Vaccine: **Injectable(s) with Intranasal/Oral** **Provider Type:** **Local Health Departments**		
Service Type	**With Physician Counseling** **Less than 8 years of age**	**Without Physician Counseling** **Less than 21 years of age**
Health Check Assessment with Immunizations	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.
Immunizations Only	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units and 90468EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP x the appropriate number of units and 90474EP x 1. Report CPT vaccine code for each vaccine given. One immunization diagnosis code **is** required.
Office Visit with Immunizations	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90465EP x 1 and 90468EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90465EP x 1, 90466EP x the appropriate number of units and 90468EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.	For one INJECTABLE vaccine and one INTRANASAL/ORAL vaccine, bill 90471EP x 1 and 90474EP x 1. For two or more INJECTABLE vaccines and one INTRANASAL/ORAL vaccine, bill 90471EP x 1, 90472EP times the appropriate number of units and 90474EP x 1. Report CPT vaccine code for each vaccine given. Immunization diagnosis code(s) is **not** required.

North Carolina Immunization Program/Vaccines for Children Program

The North Carolina Immunization Program (NCIP)/Vaccines for Children (VFC) Program provides, at no charge, all recommended vaccines for all North Carolina VFC-eligible, including Medicaid eligible, children ages birth through 18 years. Vaccines are provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Because of the availability of these vaccines for Medicaid children, Medicaid does not routinely reimburse for vaccines available from the NCIP/VFC program. Medicaid does, however, reimburse for the administration of these vaccines.

In **rare** instances, due to recalls or true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletin.

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. CPT codes for vaccine products must always be included on the claim **(without the EP modifier)**. Remember that some purchased vaccines require the SC modifier. See the specific billing guidance in the General Medicaid bulletin.

The following is a list of NCIP/VFC vaccines provided to children through 18 years of age. **Medicaid recipients are automatically eligible for VFC vaccine, even those who are dually covered by Medicaid and another insurance plan.** All of these vaccines are available to Medicaid children through 18 years of age. Because vaccines have other criteria which must be met, **and vaccine criteria are subject to change,** it is recommended that providers go to the Immunization Branch web site at http://www.immunizenc.com (select "Providers" and NCIP Coverage Criteria), or call the Immunization Branch at 1-877-873-6247.

The following is a list of NCIP/VFC vaccines:

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for intramuscular (IM) use	V05.3	12 months through 18 years of age
90636*	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for IM use	V06.8	18 years of age and above in local health departments (LHDs), FQHCs, and RHCs
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - *PedvaxHIB* **Routine** – 2 months to less than 5 years of age **High risk** – greater than 59 months through 18 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for IM use ***NOTE : The NCIP will no longer provide these products after May 1, 2010.***	V03.81	Brand name - *ActHIB* **Routine** – 2 months to less than 5 years of age **High risk** – greater than 59 months through 18 years of age Brand name – *Hiberix* Approved for the booster dose in children 15 months through 4 years of age
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular (IM) use	V04.89	9 years through 18 years of age
90655+	Influenza virus vaccine, split virus, preservative free when administered to children 6 - 35 months of age, for IM use	V04.81	6 months through 35 months of age
90656+	Influenza virus vaccine, preservative free, when administered to individuals 3 years and older, for IM use	V04.81	3 years through 18 years of age
90657+	Influenza virus vaccine, split virus, when administered to children 6 to 35 months of age, for IM use	V04.81	6 months through 35 months of age
90658+	Influenza virus vaccine, when administered to individuals 3 years of age and older, for IM use	V04.81	3 years through 18 years of age
90660+	Influenza virus vaccine, live, for intranasal use	V04.81	2 years through 18 years of age.
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use (Prevnar 13)	V03.82	2 months through 59 months of age
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for IM use	V06.3	4 years through 6 years of age, for booster dose only

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use	V06.8	2 months through 4 years of age
90700	Diphtheria , tetanus toxoids, and acellular pertussin vaccine (DTaP), when administered to individuals younger than 7 years, for IM use	V06.1	2 months through 6 years of age
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for IM use	V06.5	2 months through 6 years of age
90707*	Measles, mumps and rubella vaccine (MMR), live, for subcutaneous (SC) use	V06.4	12 months through 18 years of age
90710	Measles, mumps, rubella and varicella vaccine (MMRV), live, for SC use	V06.8	12 months through 6 years of age
90713	Poliovirus vaccine, inactivated (IPV), for SC or IM use	V04.0	2 months through 17 years of age
90714*	Tetanus and diphtheria toxiods (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for IM use	V06.5	7 years through 18 years of age
90715*	Tetanus, diphtheria toxoids an acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use **Note:** Currently, no Tdap product is licensed for individuals under 10 years of age.	V06.1	10 years through 18 years of age
90716	Varicella virus vaccine, live, for SC use	V05.4	12 months through 18 years of age
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for IM use	V06.8	2 months through 6 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for SC or IM use	V03.82	**Only for high risk children 2 years through 18 years of age.**
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V01.84	Routine - 10 years through 18 years of age High risk - 2 years through 9 years of age
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for IM use	V05.3	**Birth through 18 years of age*** **Exception:** If the first dose of Hepatitis B vaccine is administered prior to age 19, NCIP vaccine may be used to complete the series prior to age 20.

***Providers should refer to the Immunization Branch website at http://www.immunizenc.com for detailed information regarding vaccines. Certain vaccines are provided for those recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at 1-877-873-6247.**

+Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

N.C. Medicaid providers who are not enrolled in NCIP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-877-873-6247.

Out-of-state providers may obtain VFC vaccines by calling their state VFC program. VFC program telephone numbers for Border States are listed below:

- **Georgia** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-741-7343
- **Virginia** 1-804-864-8055

HEALTH CHECK BILLING REQUIREMENTS

Effective with date of processing October 2, 2009, the N.C. Medicaid Program required all providers to file claims electronically. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Instructions for billing a Health Check screening assessment are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are as follows:

Requirement 1: Identify and Record Diagnosis Code(s)
Place diagnosis code(s) in the correct order in block 21. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Periodic Health Check Screening Assessment – Use V20.2 as the Primary Diagnosis
The primary diagnosis V20.2 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V20.2) and **always** before immunization diagnoses. An immunization diagnosis code is required when one or more immunizations are provided as the only service.

Interperiodic Health Check Screening Assessment – Use V70.3 as the Primary Diagnosis
The primary diagnosis V70.3 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V70.3) and **always** before immunization diagnoses. An immunization diagnosis code is required when one or more immunizations are provided as the only service.

Requirement 2: Identify and Record Preventive Medicine Code and Component Codes
The preventive medicine CPT code with the EP modifier for Health Check screening assessments should be billed as outlined below. In addition to billing the preventive medicine code, developmental screening, vision and hearing CPT codes must be listed based on the Health Check Assessment Components requirements noted on pages 15 through 20.

- A developmental screening CPT code with the EP modifier **must** be listed in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment when age appropriate. No additional reimbursement is allowed for this code. All providers may refer to the claim samples in this guide.

- Vision CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment for children ages 3 through 10 and for other children as appropriate based on age or assessment of risk. No additional reimbursement is allowed for these codes. All providers may refer to the sample claims located at the end of this guide.

- Hearing CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment for children ages 4 through 10 and for other children as appropriate based on an assessment of risk. No additional reimbursement is allowed for these codes. All providers may refer to the sample claims in this guide.

Requirement 3: Health Check Modifier – EP
The Health Check CPT codes for periodic and interperiodic screening assessments must have the **EP** modifier listed in block 24D of the CMS-1500 claim form format. Additionally, the vision, hearing, and developmental screening CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form format. **EP is a required modifier for all Health Check claim details (except codes for vaccine products for ages 19 and 20).**

HEALTH CHECK BILLING REQUIREMENTS, continued

Requirement 4: Record Referrals
N.C. Medicaid is HIPAA-compliant and is able to receive standard electronic HIPAA transactions.

Providers billing electronically using the services of a vendor or clearinghouse may reference the National HIPAA Implementation Guide and the North Carolina 837 Professional Claim Transaction Companion Guide for values regarding follow up-visits. The National HIPAA Implementation Guide for the 837 Claim Transaction can be accessed at http://www.wpc-edi.com.

The North Carolina Medicaid 837 Companion Guide can be accessed on the DMA website at http://www.ncdhhs.gov/dma/hipaa/837prof.pdf.

Claims submitted via NCECSWeb should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment. List referral code indicator "F" when a referral is made for Family Planning services.

