MARYLAND MEDICAL ASSISTANCE

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM AUDIOLOGY PROVIDER MANUAL

July 2011

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Purpose

The purpose of this manual is to provide policy and billing instructions for Medical Assistance providers who bill on the CMS 1500/837P claim format and are reimbursed under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Audiology fee schedule. To review regulations for the EPSDT Audiology Services, you may go to: www.dsd.state.md.us (COMAR 10.09.51).

Overview

Audiologist and hearing aid service coverage is limited to Maryland Medicaid's EPSDT Program population (20 years of age or younger) who are at risk for hearing impairment. At risk for hearing impairment means the condition of a recipient with a suspect or positive hearing screening.
As of November 1999, audiologist and hearing aid dispenser services for the EPSDT population were "carved out" from the managed care organization (MCO) payment system. These services were placed back into Maryland Medicaid's fee-for-service (FFS) system of payment. The recipient *does not* have to receive a preauthorization or referral from the MCO before visiting an audiologist for evaluation and/or treatment. Maryland Medicaid requires preauthorization on certain services. In order to determine which service requires preauthorization, review the attached fee schedule for audiology services.

Covered Services

All services for which reimbursement is sought must be provided in accordance with the Maryland Medical Assistance EPSDT Audiology Services (COMAR 10.09.51).

The Program covers the following medically necessary audiological services for EPSDT recipients who are risk for hearing impairment:

1) Audiological assessments;

2) Electrophysiological measures such as auditory brainstem response (ABR), otoacoustic emissions, and brainstem auditory evoked response for recipients, when one of the following criteria is met:

(a) Failure of the recipient to provide consistent behavioral responses to auditory signals, using procedures appropriate for the recipient's developmental age;

(b) Presence of neuromotor involvement or behavioral disorder, or both, which precludes observation of consistent behavioral responses;

(c) Failure to respond to test signal intensities appropriate for the recipient's developmental age, using developmentally appropriate test procedures;

(d) Presence of inconsistencies in the results of tests administered during the audiological assessment which suggest, but do not define, a hearing impairment;

(e) The Infant High Risk Questionnaire delineates a need; or

(f) A physician refers the infant for the service;

3) Hearing aid evaluations; and

4) All services as listed on the Audiology Procedure Code and Fee Schedule, Revision 2010 contained in the EPSDT Audiology Provider Manual dated November 1, 2010.

B. Medically necessary hearing aid services, as follows:

1) Hearing aids which are:

(a) Not used or rebuilt, and which meet the current standards set forth in 21 CFR §§801.420 and 801.421, which are incorporated by reference,

(b) Recommended and fitted by an audiologist in conjunction with written medical clearance from a physician who has performed a medical examination within 6 months,

(c) Sold on a 30-day trial basis,

(d) Fully covered by a repair warranty for a period of 2 years, at least 1 year of which is provided by the manufacturer at no cost to the Program, and

(e) Insured for loss or theft for a period of 2 years per hearing aid; and

2) Hearing aid accessories and services, as listed below:

(a) Ear molds,

(b) Batteries,

(c) Chest harnesses or belts,

(d) Replacement receivers and cords,

(e) Tone hooks,

(f) Huggie aids,

(g) Protective coverings for hearing aids,

(h) Battery testers,

(i) Dehumidification kits,

(j) Hearing aid stethoscopes,

(k) Other amplification-related items recommended by an audiologist,

(l) Routine follow-ups and adjustments,

(m) Repairs after all warranties have expired,

(n) Insurance policies as required by §B(1)(c) and (d) of this regulation, and

(o) Extended repair warranties.

Service Limitations

A. Covered audiology and postoperative cochlear implant services are limited to:

(1) Recipients under 21 years old who are referred for the service or have had cochlear implant surgery;

(2) One audiological assessment per year, unless the time limitations are waived by the Program;

(3) One monaural or binaural hearing aid every 3 years unless the Program approves more frequent replacement;

(4) Replacement of hearing aids that have been lost, stolen, or damaged beyond repair, after all warranties and insurance policies have expired;

(5) Repairs and replacements that take place after all warranties and insurance policies have expired;

(6) A maximum of 48 batteries per recipient per year for a monaural hearing aid, or 96 batteries per recipient per year for a binaural hearing aid, purchased from the Department not more frequently than every 6 months, and in quantities of 24 or fewer for a monaural hearing aid, or 48 or fewer for a binaural hearing aid;

(7) A maximum of 476 disposable batteries for a cochlear implant per calendar year, purchased every 6 months in quantities of 238 or fewer.

