To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

Table of Contents

1.0 Description of the Procedure, Product, or Service ................................................................. 1
  1.1 Definitions .......................................................................................................................... 1

2.0 Eligibility Requirements ............................................................................................................... 1
  2.1 Provisions .......................................................................................................................... 1
    2.1.1 General ................................................................................................................... 1
    2.1.2 Specific .................................................................................................................. 1
  2.2 Special Provisions ............................................................................................................... 2
    2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid
         Beneficiary under 21 Years of Age ........................................................................ 2
    2.2.2 EPSDT does not apply to NCHC beneficiaries .................................................. 3
    2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through
         18 years of age ....................................................................................................... 3

3.0 When the Procedure, Product, or Service Is Covered ........................................................... 3
  3.1 General Criteria Covered .................................................................................................... 3
  3.2 Specific Criteria Covered .................................................................................................... 3
    3.2.1 Specific criteria covered by both Medicaid and NCHC ........................................ 3
    3.2.2 Medicaid Additional Criteria Covered ................................................................... 4
    3.2.3 NCHC Additional Criteria Covered ...................................................................... 4

4.0 When the Procedure, Product, or Service Is Not Covered .................................................. 5
  4.1 General Criteria Not Covered ............................................................................................. 5
  4.2 Specific Criteria Not Covered ............................................................................................. 5
    4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC ............................ 5
    4.2.2 Medicaid Additional Criteria Not Covered ....................................................... 5
    4.2.3 NCHC Additional Criteria Not Covered ............................................................ 5

5.0 Requirements for and Limitations on Coverage ................................................................. 6
  5.1 Prior Approval .................................................................................................................... 6
  5.2 American Dental Association Guidelines ........................................................................ 6
  5.3 Limitations or Requirements ............................................................................................... 6
    5.3.1 Diagnostic: Clinical Oral Evaluation ..................................................................... 6
    5.3.2 Preventive: Topical Fluoride Treatment (Office Procedure) ................................. 7
    5.3.3 Request for Special Approval of a Non-Covered Service or Service Outside the
         Policy Limitations .................................................................................................. 7

6.0 Providers Eligible to Bill for the Procedure, Product, or Service ........................................ 8
  6.1 Provider Qualifications ....................................................................................................... 8
    6.1.1 Conditions of Participation ................................................................................... 8
  6.2 Provider Certifications ....................................................................................................... 8
    6.2.1 Provider Training and Continuing Education ...................................................... 8
7.0 Additional Requirements ................................................................................................................. 8
7.1 Compliance .................................................................................................................................................. 8
  7.1.1 Record Retention ......................................................................................................................... 9
7.2 Oral Screening Requirements .............................................................................................................. 9
7.3 Application of the Fluoride Varnish .................................................................................................... 9
7.4 Health Record Documentation ............................................................................................................ 9

8.0 Policy Implementation/Revision Information ......................................................................................... 10

Attachment A: Claims-Related Information ............................................................................................... 11
  A. Claim Type ................................................................................................................................................ 11
  B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) ...................... 11
  C. Code(s) ............................................................................................................................................... 11
  D. Modifiers .............................................................................................................................................. 11
  E. Billing Units ......................................................................................................................................... 11
  F. Place of Service ................................................................................................................................. 11
  G. Co-payments ...................................................................................................................................... 12
  H. Reimbursement ............................................................................................................................... 12

Attachment B: Examples for Filing Physician Fluoride Varnish Claims (CMS-1500 Claim Forms)...... 13
1.0 Description of the Procedure, Product, or Service
Physician fluoride varnish services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations hereinafter specified. Only the procedure codes listed in this policy are covered under the N.C. Medicaid Physician Fluoride Varnish Program.

The Division of Medical Assistance (DMA) has adopted procedure codes and descriptions as defined in the most recent edition of Current Dental Terminology (CDT 2015).

1.1 Definitions
None Apply.

2.0 Eligibility Requirements
2.1 Provisions
2.1.1 General
(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in Section 3.0 of this policy.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific
(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid
   None Apply.

b. NCHC
   NCHC beneficiaries are not eligible for physician fluoride varnish services.
2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing
**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within Section 3.0 of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

---

**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

**3.2 Specific Criteria Covered**

**3.2.1 Specific criteria covered by both Medicaid and NCHC**

None Apply.
3.2.2 Medicaid Additional Criteria Covered

Medicaid covers a total of six oral screening packages (examination, preventive oral health and dietary counseling, and application of fluoride varnish) per beneficiary from the time of tooth eruption until the child is 3½ years of age. These services can be provided at well-child checkups, during a sick visit, or at a separately scheduled visit.