Requirement 5: Next Screening Date
Providers may enter the next screening date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form format.

Provider-Entered Next Screening Date
Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is OUT of range with the periodicity schedule, the system will override the provider's NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

Note: Providers billing electronically are not required to enter a screening date (NSD) for health check screening claims.

Systematically Entered Next Screening Date
Providers have the following choices for block 15 of the CMS-1500 claim form format with a Health Check screening assessment. All of these choices will result in an automatically entered NSD.

- **Leave block 15 blank.**
- **Place all zeros in block 15 (00/00/0000).**
- **Place all ones in block 15 (11/11/1111).**

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

HEALTH CHECK BILLING REQUIREMENTS, continued

Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier

Providers should refer to the tables on pages 23 through 31 in this guide, *Immunization Billing Guidelines for Recipients Birth Through Age 20,* regarding billing immunization administration CPT codes and the EP modifier. Providers may also refer to the claim examples at the end of this guide.

When reporting or billing vaccine administration, providers must use the appropriate CPT code(s) with the EP modifier listed in block 24D of the CMS-1500 claim form format. The CPT code for the vaccine product must be reported or billed without the EP modifier.

- When reporting or billing for one injectable vaccine administration, providers must use CPT code 90471 (one unit) or 90465 (one unit) **with the EP modifier** listed in block 24D. The CPT code for the vaccine product administered must be reported or billed **without the EP modifier appended**.

- When additional injectable vaccine administrations are provided, providers must use CPT code 90472 or 90466 **with the EP modifier** listed in block 24D. Providers must bill the appropriate number of units on the detail along with the total charge of all units billed. The CPT code for each vaccine product administered must be reported or billed **without the EP modifier appended**.

- When reporting or billing for one intranasal/oral vaccine providers must use CPT code 90467 (one unit) or 90473 (one unit) **with the EP modifier** in block 24D for the immunization administration. The CPT vaccine code for the vaccine product administered must be reported or billed **without the EP modifier appended**.

- When reporting or billing for one injectable vaccine and one intranasal/oral vaccine providers must use CPT codes 90465 and 90468 or 90471 and 90474 **with the EP modifier** for the immunization administrations. The CPT vaccine code for each vaccine product administered must be reported or billed **without the EP modifier appended**.

- When reporting or billing for two or more injectable vaccines and one intranasal/oral vaccine providers must use CPT codes 90465, 90466 and 90468 **with the EP modifier** or 90471, 90472 and 90474 with the EP modifier for the immunization administrations. Providers must bill the appropriate number of units on the detail along with the total charge of all units billed. The CPT vaccine code for each vaccine product administered must be reported or billed **without the EP modifier appended.**

Notes:

In **rare** instances, due to recalls or true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletin.

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. CPT codes for vaccine products must always be included on the claim **(without the EP modifier)**. Remember that some purchased vaccines require the SC modifier. Refer to specific billing guidance in the General Medicaid bulletin.

If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 is $0.00.

Health Check Related ICD-9-CM and CPT Codes

The following table lists ICD-9 and CPT codes related to Health Check screening assessments:

	Preventive CPT Codes and Modifier	**Diagnoses Codes**
Periodic Examination	CPT Codes 99381-99385; 99391-99395 EP Modifier is required in block 24D Developmental Screening CPT Code 96110; at 6, 12, 18 or 24 months of age, at age 3, 4, and 5 years of age EP Modifier is required in block 24D Autism Screening CPT Code: 99420 EP Modifier is required in block 24D Health Risk Assessments, CPT Code 99420 (GAPS/HEADSSS) and Behavioral/Mental Health Screening (PSC/SDQ/PSQ-A/Beck's); CPT 99406-99407 for Smoking/Tobacco Use Cessation; and CPT 99408-99409 for Alcohol/Substance Abuse Structured Screening and Brief Intervention (CRAFFT) are currently reimbursed. EP Modifier is required in block 24D Vision CPT Code 99172 or 99173; for children ages 3-10, and then as appropriate based on age and risk. EP Modifier is required in block 24D Hearing CPT Code 92551, 92552, or 92587; for children 4-10 and then as appropriate based on risk. EP Modifier is required in block 24D	V20.2 Primary Diagnosis
Interperiodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D	V70.3 Primary Diagnosis

Preventive Medicine CPT Codes

The following table lists Preventive Medicine CPT codes that must be listed on the CMS-1500 claim form format when filing a claim for a Periodic (V20.2) or an Interperiodic (V70.3) examination. The **EP modifier** must be listed in block 24D of the CMS-1500 claim form format with the appropriate preventive medicine code.

Age	New Patient	Established Patient	Append EP Modifier
Under age 1 year	99381	99391	Yes
1 through 4 years	99382	99392	Yes
5 through 11 years	99383	99393	Yes
12 through 17 years	99384	99394	Yes
18 through 20 years	99385	99395	Yes

TIPS FOR BILLING

All Health Check Providers

- Two Health Check screening assessments on different dates of service cannot be billed on the same claim form.
- CPT codes: 99406 EP, 99407 EP, 99408 EP, 99409 EP can be billed when performed during a periodic Health Check assessment or during an interperiodic Health Check screening assessment for adolescents ages 11 through 20.
- CPT code 99420 EP can be billed when performed during a periodic Health Check screening assessment or during an interperiodic Health Check screening assessment for children ages birth through 20.
- Immunizations and therapeutic injections may be billed on the same date of service and on the same claim.
- A formal, standardized developmental screening tool **must** be used during periodic screening assessments for children ages 6, 12, 18 or 24 months, and 3, 4, and 5 years of age.
- If the required vision and/or hearing screenings cannot be performed during a periodic screening assessment due to a condition such as blindness, deafness, autism, or uncooperative child, providers must:
    - Document in the patient's medical record the date of service and the reason(s) why the provider was unable to perform the vision and/or hearing screening;
    - Submit the claim to HP ENTERPRISE SERVICES without the vision and/or hearing CPT code; and
    - HP ENTERPRISE SERVICES will process the claim.
- Report payments received from third party insurance in block 29 of the CMS-1500 claim form format when preventive services (well child assessments) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit the claim to Medicaid.
- All electronically submitted claims should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment.

Private Sector Health Check Providers Only

- A Health Check screening assessment and an office visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier can be billed with a Health Check screening assessment, office visit or if the vaccine administration is the only service provided that day. When billing in conjunction with an examination code or an office visit code, an immunization diagnosis is **not required** in block 21 of the claim form. When billing an administration code for immunizations as the only service for that day, providers **are required** to use an immunization diagnosis code in block 21 of

the claim form. Always list the CPT vaccine codes when billing these administration codes with the EP modifier. Refer to the claim examples at the end of this guide.

- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for the Health Check screening assessment and the amount billed for immunizations and any other service billed on the same date of service. Thus, it is necessary to check claim status for two separate claims.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers Only

- Providers may bill a core Behavioral Health visit (T1015 HI) and a Health Check screening assessment on the same date of service on separate claims.
- A Health Check screening assessment and a core visit (T1015) cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 with the EP modifier can be billed with a Health Check screening assessment or if the vaccine administration is the only service provided that day. When billing in conjunction with an examination code, an immunization diagnosis is **not** required in block 21 of the claim form format. When billing an administration code for immunizations as the only service for that day, an immunization diagnosis code **is** required to be entered in block 21 of the claim form format. An administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list CPT vaccine codes in the appropriate block on the claim form format. Always list CPT vaccine codes when billing any immunization administration code with the EP modifier. Refer to the claim examples at the end of this guide.

Local Health Departments

- Two Health Check screening assessments on different dates of service cannot be billed on the same claim form (format).
- An immunization administration fee may be billed if the immunization(s) is provided in addition to a Health Check screening visit. In addition, immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474 with the EP modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit.** When billing immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474, the EP modifier must be entered. Refer to the claim examples at the end of this guide.
- A formal, standardized developmental screening tool **must** be used during periodic examinations for children ages 6 months, 12 months, 18 or 24 months, and 3, 4, and 5 years of age.

HEALTH CHECK COORDINATION

Health Check Coordination is the responsibility of the 14 Community Care of North Carolina (CCNC) regional networks. Under the direction of the CCNC networks, the Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services.

HCCs provide education and outreach services in 100 North Carolina counties and the Qualla Boundary. HCCs are stationed at certain regional CCNC network sites, local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA website at: http://www.ncdhhs.gov/dma/provider/provcontacts.htm.