(8) Two replacement cochlear implant component rechargeable batteries per 12-month period;

(9) Two cochlear implant replacement transmitter cables per 12-month period;

(10) Two cochlear implant replacement headset cables per 12-month period; and

(11) Charges for routine follow-ups and adjustments which occur more than 60 days after the dispensing of a new hearing aid.

B. Services which are not covered are:

(1) Services not medically necessary;

(2) Hearing aids and accessories not medically necessary;

(3) Cochlear implant services and external components not medically necessary;

(4) Cochlear implant audiological services and external components provided less than 90 days after the surgery or covered through initial reimbursement for the implant and the surgery;

(5) Spare or backup cochlear implant speech processors;

(6) Upgrades to new generation hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;

(7) Replacement of hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;

(8) Spare or backup hearing aids, equipment, or supplies;

(9) Repairs to spare or backup hearing aids, equipment, or supplies;

(10) Investigational, experimental, or ineffective services or devices, or both;

(11) Educationally or socially needed services or equipment;

(12) Replacement of improperly fitted ear mold or ear molds unless:

(a) Replacement service is administered by someone other than the original provider; and

(b) Replacement service has not been claimed before;

(13) Additional professional fees and overhead charges for a new hearing aid when a dispensing fee claim has been made to the Program; and

(14) Loaner hearing aids.

Eligibility Verification System – (EVS)

The Eligibility Verification System (EVS) is a telephone inquiry system that enables health care providers to verify quickly and efficiently a Medicaid recipient's current eligibility status. Medicaid eligibility should be verified on EACH DATE OF SERVICE *prior* to rendering services. Although Medicaid eligibility validation via the Program's EVS system is not required, it is to your advantage to do so to prevent the rejection of claims for services rendered to a canceled/non-eligible recipient. ***Before* rendering a Medicaid service, verify the recipient's eligibility *on the date of service* via the Program's Eligibility Verification System (EVS) 1-866-710-1447.**

If you need additional EVS information, please call the Provider Relations Unit at 410-767-5503 or 800-445-1159. EVS is an invaluable tool that is fast and easy to use.

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application, is now available at www.emdhealthchoice.org. The provider must be enrolled in eMedicaid in order to access the web EVS system. For additional information view the website or contact 410-767-5340 for provider application support.

Preauthorization Requirements

A. The Department shall issue preauthorization for EPSDT Audiology Services when the provider:

(1) Meets Program procedures and limitations; and

(2) Submits to the Department adequate documentation demonstrating that the services to be preauthorized are necessary, as stated in COMAR 10.09.23.07.

B. The Program requires preauthorization for the following audiology services:

(1) Certain hearing aids;

(2) Unlisted hearing aid accessories; and

(3) Unlisted post-cochlear implant external components.

C. Preauthorization for audiology services expires 6 months from the authorized span of time that is issued by the Department and is valid if the recipient is eligible at the time the service is rendered to the recipient.

D. The following written documentation shall be submitted by the provider with each new hearing aid that requires preauthorization:

(1) Audiology report;

(2) Audiogram; and

(3) Written medical approval by a physician.

A preauthorization request for EPSDT audiologist or hearing aid dispenser service is submitted on form DHMH 4525. The provider must complete, sign (original signature from the audiologist or hearing aid dispenser is required) and mail to the address listed on the form *prior* to rendering the service to the recipient to ensure coverage. It is imperative that correct procedure codes be placed on the request form. Incorrect or omitted information will result in a rejected request.

Determination of authorization is issued via a letter after the receipt and review of the request (form DMHM-4525) has taken place. A copy of the notification letter is sent to the provider as well as to the recipient.

Billing Information

Services such as developmental screens or pure tone audiologic screening tests provided by a physician or nurse practitioner to identify children who need a referral for further evaluation are not billable to the Medical Assistance Program. These screening tests remain the responsibility of the child's MCO and need to be provided within the MCO'S guidelines. Newborn hearing screens, in or out of the hospital, also remains under the MCO payment system.

Payment Procedures

Providers shall submit requests for payment for Audiology services as stated in COMAR 10.09.36. A copy of the EPSDT: Audiology Services Procedure Code and Fee Schedule can be viewed by visiting the following Program website:

www.dhmh.state.md.us/mma/providerinfo

A. Providers shall submit requests for payment for audiology services as stated in COMAR 10.09.36.04.

B. The Audiology Procedure Code and Fee Schedule, Revision 2010 is incorporated by reference and is contained in the EPSDT Audiology Provider Manual dated November 1, 2010.