Example of Oral Screening Preventive Package Visits

<table>
<thead>
<tr>
<th>Well-Child Visit (months)</th>
<th>Procedure Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Yes (if teeth are erupted)</td>
</tr>
<tr>
<td>9</td>
<td>Yes (if teeth are erupted)</td>
</tr>
<tr>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>24</td>
<td>Yes</td>
</tr>
<tr>
<td>36</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Begin providing the services as soon as the first teeth erupt. If services are provided at the 6- or 9-month well-child checkup, providers must wait at least 60 calendar days before providing the service again. Ideally, the service should be performed every 3 to 6 months; however, flexibility is allowed to permit scheduling in conjunction with visits for other health services. Please note that the service can be provided until the beneficiary reaches age 3½ (or through age 41 months) since typically the 36-month well-child visit does not occur until after the beneficiary’s third birthday.

3.2.3 NCHC Additional Criteria Covered

None Apply.
4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in Section 2.0;

b. the beneficiary does not meet the criteria listed in Section 3.0;

c. the procedure, product, or service duplicates another provider’s procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover physician fluoride varnish services when the criteria specified in Sections 3.0 and 5.0 of this policy have not been met.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”
5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for physician fluoride varnish services.

5.2 American Dental Association Guidelines

Only topical fluoride varnish materials professionally applied as recommended by the guidelines of the American Dental Association Council on Scientific Affairs are accepted for use in the dental care of Medicaid beneficiaries. Specific use of these materials must follow the ADA Council on Scientific Affairs guidelines.

5.3 Limitations or Requirements

By State legislative authority, NC Medicaid applies service limitations to ADA procedure codes as they relate to individual beneficiaries. These service limitations are applied without modification of the ADA procedure description. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*) beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid beneficiary under age 21. Refer to Subsection 5.3.3 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations.

CDT 2015 (including procedure codes, descriptions, and other data) is copyrighted by the American Dental Association. © 2014 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

5.3.1 Diagnostic: Clinical Oral Evaluation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver  
* replaced procedure codes D0150, D0120, and D1330 effective January 1, 2007  
* includes early caries screening, evaluation of caries susceptibility, and recording of other notable findings in the oral cavity  
* includes preventive oral health and dietary counseling with the primary caregiver  
* includes prescribing a fluoride supplement, if needed  
* must be billed in conjunction with D1206  
* limited to beneficiaries under 3½ years of age  
* allowed once every 60 calendar days  
* limited to six times prior to the beneficiary reaching 3½ years of age  
* procedure code D1206 must be billed on the detail line before D0145 |
5.3.2 Preventive: Topical Fluoride Treatment (Office Procedure)

Topical fluoride must be applied to all teeth erupted on the date of service. Medicaid will only allow reimbursement for this procedure when teeth are present and fluoride varnish is applied to the teeth.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
<tr>
<td></td>
<td>* replaced procedure code D1203 effective January 1, 2007</td>
</tr>
<tr>
<td></td>
<td>* must be billed in conjunction with D0145</td>
</tr>
<tr>
<td></td>
<td>* limited to beneficiaries under 3½ years of age</td>
</tr>
<tr>
<td></td>
<td>* allowed once every 60 calendar days</td>
</tr>
<tr>
<td></td>
<td>* limited to six times prior to the beneficiary reaching 3½ years of age</td>
</tr>
<tr>
<td></td>
<td>* procedure code D1206 must be billed on the detail line before D0145</td>
</tr>
</tbody>
</table>

5.3.3 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid beneficiary under age 21. All such requests must be submitted in writing prior to delivery of the service. The request must include:

a. a completed CMS-1500 claim form,

b. any materials needed to document medical necessity (e.g., radiographs, photographs), and

c. the completed Non-Covered State Medicaid Plan Services Request Form (for beneficiaries under 21 years of age) or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

Requests should be mailed to:

Assistant Director  
Clinical Policy and Programs  
Division of Health Benefits  
NC Medicaid  
2501 Mail Service Center  
Raleigh, NC 27699-2501  
FAX: 919-715-7679

If the procedure(s) receives special approval and the beneficiary is Medicaid-eligible on the date the service is rendered, the provider then can file for reimbursement.
Note: A copy of the Non-Covered State Medicaid Plan Services Request Form (for beneficiaries under 21 years of age) can be found on the EPSDT provider page: https://medicaid.ncdhhs.gov/

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

6.1.1 Conditions of Participation

Licensed physicians and Non-Physician Practitioners (physician assistant, nurse practitioner, registered nurse, and licensed practical nurse) who meet Medicaid’s training requirement can render this service in eligible physicians’ offices. All providers participating in the Medicaid program shall provide services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are made available at the time of provider enrollment.

6.2 Provider Certifications

6.2.1 Provider Training and Continuing Education

Provider training is required as a condition of participation. Providers shall receive Medicaid recognized training to prepare for the delivery of this service. Only providers who have been trained are allowed to render the services and submit claims for payment.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid’s clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).
7.1.1 Record Retention

Providers are responsible for maintaining all financial, medical and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of not less than six years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations or agreements.

7.2 Oral Screening Requirements

a. Early caries screening and detection of notable findings (obvious pathology of hard and soft tissues) in the oral cavity using a dental mirror and directed light.

b. Counseling and educational materials on good oral hygiene practices and nutrition for children.

c. Prescribing a fluoride supplement, if indicated, per the guidelines of the American Association of Pediatrics:

http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/1113

Note: It is critical to have the beneficiary’s drinking water tested for fluoride content if the level of fluoride in the source of drinking water is unknown. Providers shall refer the beneficiary to a dentist for continued treatment at the appropriate age based on the beneficiary’s need for dental services.

d. Application of the fluoride varnish to all erupted primary teeth, beginning at tooth eruption until the beneficiary is 3½ years of age.

e. Documentation in the beneficiary’s health record shall include all of the following:

1) an oral evaluation and any notable findings;

2) preventive oral health and dietary counseling with the primary caregiver;

3) application of fluoride varnish; and

4) referral to a dentist, if appropriate.

7.3 Application of the Fluoride Varnish

Fluoride varnish is practical, safe, and easy to apply to the teeth of infants and very young children and is extremely useful in the prevention of early childhood caries. Teeth should be wiped with a 2” x 2” gauze pad prior to fluoride varnish application. The varnish is then applied in a thin layer to all surfaces of the teeth using a disposable brush.

7.4 Health Record Documentation

The provider must furnish upon request appropriate documentation, including beneficiary records, supporting material, and any information regarding payments claimed by the Provider, for review by the DMA, its agents, the Centers for Medicare and Medicaid, the State Medicaid Fraud Control Unit of the Attorney General's Office, and other entities as required by law. Providers cannot charge for records requested by Medicaid.
### 8.0 Policy Implementation/Revision Information

**Original Effective Date:** February 1, 2001

**Revision Information:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Section Revised</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/2007</td>
<td>Section 3.2</td>
<td>The coverage criteria was revised to indicate that the procedure is limited to once every 60 days and the treatment can be covered through the age of 3 ½ years effective with date of service 01/01/2007.</td>
</tr>
<tr>
<td>3/12/2012</td>
<td>Throughout</td>
<td>Technical changes to merge Medicaid and NCHC current coverage into one policy.</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>All Sections and Attachments</td>
<td>Updated CDT-2015 procedure code descriptions effective with date of service 1/1/2015.</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>All Sections and Attachments</td>
<td>Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.</td>
</tr>
<tr>
<td>03/15/2019</td>
<td>Table of Contents</td>
<td>Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”</td>
</tr>
<tr>
<td>03/15/2019</td>
<td>All Sections and Attachments</td>
<td>Updated policy template language.</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. **Claim Type**

Professional (CMS-1500/837P transaction)

B. **International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Note: According to the ICD-10-CM Official Guidelines for Coding and Reporting, the word “and” should be interpreted to mean either “and” or “or” when it appears in a title.

Examples: Provider does not have to be providing a cleaning to use the ICD code listed below.