The role and responsibilities of the HCC include but are not limited to the following:

- Using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- Educating families about the importance of establishing a medical home **that provides ongoing, comprehensive, family-centered, and accessible care** for their children **and youth**
- Assisting families to use the health care services in a consistent and responsible manner
- Assisting with scheduling appointments or securing transportation
- Acting as a local information, referral, and resource person for families
- Providing advocacy services in addressing social, educational or health needs of the recipient
- Initiating follow-up as requested by providers when families need special assistance or fail to bring children in for Health Check or follow-up examinations
- Promoting Health Check and health prevention with other public and private organizations

Physicians, primary care providers (PCPs), and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and helps make preventive health care services more timely and effective.

HEALTH CHECK CLAIM DENIALS – EXPLANATION OF BENEFITS (EOB)

EOB	Message	Tip
010	Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.	Verify the recipient's Medicaid identification (MID) number, date of birth (DOB), diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to HP ENTERPRISE SERVICES as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2501 Mail Service Center, Raleigh, NC 27699-2501.
079	This type of service is not payable to your provider type or specialty.	Check your claim for keying errors, make corrections if necessary. Verify the provider type and specialty for your Medicaid provider number by contacting a Health Check Consultant at 919-855-4780.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.	Verify diagnosis code is V20.2 or V70.3 for the Health Check screening assessment according to the billing guidelines on page 36. Correct claim and resubmit.
349	Health Check Screen and related service not allowed same day, same provider, or member of same group.	Resubmit as an adjustment with documentation supporting unrelated services.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient's age. Only recipients age birth through 20 years of age are eligible for Health Check services.
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Immunizations(s) are available at no charge through the NCIP/VFC Program.
1058	The only well child exam billable through the Medicaid program is a Health Check screening assessment. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic examination with primary diagnosis V20.2 and Interperiodic examinations with primary diagnosis V70.3. Check the preventive medicine code entered in block 24D of the claim form and append the EP modifier.
1422	Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check Special Bulletin.	Check the claim to ensure that the immunization procedure code(s) are billed on the same claim as the immunization administration code(s). Make corrections and resubmit as a new day claim.
1769	No additional payment made for vision, hearing and/or developmental screening services.	Payment is included in Health Check reimbursement.
1770	Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	Health Check services must be billed with the primary diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V25.9.

HEALTH CHECK BILLING REFERENCE SHEET

Date of Service _____

Patient's Name	Next Examination Date (optional)		
Medicaid ID number	Date of Birth		
Health Check Diagnosis Code			
Periodic Health Check screening assessment	Periodic Health Check Screening V20.2		
Interperiodic Health Check screening assessment	Interperiodic Health Check screening assessment V70.3		
Health Check screening assessment Code			
Description	**Preventive Medicine Codes**	**Diagnosis Code**	✓
Regular Periodic Examination- Birth through 20 years	99381-9985; 99391-99395 **With EP Modifier**	V20.2	
Developmental Screening based on age	Development Screening CPT Code 96110 **With EP Modifier**		
Autism Screening based on age	Autism Screening CPT Code: 99420 **With EP Modifier**		
Adolescent Health Risk Assessment and B/MH Screening	CPT 99420 **With EP Modifier**		
Vision Screening based on age	Vision Screening CPT Code 99172 or 99173 **With EP Modifier**		
Hearing Screening based on age	Hearing Screening CPT Code 92551, 92552 or 92587 **With EP Modifier**		
Interperiodic Examination - Birth through 20 years	99381-99385; 99391-99395 **With EP Modifier**	V70.3	
Second Diagnosis _____ (if applicable)			
Description	**Indicator**		✓
Follow-up with HC provider or another provider	E or F - providers billing electronically		
Third Diagnosis _____ (if applicable)			
Description	**Indicator**		✓
Follow-up with HC provider or another provider	E or F - providers billing electronically		
Fourth Diagnosis _____ (if applicable)			
Description	**Indicator**		✓
Follow-up with HC provider or another provider	E or F - providers billing electronically		
Description	**CPT Codes**	**Unit**	
Immunization Administration Fee	90471 **or** 90465 EP Modifier 90467 **or** 90473 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 **or** 90466 EP Modifier 90468 **or** 90474 EP Modifier	Additional immunizations	

IMMUNIZATION BILLING REFERENCE SHEET

Note: Do not bill Medicaid for the cost of a vaccine or immune globulin on this table if the product was provided through the NCIP/VFC program. Only the administration code should be billed.

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous (IV) use	V07.2	
J1460-J1560	Injection, gamma globulin codes, intramuscular (IM) (GamaSTAN SD). Use the code for the amount administered	V07.2	Limited distribution to health departments (LHDs) only, and only during outbreaks.
J1571	Injection, hepatitis B immune globulin (Hepagam B), IM, 0.5 ml	V07.2	
J1573	Injection, hepatitis B immune globulin (Hepagam B), IV, 0.5 ml	V07.2	
90371	Injection, hepatitis B immune globulin (HBIg), human, IM	V07.2	
J1562	Injection, immune Globulin, (Vivaglobin), 100 mg	V07.2	
J1566	Injection, immune globulin, IV, lyophilized (e.g., powder), NOS, 500 mg	V07.2	
J1569	injection, immune globulin, (Gammagard liquid), IC, nonlyophilized (e.g., liquid), 500 mg	V07.2	
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), IV, nonlyophilized (e.g., liquid), 500 mg	V07.2	
J1561	Injection, immune globulin, (Gamunex), IV, nonlyohilized (e.g., liquid), 500 mg non-lyophilized (liquid) (Gamunex)	V07.2	
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg (Atgam)	V07.2	
90375	Rabies immune globulin, (RIg), human, for IM and/or SC SC use (BayRab)	V07.2	
90376	Rabies immune globulin – Heat treated (RIG-HT), IM and/or SC,use (Imogam Rabies)	V07.2	
90379	Respiratory syncytial virus immune globulin (RSV-IgIV), human, for IV use	V07.2	
J2790	Injection, Rho (D) immune globulin, human, full dose, 300 mg,(1500 i.u.) (Rhophylac)	V07.2	
J2788	Injection, Rho (D) immune globulin, human, min dose, 50 mcg (250 i.u.), MiCRhoGAM	V07.2	
J2791	Injection, Rho (D) immune globulin, (human) (Rhophylac) IM or IV, 100 IU HypRho, WINRho SDF)	V07.2	
J2792	Injection, Rho(D) immune globulin, IV, human, solvent detergent, 100 IU	V07.2	
90389	Tetanus immune globulin (TIg), human, for IM use	V07.2	
90396	Varicella-zoster immune globulin, human, for IM use	V07.2	
90585	Bacillus Calmette-Guerin (BCG) for tuberculosis, live for percutaneous use	V03.2	
90632	Hepatitis A vaccine, adult dosage, for IM use	V05.3	19 years of age and above Limited distribution to LHDs only, and only during outbreaks.
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for IM use	V05.3	12 months of age through 18 years of age
90636*	Hepatitis A and B combination (HepA-HepB), adult dosage, for IM use	V06.8	18 years of age and above only in LHDs, FQHCs, and RHCs*

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - *PedvaxHIB* Routine - 2 months to less than 5 years of age High risk, greater than 59 months through 18 years of age.
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for IM use ***Note : The NCIP will no longer provide these products after May 1, 2010***	V03.81	Brand name - *ActHIB* Routine - 2 months to less than 5 years of age; High risk - greater than 59 months through 18 years of age. Brand name – *Hiberix* Approved for the booster dose in children 15 months through 4 years of age
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular (IM) use	V04.89	9 years through 18 years of age
90655+	Influenza virus vaccine, split virus, preservative free when administered to children 6-35 months of age, for IM use	V04.81	6 months through 35 months of age
90656+	Influenza virus vaccine, preservative free, when administered to individuals 3 years and older	V04.81	3 years through 18 years of age
90657+	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for IM use	V04.81	6 months through 35 months of age
90658+	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for IM use	V04.81	3 years through 18 years of age
90660+	Influenza virus vaccine, live, for intranasal use	V04.81	2 years through 18 years of age
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use (Prevnar 13)	V03.82	2 months through 59 months of age
90675	Rabies vaccine for IM use	V04.5	
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	V04.89	6 weeks through 7 months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for IM use	V06.3	4 years through 6 years of age for the booster dose only
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use	V06.8	2 months through 4 years of age
90700	Diphtheria , tetanus toxoids, and acellular pertussin vaccine (DTap), when administered to individuals younder than 7 years, for IM use	V06.1	2 months through 6 years of age
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for IM use	V06.5	2 months through 6 years of age
90703	Tetanus toxoid adsorbed, for IM use	V03.7	
90704	Mumps virus vaccinelive, for SC use	V04.6	
90705	Measles virus vaccine, live, for SC use	V04.2	
90706	Rubella virus vaccine, live, for SC use	V04.3	
90707*	Measles, mumps, and rubella virus vaccine (MMR), live, for SC use	V06.4	12 months through 18 years of age*