C. Audiologists, audiological centers, and hearing aid dispensers shall charge the Program usual and customary charges, not exceeding those charged to the general public for similar professional services.

D. The provider shall charge the Program the acquisition cost for certain hearing aids, accessories, external cochlear implant accessories, and supplies.

E. The provider shall itemize all hearing aid and external cochlear implant charges including accessories, supplies, shipping or handling, or both, insurance, and warranties.

F. The provider shall submit the request for payment on the form designated by the Department.

G. The provider may not bill the Department for:

(1) Completion of forms and reports;

(2) Broken or missed appointments;

(3) Professional services rendered by mail or telephone; and

(4) Services provided at no charge to the general public.

H. Audiological centers licensed as a part of a hospital may charge for and be reimbursed according to rates approved by the Health Services Cost Review Commission (HSCRC), set forth in COMAR 10.37.03.

I. The provider shall refund to the Program payment for hearing aids, supplies, or both, that have been returned to the manufacturer.

J. The provider shall give the Program the full advantage of any and all manufacturer's warranty and trade-ins offered on hearing aids, equipment, or both.

K. The Program shall reimburse for covered services at the lower of:

(1) The provider's usual and customary charge to the general public; or

(2) The Program's fee schedule; or

(3) The provider's acquisition cost.

The Health Insurance Portability and Accountability Act Of 1996(HIPAA) and NPI

HIPAA is the Health Insurance Portability and Accountability Act. HIPAA requires that standard electronic health transactions be used by health plans, including private, commercial, Medicaid and Medicare, healthcare clearinghouses and health care providers. The intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. More information on HIPAA can be found at: www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.htm.

The National Provider Identifier (NPI) is a 10 digit, numeric identifier that does not expire or change. It is administered by CMS and is required by HIPAA. The NPI will replace all of your existing provider numbers that you use to bill Medicaid, Medicare and other health care payers.

If you have not applied for your NPI, please do so at once and report it to us. You should be using the NPI as the primary identifier and your Medicaid Provider number as the secondary identifier on all paper and electronic claims.

FREQUENTLY REQUESTED TELEPHONE NUMBERS

Audiology Policy/Coverage Issues	**(410) 767-1903**
Healthy Start/Family Planning Coverage	**(800) 456-8900**
MD Medicaid Children's Services	**(410) 767-1903**
REM Program	**(800) 565-8190**
Eligibility Verification System (EVS)	**(866) 710-1447**
BD of Audiologists/Hearing Aid Dispensers/Speech Language Pathologists	**(410) 764-4725**
Provider Enrollment P.O. Box 17030 Baltimore, MD 21203	**(410) 767-5340**
Provider Relations P.O. Box 22811 Baltimore, MD 21203	**(410) 767-5503 (800) 445-1159**
Missing Payment Voucher/Lost or Stolen Check	**(410) 767-5503**
Third Party Liability/Other Insurance	**(410) 767-1771**
Recoveries	**(410) 767-1783**

Attachment A

Audiology Procedure Codes and Fee Schedule July 2011

KEY

***** **REQUIRES PREAUTHORIZATION FOR ALL RECIPIENTS**

****** **REQUIRES PREAUTHORIZATION FOR RECIPIENTS 3 YEAR S OLD AND OLDER**

A/C ACQUISITION COST TO THE PROVIDER [PROVIDER MUST BILL ACQUISITION COST]
B/R BY REPORT-ATTACH AUDIOLOGY REPORT, AUDIOGRAM, MEDICAL CLEARANCE & INVOICE TO CLAIM
I/C INDIVIDUAL CONSIDERATION