- Z01.20 (Encounter for dental examination and cleaning without abnormal findings)
- Z01.21 (Encounter for dental examination and cleaning with abnormal findings)

C. **Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Dental Terminology (CDT 2015).

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
</tr>
</tbody>
</table>

Note: Procedure code D1206 must be billed on the detail line before D0145.

D. **Modifiers**

Provider(s) shall follow applicable modifier guidelines.

E. **Billing Units**

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

F. **Place of Service**

The oral screening package is allowed in the physician’s office, health department clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and the beneficiary’s residence.
G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/
Attachment B: Examples for Filing Physician Fluoride Varnish Claims
(CMS-1500 Claim Forms)

The following three examples apply to NC Medicaid and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at www.nucc.org.
Example 1:
Periodic Oral Screening as a Separate Procedure

NC Medicaid
Physician Fluoride Varnish Services
Clinical Coverage Policy No.: 1A-23
Amended Date: March 15, 2019
Example 2:
Periodic Oral Screening in Conjunction with an Office Visit
Example 3: Periodic Oral Screening in Conjunction with Health Check Screening
Because this form is used by various government and private health programs, see separate instructions issued by applicable programs.

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

Refers to government programs only.

Medicaid and CHAMPUS Payments: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 1 through 15 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes release of any necessary information, including identifying information, employment status, and whether the person has employer group health insurance or Medicare. In the event of a Medicaid claim, the patient's signature authorizes release of any necessary information, including identifying information, employment status, and whether the person has employer group health insurance.

BLACK LUNG AND FECA CLAIMS

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

Signature of Physician or Supplier (Medicare, CHAMPUS, FECA and Black Lung)

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

For services to be considered as “incident” to a physician's professional services, 1) they must be rendered under the physician's immediate personal supervision by an employee 2) they must be furnished by a controlled physician's service, 3) they must be furnished under the immediate personal supervision by a controlled physician's service, 4) the employee must be on the covered physician's service, and 5) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that for any employee who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5393). For Black Lung claims, I further certify that the services performed were not for a silicosis Lung-related disorder.

Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 404.32).

Notice: Any one who represents or falsifies essential information to receive payment from Federal funds requested by this form may be convicted under the laws established or applicable Federal laws.

Notice to Patient about the Collection and Use of Medicare, CHAMPUS, FECA, and Black Lung Information

We are authorized by CMS, CHAMPUS, and OPM to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is section 205(a), 1601, 1787, and 1787 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.6(a), (8), and 44 USC 3101 through 3117 of Title 44, and 30 USC 901 through 3061. E.O. 12083.

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

The information may also be given in other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs. We require other third parties paying to pay primary to Federal programs, and as otherwise necessary to determine eligibility.

Policy: Any information required to determine eligibility is in the following types: name, address, social security number, date of birth, income, and any other information about the benefits you are enrolled in a health maintenance or died.

Additional documentation is made through routine use for information contained in systems of records.

For Medicare Claims: See the notice modifying system No. 09-70-5001, Title, Carrier Medicare Claims Record published in the Federal Register, Vol. 55 No. 172, page 42956, Wed. Dec. 12, 1990, as updated and republished.


For CHAMPUS Claims: Principle (1963): To evaluate eligibility for medical care provided by civilian sources and to issue payments upon establishment of eligibility and determination that the services furnished were received as authorized.

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

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

It is mandatory that you inform us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 26511-26517 provides penalties for withholding this information.

You should be aware that P.L. 100-605, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by use of computer matches.

Medicaid Payments: Provider Certification

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

If you agree to accept payment in full, the amount paid by the Medicaid program for each claim submitted for payment under that program, with the exception of authorized transferable, the payer, and co-payment or sharing charge.

Signature of Physician or Supplier: I certify that the services listed above were medically indicated and necessary for the health of the patient and were personally furnished by me or my employee under my personal direction.

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

According to the Reports Federal Act of 1976, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this Information is 0911-0060. The time required to complete this information collection is estimated to average 10 minutes per response. Including the time for instructions, gathering the data, and completing and reviewing the information on this form, you may reasonably expect to spend no more than 10 minutes on this form. This information is collected to improve and complete the information on this form. If you believe that you have any reason to believe that the accuracy of the information contained in this document is incorrect, please write to CMS, Attn: FDA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-8699. This addresses for comments and questions only, DO NOT MAIL COMPLETED FORMS TO THIS ADDRESS.

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