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for SC use	V06.8	12 months through 6 years of age
90713	Polio virus vaccine, inactivated (IPV), for SC or IM use	V04.0	2 months through 17 years of age
90714*	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for IM use	V06.5	7 years through 18 years of age*
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use Note: Currently no Tdap vaccine is licensed for use in persons under the age of 10 years	V06.1	10 years through 18 years of age*
90716	Varicella virus vaccine, live, for SC use	V05.4	12 months through 18 years of age
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (Dtap-Hib), for IM use	V06.8	
90723	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (Dtap-HepB-IPV), for IM use	V06.8	2 months through 6 years of age
90732	Pneumococcal polysaccharide vaccine , 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for SC or IM use	V03.82 or V05.8	Only for high-risk children 2 years through 18 years of age 2 years through 18 years
90733	Meningococcal polysaccharide vaccine (any group(s)), for SC use	V01.84	
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V01.84	**Routine -** 10 years through 18 years of age; **High risk -** 2 years through 9 years of age
90740	Hepatitis B vaccine, dialysis or immunocompromised patient dosage (3-dose schedule), for IM use	585.1-585.9 or diagnosis related to the immuno-compromised state	
90744*	Hepatitis B vaccine pediatric/adolescent dosage (3 dose schedule), for IM use	V05.3	Birth through 18 years of age* **Exception**: If the first dose of Hepatitis B vaccine is administered prior to age 19, NCIP/VFC pediatric vaccine may be used to complete the series prior to age 20*.
90746*	Hepatitis B vaccine, adult dosage, for IM use	V05.8	20 years of age and older, only in LHDs*
90747	Hepatitis B vaccine dialysis or immunosuppressed patient dosage (4-dose schedule), for IM use	585.1-585.9 or diagnosis related to the immuno-compromised state	

***Providers should refer to the Immunization Branch website at http://www.immunizenc.com for detailed information regarding vaccines. Certain vaccines are provided for recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at 1-877-873-6247.**

+Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

Note: This list is subject to change. Updates regarding vaccines are published in the general Medicaid bulletins on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

RESOURCE LIST

Children with Special Health Care Needs Helpline
1-800-737-3028

Dental Varnishing
Clinical Coverage Policy #1A-23, *Physician Fluoride Varnish Services*
http://www.ncdhhs.gov/dma/mp/

Developmental Screening standardized and validated screening tools
http://www.dbpeds.org
http://www.brightfutures.aap.org

Developmental Surveillance and Screening
http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/1/405.pdf

DMA Customer Services Center
1-888-245-0179

HP Enterprise Services Provider Services
1-800-688-6696 or 919-851-8888

Health Check Coordinator Contact List
http://www.ncdhhs.gov/dma/provider/provcontacts.htm

National HIPAA Implementation Guide
http://www.wpc-edi.com/hipaa

NC Healthy Start Foundation
http://www.nchealthystart.org/.

North Carolina 837 Professional Claim Transaction Guide
http://www.ncdhhs.gov/dma/hipaa/837prof.pdf

North Carolina Immunization Branch
North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)
http://www.immunizenc.com

North Carolina Lead Screening and Follow Up Manual
http://www.deh.enr.state.nc.us/ehs/Children_Health/index.html

December 2005 Special Bulletin, *Medicaid for Children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Health Check*
http://www.ncdhhs.gov/dma/bulletin/

Basic Medicaid Billing Guide
http://www.ncdhhs.gov/dma/basicmed/

EPSDT Provider Page
http://www.ncdhhs.gov/dma/epsdt/

Physician's Fee Schedule
http://www.ncdhhs.gov/dma/fee/

Policy Instructions: Early and Periodic Screening, Diagnostic and Treatment
http://www.ncdhhs.gov/dma/epsdt/

Prior Approval Process and Request for Non-Covered Services
http://www.ncdhhs.gov/dma/provider/forms.htm
http://www.ncdhhs.gov/dma/basicmed/

Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2010
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5701a8.htm?s_cid=mm5701a8_e

Printable versions of the schedule can be found at:
http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable

Recommendations for Preventive Pediatric Health Care
http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1

2008 Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Third Edition: Bright Futures 3rd Edition Pocket Guide: Bright Futures Tool and Resource Kit
http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf

U.S. Preventive Services Task Force Recommendations
http://www.ahrq.gov/clinic/USpstfix.htm

Private Provider
Periodic Examination
Developmental Screening

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 01 15 06 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single Married Other	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.

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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V20.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 03 10	05 03 10	11		99392	EP		80.33	1		ZZ NPI	Taxonomy NPI Number
2	05 03 10	05 03 10	11		96110	EP		0.00	1		ZZ NPI	Taxonomy NPI Number
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 $ 80.33
29. AMOUNT PAID $	30. BALANCE DUE $ 80.33		
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI b. ZZ Taxonomy	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Physician Counseling with Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 02 14 04 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.

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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V06.8 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 05 10	05 05 10	11		90465	EP		17 25	1		ZZ NPI	Taxonomy NPI Number
2	05 05 10	05 05 10	11		90466	EP		9 71	1		ZZ NPI	Taxonomy NPI Number
3	05 05 10	05 05 10	11		90710			0 00	1		ZZ NPI	Taxonomy NPI Number
4	05 05 10	05 05 10	11		90700			0 00	1		ZZ NPI	Taxonomy NPI Number
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 $ 26.96
29. AMOUNT PAID $	30. BALANCE DUE $ 26.96		

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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Periodic Examination

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joanna	3. PATIENT'S BIRTH DATE MM DD YY: 03 22 10 SEX M F: X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single Married Other	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V20.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. 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	05	03	10	05	03	10	11		99381	EP		80.33	1		ZZ NPI	Taxonomy NPI Number
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 $ 80.33 / 29. AMOUNT PAID $ / 30. BALANCE DUE $ 80.33
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Private Provider
Interperiodic Screening
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joe**	3. PATIENT'S BIRTH DATE MM DD YY: **03 28 00** SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. **V70.3** 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 05 10	05 05 10	11		99383	EP		80 33	1		ZZ	Taxonomy
											NPI	NPI Number
2	05 05 10	05 05 10	11		90471	EP		17 25	1		ZZ	Taxonomy
											NPI	NPI Number
3	05 05 10	05 05 10	11		90472	EP		19.42	2		ZZ	Taxonomy
											NPI	NPI Number
4	05 05 10	05 05 10	11		90715			0 00	1		ZZ	Taxonomy
											NPI	NPI Number
5	05 05 10	05 05 10	11		90716			0 00	1		ZZ	Taxonomy
											NPI	NPI Number
6	05 05 10	05 05 10	11		90707			0 00	1		ZZ	Taxonomy
											NPI	NPI Number

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 $ **117.00**	29. AMOUNT PAID $	30. BALANCE DUE $ **117.00**
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **ZZ Taxonomy**	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider – Split Claim
Periodic Examination
Developmental, Vision, and Hearing Screening
(Block 24H) Referral Indicator "R"
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 03 02 06 SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V20.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 01 10	05 01 10	11		99382	EP		80 33	1	R	ZZ NPI	Taxonomy NPI Number
2	05 01 10	05 01 10	11		96110	EP		0 00	1		ZZ NPI	Taxonomy NPI Number
3	05 01 10	05 01 10	11		99172	EP		0 00	1		ZZ NPI	Taxonomy NPI Number
4	05 01 10	05 01 10	11		92551	EP		0 00	1		ZZ NPI	Taxonomy NPI Number
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 $ 80.33	29. AMOUNT PAID $	30. BALANCE DUE $ 80.33
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI NPI b. ZZ Taxonomy		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

