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</tr>
</thead>
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</tr>
<tr>
<td>7.4</td>
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<tr>
<td>8.0</td>
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</tr>
</tbody>
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Attachment A: Claims-Related Information

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

Attachment B: Examples for Filing Physician Fluoride Varnish Claims (CMS-1500 Claim Forms)
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
Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.  
NCTracks Provider Claims and Billing Assistance Guide:  
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html  
EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/  

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  
The Division of Medical Assistance (DMA) 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 DMA 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, DMA 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 Medical Assistance
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.
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 DMA’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>
</tbody>
</table>
Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, DMA’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, 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**


H. **Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, refer to: [http://www.ncdhhs.gov/dma/fee/](http://www.ncdhhs.gov/dma/fee/)
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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)  999-99-9999A

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

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

12. IS PATIENT'S CONDITION RELATED TO:
   a. EMPLOYMENT? (Current or Previous)
   b. AUTO ACCIDENT?
   c. OTHER ACCIDENT?

13. INSURED'S POLICY GROUP OR PICA NUMBER  

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, 4 to Item 24 by Line)

23. PRIOR AUTHORIZATION NUMBER  

29. PATIENT'S ACCOUNT NO.  

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the invoice apply to the item and are made a part thereof.)  

32. SERVICE FACILITY LOCATION INFORMATION  

33. BILLING PROVIDER INFO & PH #  

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0958-0999 FORM CMS-1500 (08-05)
Example 2:
Periodic Oral Screening in Conjunction with an Office Visit

NC Division of Medical Assistance
Physician Fluoride Varnish Services

Medicaid and Health Choice
Clinical Coverage Policy No.: 1A-23
Amended Date: October 1, 2015
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 boxes 1 through 19 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes release of medical and demographic information, including employment status, and whether the person has employer group health insurance coverage. Failure to obtain a signature or submission of an incorrect signature may result in denial of the claim and may adversely affect any further payment of claim under these programs. It is the responsibility of the provider to collect any Medicare copay, deductible or coinsurance amount and return the claim to the payer for further processing. 

BENEFITS PAID UNDER MEDICAID AND CHAMPUS: Benefits paid under these programs for services provided to under the age of 21 who are blind or have other significant limitations, such as those with autism or other developmental disabilities, are paid by Medicaid. Benefits paid for any other services provided to the patient are not paid under Medicaid but may be paid under CHAMPUS.

AMENDED DATE: October 1, 2015

BLACK LEAF AND FECA CLAIMS

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

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

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

For services to be considered as "billable" to a physician's professional service, (i) they must be rendered and the physician must be present, and (ii) the physician must be a licensed physician and must have the authority to order, admit, examine, and treat the patient. This includes, but is not limited to, the services of nonphysicians who must be under the supervision of the attending physician.

For CHAMPUS claims, I further certify that for any employee or independent contractor to whom services were not annuated by the member of the United States Government or a contractor employee of the United States Government, either civilian or military (to 5 USC 5536). For Black Leaf claims, I further certify that the services were performed for a Black Leaf-related disorder.

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

NOTICE: Any person who misrepresents or fabricates essential information to receive payment from Federal funds is subject to fines and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LEAF INFORMATION

PRIVACY ACT STATEMENT

We are authorized by CMS, CHAMPUS, and OWCP to ask for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is set forth in 5 USC 1809 and 42 USC 1320a-7a (b)(2), and 42 CFR 411.24(a) and 414.6(a) (b), (c), and (f). The Bureau of Labor Statistics, the Social Security Administration, and the Department of Labor also have authority to use this information.

The information we obtain from claims in order to determine if a claimant is entitled to benefits is covered by these programs and to ensure that proper payment is made.

The information may also be used to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other Federal and program payments to be made to Federal programs and other programs or otherwise necessary to the administration of Federal programs. In some cases, it may be necessary to disclose information about the benefits you have earned to a hospital or other health care provider. Additional protections are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying systems No. 09-06-020, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 43726, Nov. 9, 1990, as updated and republished.


FOR CHAMPUS CLAIMS: PRIVACY IMPLEMENTATION: To evaluate eligibility for medical care provided by civil service sources and to pay claims upon establishment of eligibility and statement that the services received, were authorized by law.

ROUTINE USES: Information from claims and related documents may be given to the Dept of Veterans Affairs, the Dept of Health and Human Services and/or the Dept of Transportation consistent with their administrative, technical, and administrative responsibilities under the CHAMPUS and CHAMPUS. To the Dept of Justice for representation of the Secretary of Defense in connection with the Internal Revenue Service, private collection agencies, and consumer reporting agencies connected with employment services, and to Congress and its Committees in accordance with public service laws, and individual providers of care on matters relating to entitlement, claims adjudication, fraud program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

If you have any questions relating to this form, you may contact the Privacy Officer at the OWCP office. The Privacy Officer will provide information on the types of records maintained, the purposes for which the information is used, the persons to whom the information is disclosed, and the safeguards for protecting the information. (If you have any questions concerning the accuracy of the information collected or for improving the form, please write to: CMS, IRM, BB/Reports Cancellation Office, 7600 Security Boulevard, Baltimore, Maryland 21249-1800. This address is for comments and suggestions only. NOT TO BE USED FOR CLAIMS FOR MEDICAID.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 1605-0285. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data sources, gather the information needed, and complete and review the information collection. If you have any comments concerning the burden of the information collection, including whether the collection of information is necessary or the accuracy of the information collection, please write to: CMS, IRM, BB/Reports Cancellation Office, 7600 Security Boulevard, Baltimore, Maryland 21249-1800. This address is for comments and suggestions only. NOT TO BE USED FOR CLAIMS FOR MEDICAID.