Audiology Services

PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS (DO NOT REPORT 92567 OR 92568 IN ADDITION TO 92550)	$35.00
92551	SCREENING TEST, PURE TONE, AIR ONLY	$7.82
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	$ 18.58
92557	COMPREHENSIVE AUDIOMETRY- PURE TONE, AIR AND BONE, AND SPEECH THRESHOLD AND DISCRIMINATION - **ANNUAL AUDIOLOGICAL ASSESSMENT** *(annual limitation may be waived if medically necessary and appropriate)*	$ 46.80
92567	TYPANOMETRY (IMPEDANCE TESTING) (DO NOT REPORT 92550 OR 92568 IN ADDITION TO 92567)	$ 20.00
92568	ACOUSTIC REFLEX TESTING; threshold (DO NOT REPORT 92550 OR 92567 IN ADDITION TO 92568)	$ 16.22
92570	ACOUSTIC IMMITTANCE TESTING (INCLUDES TYMPANOMETRY ACOUSTIC RELEX THRESHOLD AND ACOUSTIC REFLEX DECAY TESTING**)**	$50.00
92585	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR) COMPREHENSIVE	$140.00
92586	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR)-LIMITED	$70.00
92587	EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT ORDISTORTION PRODUCTS)	$50.00
92588	EVOKED OTOACOUSTIC EMISSIONS; COMPREHENSIVE (COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)	$75.00
92601	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, PATIENT UNDER 7 YEARS OF AGE; WITH PROGRAMMING	$140.40
92602	SUBSEQUENT REPROGRAMMING (DO NOT REPORT 92602 IN ADDITION TO 92601)	$ 96.30
92603	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, AGE 7 YRS OR OLDER, WITH PROGRAMMING	$108.84
92604	SUBSEQUENT REPROGRAMMING (DO NOT REPORT 92604 IN ADDITION TO 92603)	$65.33
92620	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; INITIAL 60 MINUTES	$50.00
V5299	HEARING SERVICE, MISCELLANEOUS (Procedure not listed; service not typically covered, request for consideration. Documentation demonstrating medical necessity required– to be submitted with preauthorization request.)	I/C*

HEARING AID AND COCHLEAR IMPLANT CODES AND SUPPLIES

PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
92590	HEARING AID EXAMINATION AND SELECTION; MONAURAL	$78.00
92591	HEARING AID EXAMINATION AND SELECTION; BINAURAL	$78.00
92592	HEARING AID CHECK; MONAURAL	$42.00
92593	HEARING AID CHECK, BINAURAL	$42.00
L8614	COCHLEAR DEVICE/SYSTEM (LIMITED EXTERNAL REPLACEMENT COMPONENTS)	B/R*
L8615	COCHLEAR IMPLANT HEADSET/HEADPIECE, REPLACEMENT	$450
L8616	COCHLEAR IMPLANT MICROPHONE, REPLACEMENT	$300
L8617	COCHLEAR IMPLANT TRANSMITTING COIL, REPLACEMENT	$250
L8618	COCHLEAR IMPLANT TRANSMITTER CABLE, REPLACEMENT	$95.00
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR (LIMITED TO NON-REPAIRABLE OUT OF WARRANTY CASES)	A/C*
L8621	COCHLEAR IMPLANT, BATTERY, ZINC AIR, REPLACEMENT	$ 1.56
L8622	COCHLEAR IMPLANT, BATTERY, ALKALINE, REPLACEMENT	$ 1.56
L8623	COCHLEAR IMPLANT SPEECH PROCESSOR LITHIUM ION BATTERY, (REPLACEMENT)	$150
L8624	COCHLEAR IMPLANT SPEECH PROCESSOR LITHIUM ION BATTERY, EAR (REPLACEMENT)	$165
V5030	BODY WORN, AIR CONDUCTION HEARING AID	B/R
V5040	BODY WORN, BONE CONDUCTION HEARING AID	$2500
V5050	MONAURAL, IN THE EAR	$350
V5060	MONAURAL BEHIND THE EAR AIDS (SPECIFY)	$350
V5080	GLASSES, BONE CONDUCTION	A/C*
V5100	BODY WORN, BILATERAL	B/R
V5120	BODY, BINAURAL	B/R
V5130	IN THE EAR, BINAURAL	$700
V5140	BEHIND THE EAR, BINAURAL (SPECIFY)	$700
V5150	GLASSES, BINAURAL	A/C*
V5170	CROS, IN THE EAR	$1600
V5180	CROS, BEHIND THE EAR	$1190
V5190	CROS, GLASSES	A/C*