2nd Page of Split Claim
Private Provider
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 03 02 06 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V03.82 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 01 10	05 01 10	11		90465	EP		17 25	1		ZZ NPI	Taxonomy NPI Number
2	05 01 10	05 01 10	11		90466	EP		19 42	2		ZZ NPI	Taxonomy NPI Number
3	05 01 10	05 01 10	11		90713			0 00	1		ZZ NPI	Taxonomy NPI Number
4	05 01 10	05 01 10	11		90700			0 00	1		ZZ NPI	Taxonomy NPI Number
5	05 01 10	05 01 10	11		90707			0 00	1		ZZ NPI	Taxonomy NPI Number
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 $ 36. 67
29. AMOUNT PAID $	30. BALANCE DUE $ 36. 67		
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI b. ZZ Taxonomy	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Periodic Examination
Vision & Hearing Screenings
(Block 24H) Referral Indicator "E"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): **123456789K**
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Joanna**	3. PATIENT'S BIRTH DATE MM DD YY: **01 01 01** SEX M F **X**
5. PATIENT'S ADDRESS (No., Street): **123 Fun Street**	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
CITY: **Fun Town** STATE: **NC**	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
ZIP CODE: **11111** TELEPHONE (Include Area Code): **(555) 555-5555**	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

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 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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. **V20.2** 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 03 10	05 03 10	11		99383	EP		80.33	1	E	ZZ NPI	Taxonomy NPI Number
2	05 03 10	05 03 10	11		99172	EP		0.00	1		ZZ NPI	Taxonomy NPI Number
3	05 03 10	05 03 10	11		92551	EP		0.00	1		ZZ NPI	Taxonomy NPI Number
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 $ **80.33**
29. AMOUNT PAID $	30. BALANCE DUE $ **80.33**		
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.) **Signature on File** SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION **123 That St That City, NC 27606-1234** a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) **Dr J P Provider 123 Any St Any City, NC 27523-5678** a. **NPI** NPI b. **ZZ Taxonomy**

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Periodic Examination
Vision & Hearing Screenings

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 03 11 97 SEX M [x] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V20.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. 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	05 03 10 05 03 10	11		99394	EP		80.33	1		ZZ	Taxonomy
										NPI	NPI Number
2	05 03 10 05 03 10	11		99172	EP		0.00	1		ZZ	Taxonomy
										NPI	NPI Number
3	05 03 10 05 03 10	11		92551	EP		0.00	1		ZZ	Taxonomy
										NPI	NPI Number
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 $ 80.33
29. AMOUNT PAID $	30. BALANCE DUE $ 80.33		
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) The JP Provider Clinic 123 Any St Any City, NC 27523-5678 a. NPI b. ZZ Taxonomy	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Interperiodic Examination
(Block 24H) Referral Indicator "F"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joanna	3. PATIENT'S BIRTH DATE MM DD YY: 06 15 91 SEX M F X
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code): ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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 TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. V70.3 2. 3. 4.	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	05 15 10	05 15 10	11		99395	EP		80 33	1	F	ZZ NPI	Taxonomy NPI Number
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: $ 80.33	29. AMOUNT PAID: $	30. BALANCE DUE: $ 80.33
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: 123 That St, That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ): The JP Provider Clinic, 123 Any St, Any City, NC 27523-5678 a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Immunizations Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 12 25 08 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY STATE	
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	
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.	
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 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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. V03.81 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. 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	05	05	10	05	05	10	11		90471	EP		17 25	1		ZZ NPI	Taxonomy NPI Number
2	05	05	10	05	05	10	11		90472	EP		29 13	3		ZZ NPI	Taxonomy NPI Number
3	05	05	10	05	05	10	11		90713			0 00	1		ZZ NPI	Taxonomy NPI Number
4	05	05	10	05	05	10	11		90716			0 00	1		ZZ NPI	Taxonomy NPI Number
5	05	05	10	05	05	10	11		90647			0 00	1		ZZ NPI	Taxonomy NPI Number
6	05	05	10	05	05	10	11		90700			0 00	1		ZZ NPI	Taxonomy NPI Number

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 $ 46.38
29. AMOUNT PAID $	30. BALANCE DUE $ 46.38		
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) The JP Provider Clinic 123 Any St Any City, NC 27523-5678 a. NPI NPI b. ZZ Taxonomy	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

FQHC/RHC
Core Visit
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 09 09 08 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. 382.9 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. 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	05 20 10 05 20 10	11		T1015			65 00	1		ZZ NPI	Taxonomy NPI Number
2	05 20 10 05 20 10	11		90700			0 00	1		ZZ NPI	Taxonomy NPI Number
3	05 20 10 05 20 10	11		90707			0 00	1		ZZ NPI	Taxonomy NPI Number
4	05 20 10 05 20 10	11		90716			0 00	1		ZZ NPI	Taxonomy NPI Number
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 $ 65.00	29. AMOUNT PAID $	30. BALANCE DUE $ 65.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) The JP Provider Clinic 123 Any St Any City, NC 27523-5678 a. NPI NPI b. ZZ Taxonomy		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider – Split Claim
Periodic Examination

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joanna	3. PATIENT'S BIRTH DATE MM DD YY: 04 30 10 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V20.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. 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	06	29	10	06	29	10	11		99391	EP		80.33	1		ZZ	Taxonomy
														NPI	NPI Number
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 $ 80.33	29. AMOUNT PAID $	30. BALANCE DUE $ 80.33
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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI NPI b. ZZ Taxonomy		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

2nd Page of Split Claim
Private Provider
Immunizations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joanna	3. PATIENT'S BIRTH DATE MM DD YY: 04 30 10 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY: Fun Town STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY STATE	
ZIP CODE: 11111 TELEPHONE (Include Area Code): (555) 555-5555	
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.	

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 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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. V05.3 3. 2. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	06 29 10	06 29 10	11		90465	EP		17 25	1		ZZ NPI	Taxonomy NPI Number
2	06 29 10	06 29 10	11		90466	EP		19 42	2		ZZ NPI	Taxonomy NPI Number
3	06 29 10	06 29 10	11		90680			0 00	1		ZZ NPI	Taxonomy NPI Number
4	06 29 10	06 29 10	11		90744			0 00	1		ZZ NPI	Taxonomy NPI Number
5	06 29 10	06 29 10	11		90669			0 00	1		ZZ NPI	Taxonomy NPI Number
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 $ 36 67
29. AMOUNT PAID $	30. BALANCE DUE $ 36 67		

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.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Private Provider
Immunizations Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789K
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 09 06 05 SEX M X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street)
CITY: Fun Town / STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student		CITY / STATE
ZIP CODE: 11111 / TELEPHONE (Include Area Code): (555) 555-5555			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.
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 TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. V06.1 2. 3. 4.			22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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	03 21 10	03 21 10	11		90471	EP		17.25	1		ZZ	Taxonomy
											NPI	NPI Number
2	03 21 10	03 21 10	11		90472	EP		19.42	2		ZZ	Taxonomy
											NPI	NPI Number
3	03 21 10	03 21 10	11		90700			0.00	1		ZZ	Taxonomy
											NPI	NPI Number
4	03 21 10	03 21 10	11		90713			0.00	1		ZZ	Taxonomy
											NPI	NPI Number
5	03 21 10	03 21 10	11		90707			0.00	1		ZZ	Taxonomy
											NPI	NPI Number
6												
											NPI	

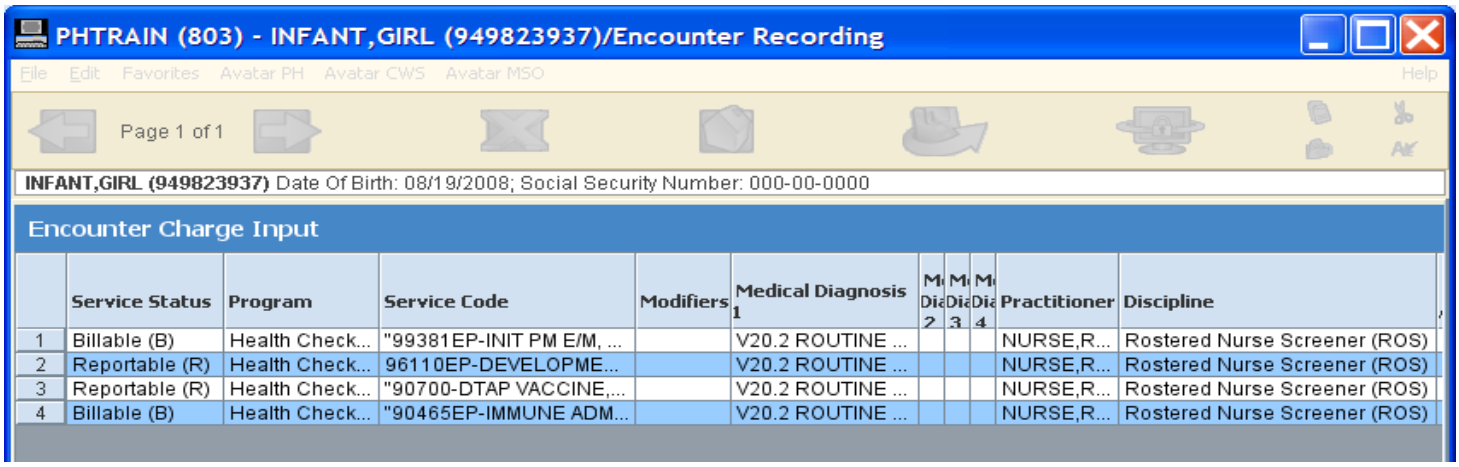
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 36.67 / 29. AMOUNT PAID $ / 30. BALANCE DUE $ 36.67
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234 a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) Dr J P Provider 123 Any St Any City, NC 27523-5678 a. NPI NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

