5 digits long and is assigned by the Food and Drug Administration (FDA) to identify the facility that manufactures, repacks or distributes the drug product.
- The second segment is 4 digits long and identifies a specific strength, dosage form, and formulation for a particular product.
- The third segment is 2 digits long and identifies package forms and sizes,

Proper billing requires an 11-digit number in the 5-4-2 format. The NDC may be displayed on the package in a 10-digit format. Converting the NDC from 10 to 11 digits requires adding a zero to the beginning of the segment that is too short. The following table shows where to add the zero. The example is shown in bold and underlined solely to illustrate the examples.

**Do not use hyphens when entering the actual data in your claim.**

Converting NDCs from 10 to 11 digits.				
10-Digit Example	11-Digit Example	Actual NDC Conversion		Claim NDC
9999 – 9999 – 99 4 – 4 – 2	<b><u>0</u></b> 9999 – 9999 – 99 5 – 4 – 2	0002-7597-01	<b><u>0</u></b> 0002-7597-01	00002759701
99999 – 999 – 99 5 – 3 – 2	99999 – <b><u>0</u></b> 999 – 99 5 – 4 – 2	50242-040-62	50242- <b><u>0</u></b> 040-62	50242004062
99999 – 9999 – 9 5 – 4 – 1	99999 – 9999 – <b><u>0</u></b> 9 5 – 4 – 2	60575-4112-1	60575-4112- <b><u>0</u></b> 1	60575411201