PROCEDURE CODE	**BRIEF DESCRIPTION**	**MAXIMUM FEE**
V5210	BICROS, IN THE EAR	$1190
V5220	BICROS, BEHIND THE EAR	$1190
V5230	BICROS, GLASSES	A/C*
V5242	ANALOG, MONAURAL, CIC (COMPLETELY IN THE EAR CANAL)	A/C*
V5243	ANALOG, MONAURAL, ITC (IN THE CANAL)	A/C*
V5244	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, CIC	A/C*
V5245	DIGITALLY PROGRAMMABLE ANALOG MONAURAL, ITC	A/C*
V5246	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, ITE (IN THE EAR)	A/C*
V5247	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, BTE (BEHIND THE EAR)	$900
V5248	ANALOG, BINAURAL, CIC	A/C*
V5249	ANALOG, BINAURAL, ITC	A/C*
V5250	DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, CIC	A/C*
V5251	DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, ITC	A/C*
V5252	DIGITALLY PROGRAMMABLE, BINAURAL, ITE	$1900
V5253	DIGITALLY PROGRAMMABLE, BINAURAL, BTE	$1900
V5254	DIGITAL, MONAURAL, CIC	A/C*
V5255	DIGITAL, MONAURAL, ITC	A/C*
V5256	DIGITAL, MONAURAL, ITE	$950
V5257	DIGITAL, MONAURAL, BTE	$950
V5258	DIGITAL, BINAURAL, CIC	A/C*
V5259	DIGITAL, BINAURAL, ITC	A/C*
V5260	DIGITAL, BINAURAL, ITE	$1900
V5261	DIGITAL, BINAURAL, BTE	$1900
V5160	DISPENSING FEE+, BINAURAL	$175.00
V5200	DISPENSING FEE+, CROS	$106.00
V5240	DISPENSING FEE+, BICROS	$106.00
V5241	DISPENSING FEE +, MONAURAL	$106.00
V5264	EAR MOLD, NOT DISPOSABLE, (LIMITATION = UP TO 2 PER MONAURAL/4 PER BINAURAL PER YEAR)	$ 27.00
V5266	REPLACEMENT BATTERY FOR USE IN HEARING DEVICE MAXIMUM 48 PER YEAR FOR MONAURAL MAXIMUM 96 PER YEAR FOR BINAURAL	$ 1.56
V5267	HEARING AID SUPPLIES /ACCESSORIES *(Medically necessary and effective services. Note: prophylactic ear protection - a copy of the signed Rx from the primary care*	A/C*

	doctor, and a documented history of tympanostomy tube must be on file.)	
V5014	REPAIR/MODIFICATION OF A HEARING AID ***(Extended warranty period for aid has expired. Note: Regulations stipulate that new aids be fully covered by a repair warranty and insured for loss or theft for a period of 2 years per hearing aid.)***	$250
X0103	HEARING AID INSURANCE/WARRANTY	$150
99002	HANDLING/CONVEYANCE SERVICE FOR DEVICES	$15

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
AUDIOLOGY SERVICES

SECTION I - Patient Information

Medicaid Number I ___I ___I ___ I___I ___I ___I ___I ___I ___I ___I ___I

Name_____ DOB_____ Sex_____ Telephone (____)_____
(Last) (First) (MI)

Address_____

SECTION II - Preauthorization General Information

Pay to Provider Number I___I ___ I___I___I ___I ___I___ I___ I___I

Name _____ Request Date _____

Address _____

Contact _____ Telephone (_____) _____

Provider's Signature _____

SECTION III - Additional Preauthorization Information

Prescribing Audiologist Provider Number I___ I___ I___ I___ I___I ___ I___I ___I ___I

Name _____Telephone (____) _____

Address _____

SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	MOD	REQUESTED UNITS	AMOUNT	DATES OF SERVICE FROM	THRU	AUTHORIZED UNITS	AMOUNT
_____	_____	____	____	$_____	___/___/___	___/___/___	_____	_____
_____	_____	____	____	$_____	___/___/___	___/___/___	_____	_____
_____	_____	____	____	$_____	___/___/___	___/___/___	_____	_____

PREAUTHORIZATION NUMBER

|___| ___ |___ |___| ___ |___| ___ |___| ___ |___| ___|

SUBMIT TO: Office of Operations and Eligibility Services

Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

DOCUMENT CONROL NUMBER
(STAMP HERE)

DHMH 4525 Rev.3/97
SEE REVERSE SIDE
PA- 1

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
AUDIOLOGY SERVICES

SECTION V - Specific Program Preauthorization Information

Patient Location: Home___ Nursing Home ___ Hospital Inpatient___ Discharge Date _____

Address where equipment will be used (if different from Above):

_____

_____

_____

Period of time required:

_____

MFGR	MODEL/PRODUCT	SINGLE UNIT	AMT. PKG
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____

Diagnosis and Present Physical Condition _____

Prognosis _____

Treatment Plan _____

Expected Therapeutic Effect _____

_____

SECTION VI (DHMH USE ONLY)

_____Approved _____Denied

REASON (S) _____

Medical Consultant's Signature _____ Date _____

PA-2

Attachment C

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA ☐☐☐ PICA ☐☐☐

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete item 9 a-d.*	

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

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