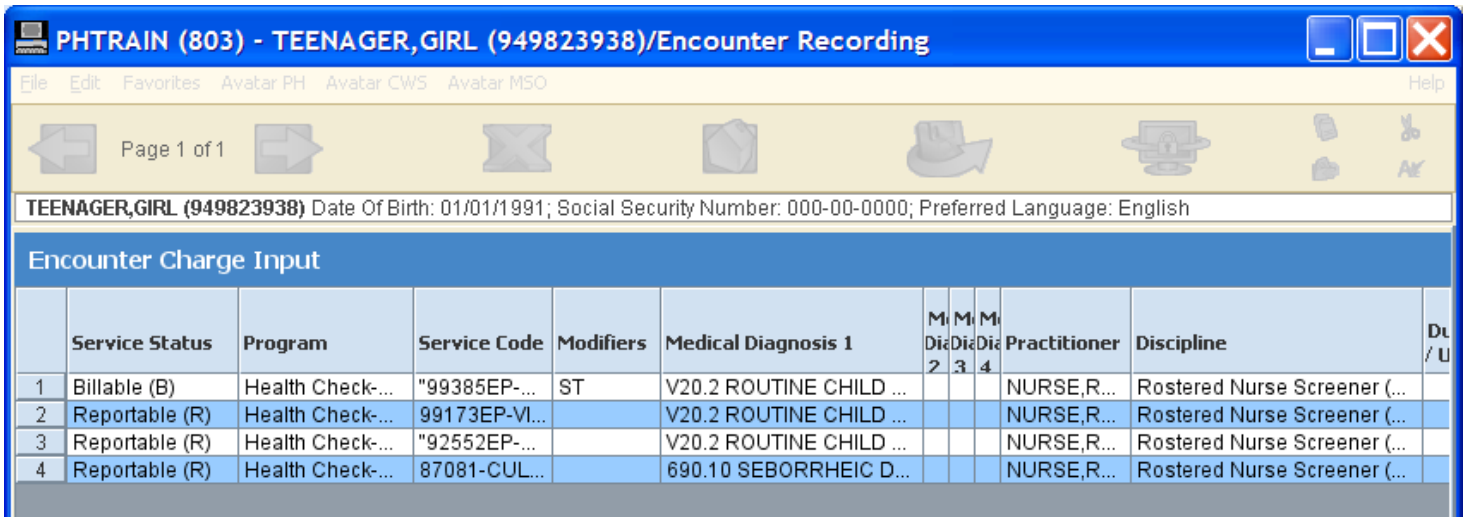
SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN FOR LOCAL HEALTH DEPARTMENT'S THAT USE THE NEW HEALTH INFORMATION SYSTEM (HIS)

Example #1 - Health Check Periodic Screening assessment for six-month-old child
Developmental Screening
Immunizations Injections



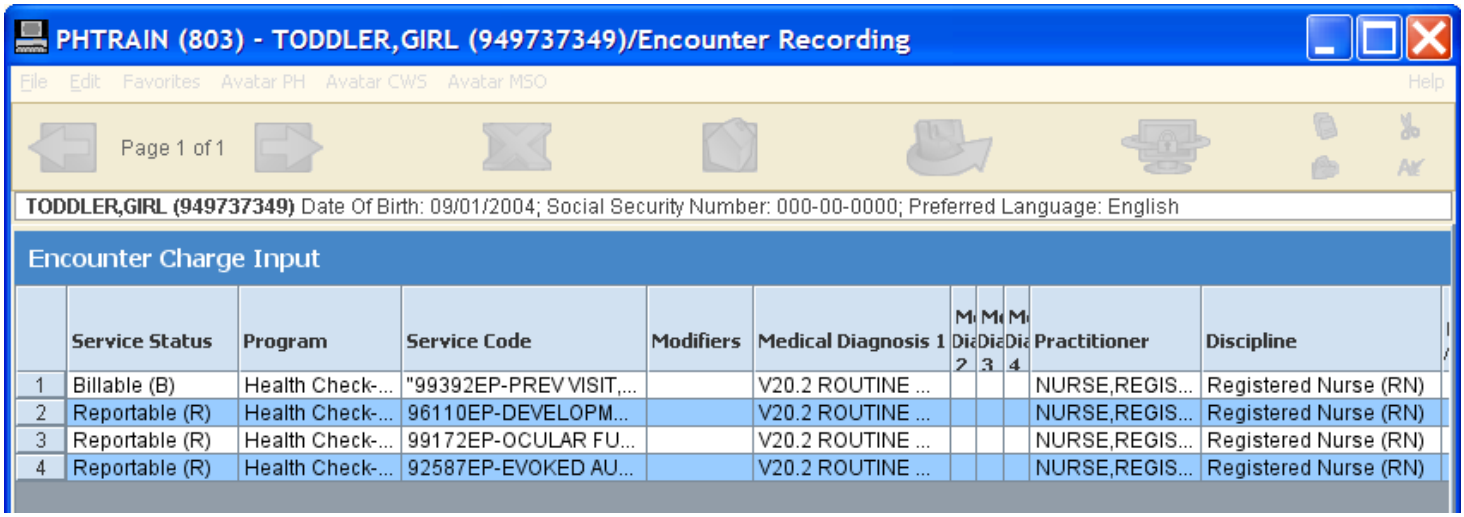
	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	M Dia 2	M Dia 3	M Dia 4	Practitioner	Discipline
1	Billable (B)	Health Check...	"99381EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)
2	Reportable (R)	Health Check...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)
3	Reportable (R)	Health Check...	"90700-DTAP VACCINE,...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)
4	Billable (B)	Health Check...	"90465EP-IMMUNE ADM...		V20.2 ROUTINE ...				NURSE,R...	Rostered Nurse Screener (ROS)

Example #2 – Health Check Periodic Screening assessment for 18-year-old
Vision Screening
Hearing Screening
Diagnosis warrants a referral for a follow-up visit, designated with "ST/S2"



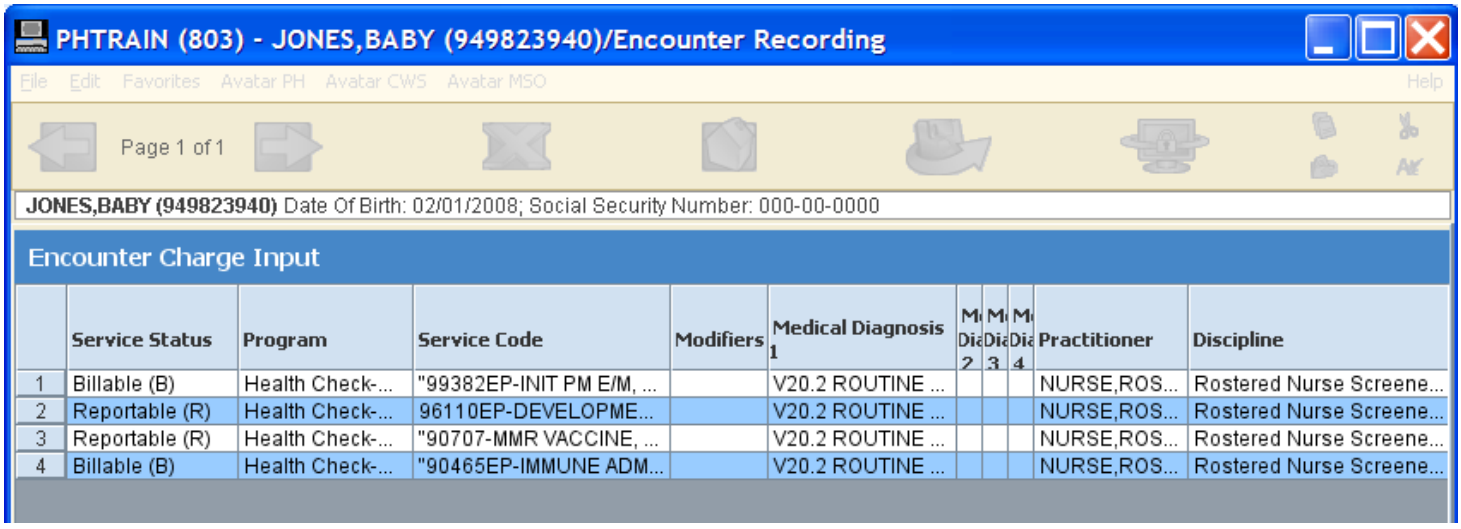
	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	M Dia 2	M Dia 3	M Dia 4	Practitioner	Discipline	Du / U
1	Billable (B)	Health Check-...	"99385EP-...	ST	V20.2 ROUTINE CHILD ...				NURSE,R...	Rostered Nurse Screener (...	
2	Reportable (R)	Health Check-...	99173EP-VI...		V20.2 ROUTINE CHILD ...				NURSE,R...	Rostered Nurse Screener (...	
3	Reportable (R)	Health Check-...	"92552EP-...		V20.2 ROUTINE CHILD ...				NURSE,R...	Rostered Nurse Screener (...	
4	Reportable (R)	Health Check-...	87081-CUL...		690.10 SEBORRHEIC D...				NURSE,R...	Rostered Nurse Screener (...	

Example #3 – Health Check Periodic Screening assessment for 4-year-old child With Developmental Screening, Vision Screening, Hearing Screening



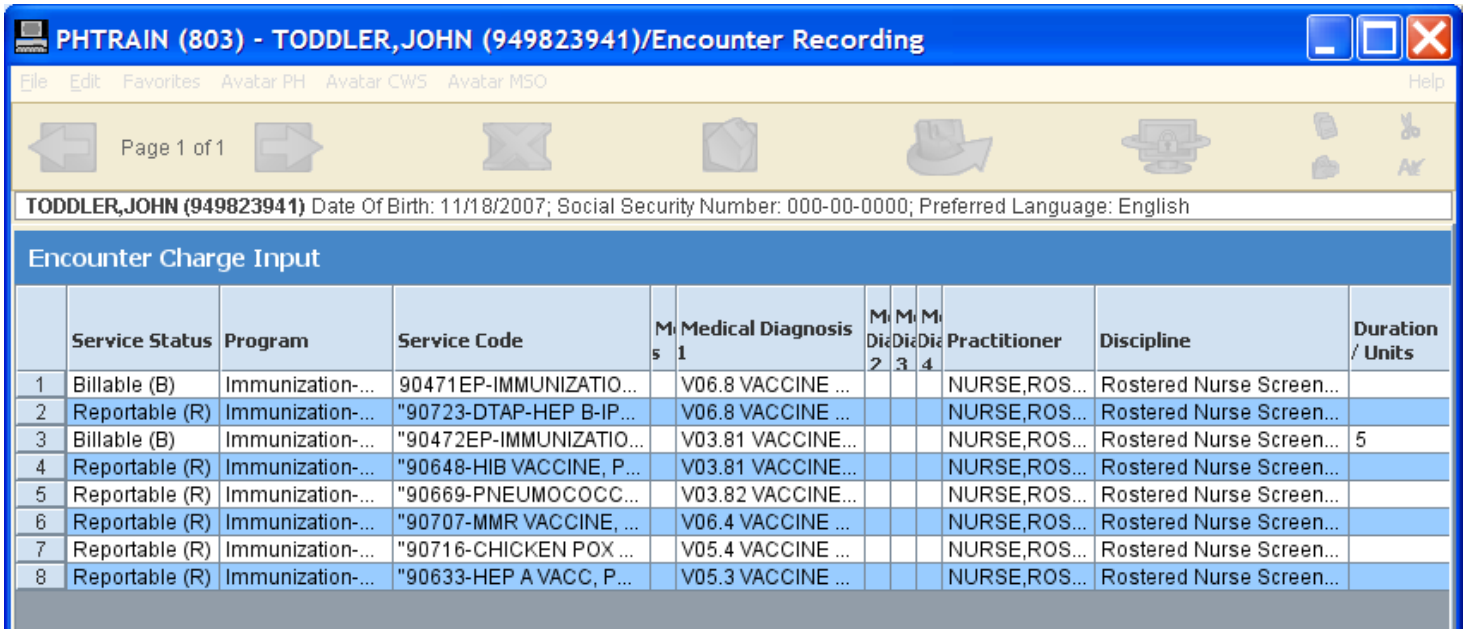
	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	M Dia 2	M Dia 3	M Dia 4	Practitioner	Discipline
1	Billable (B)	Health Check-...	"99392EP-PREV VISIT,...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)
2	Reportable (R)	Health Check-...	96110EP-DEVELOPM...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)
3	Reportable (R)	Health Check-...	99172EP-OCULAR FU...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)
4	Reportable (R)	Health Check-...	92587EP-EVOKED AU...		V20.2 ROUTINE ...				NURSE,REGIS...	Registered Nurse (RN)

Example #4 – Health Check Periodic Screening assessment for 2-year-old child Developmental Screening



	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	M Dia 2	M Dia 3	M Dia 4	Practitioner	Discipline
1	Billable (B)	Health Check-...	"99382EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...
2	Reportable (R)	Health Check-...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...
3	Reportable (R)	Health Check-...	"90707-MMR VACCINE, ...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...
4	Billable (B)	Health Check-...	"90465EP-IMMUNE ADM...		V20.2 ROUTINE ...				NURSE,ROS...	Rostered Nurse Screene...

Example #5 – Immunization Administration Fee with Vaccine Injections ONLY for 15 month old child without physician counseling



PHTRAIN (803) - TODDLER,JOHN (949823941)/Encounter Recording

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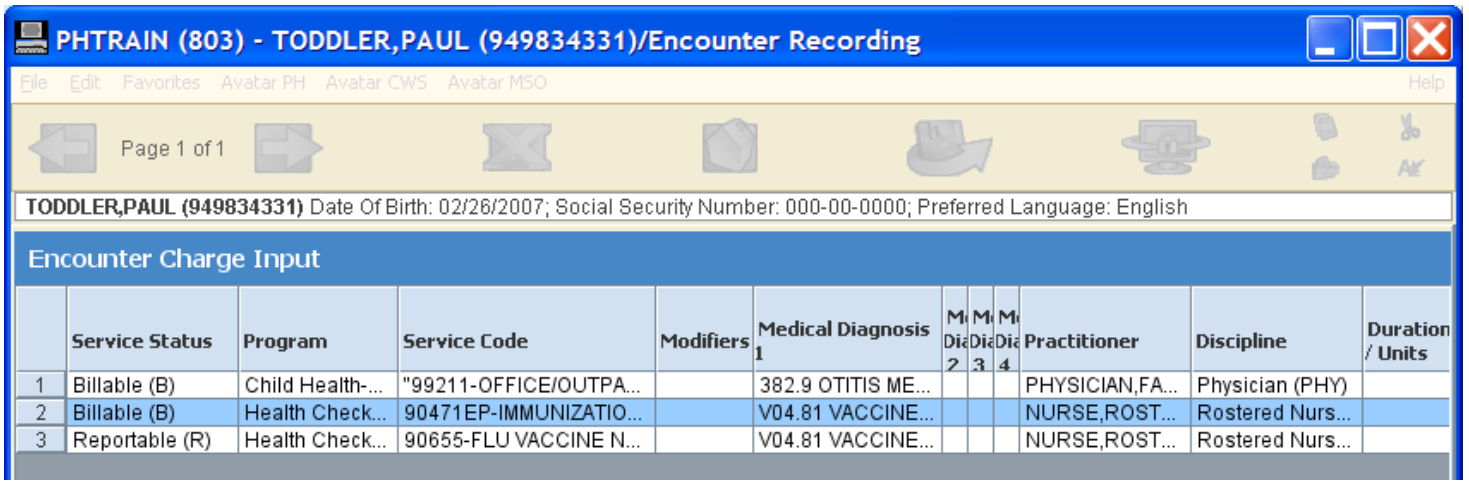
TODDLER,JOHN (949823941) Date Of Birth: 11/18/2007; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Ms	Medical Diagnosis 1	Dia 2	Dia 3	Dia 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization-...	90471EP-IMMUNIZATIO...		V06.8 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
2	Reportable (R)	Immunization-...	"90723-DTAP-HEP B-IP...		V06.8 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
3	Billable (B)	Immunization-...	"90472EP-IMMUNIZATIO...		V03.81 VACCINE...				NURSE,ROS...	Rostered Nurse Screen...	5
4	Reportable (R)	Immunization-...	"90648-HIB VACCINE, P...		V03.81 VACCINE...				NURSE,ROS...	Rostered Nurse Screen...	
5	Reportable (R)	Immunization-...	"90669-PNEUMOCOCC...		V03.82 VACCINE...				NURSE,ROS...	Rostered Nurse Screen...	
6	Reportable (R)	Immunization-...	"90707-MMR VACCINE, ...		V06.4 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
7	Reportable (R)	Immunization-...	"90716-CHICKEN POX ...		V05.4 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	
8	Reportable (R)	Immunization-...	"90633-HEP A VACC, P...		V05.3 VACCINE ...				NURSE,ROS...	Rostered Nurse Screen...	

Example #6 – Office Visit with One Vaccine Injection for two-year old child



PHTRAIN (803) - TODDLER,PAUL (949834331)/Encounter Recording

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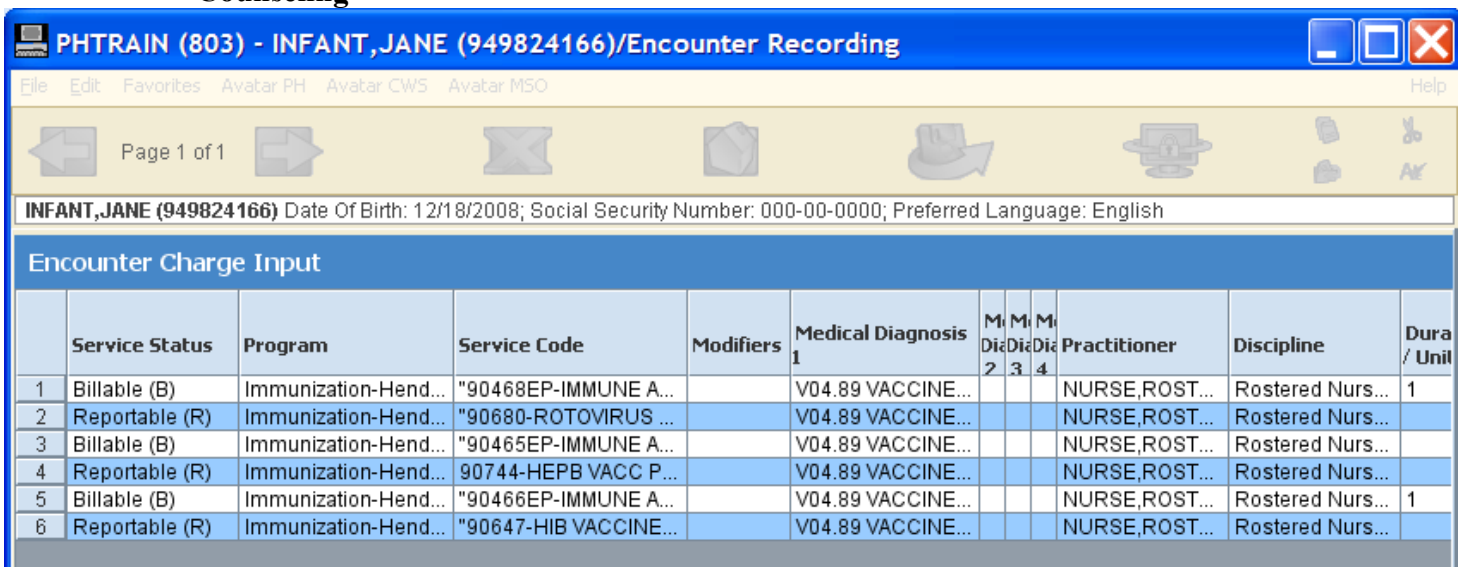
TODDLER,PAUL (949834331) Date Of Birth: 02/26/2007; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Dia 2	Dia 3	Dia 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Child Health-...	"99211-OFFICE/OUTPA...		382.9 OTITIS ME...				PHYSICIAN,FA...	Physician (PHY)	
2	Billable (B)	Health Check...	90471EP-IMMUNIZATIO...		V04.81 VACCINE...				NURSE,ROST...	Rostered Nurs...	
3	Reportable (R)	Health Check...	90655-FLU VACCINE N...		V04.81 VACCINE...				NURSE,ROST...	Rostered Nurs...	

Example #7 – Immunizations Only for eight-week old child
Immunization Administration Fee for Oral Vaccine w/Physician Counseling
Immunization Administration Fee with Vaccine Injection w/Physician Counseling


PHTRAIN (803) - INFANT,JANE (949824166)/Encounter Recording

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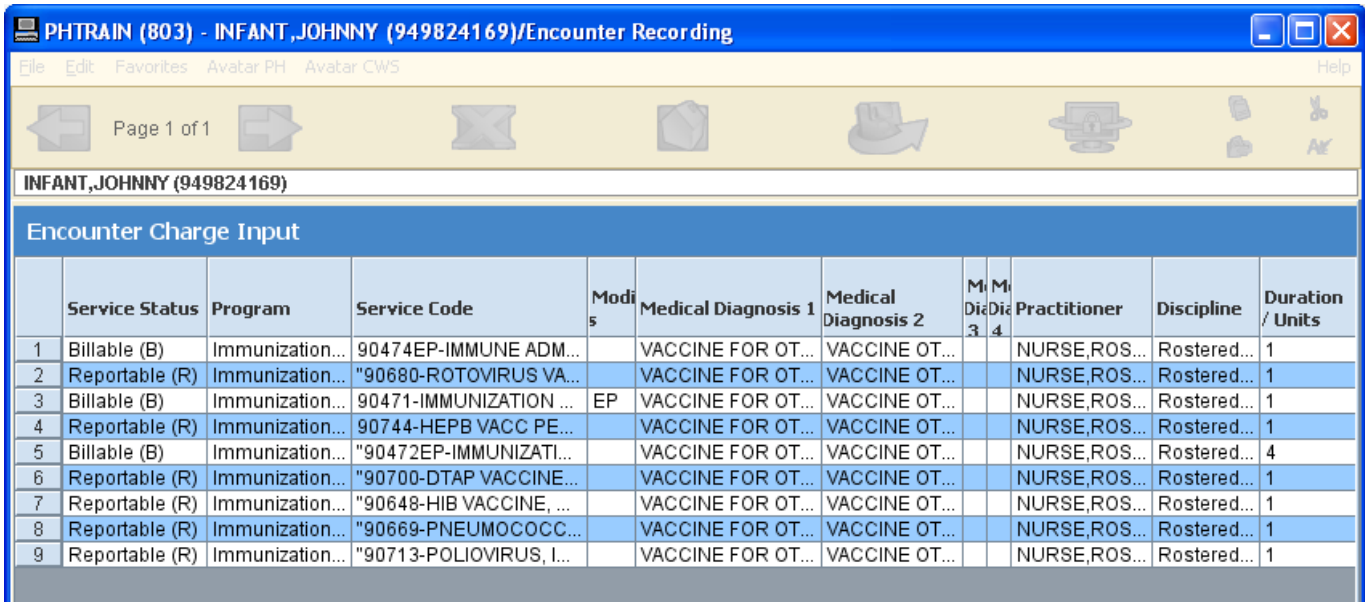
INFANT,JANE (949824166) Date Of Birth: 12/18/2008; Social Security Number: 000-00-0000; Preferred Language: English

Encounter Charge Input

	Service Status	Program	Service Code	Modifiers	Medical Diagnosis 1	Dia 2	Dia 3	Dia 4	Practitioner	Discipline	Dura / Unit
1	Billable (B)	Immunization-Hend...	"90468EP-IMMUNE A...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	1
2	Reportable (R)	Immunization-Hend...	"90680-ROTOVIRUS ...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	
3	Billable (B)	Immunization-Hend...	"90465EP-IMMUNE A...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	
4	Reportable (R)	Immunization-Hend...	90744-HEPB VACC P...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	
5	Billable (B)	Immunization-Hend...	"90466EP-IMMUNE A...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	1
6	Reportable (R)	Immunization-Hend...	"90647-HIB VACCINE...		V04.89 VACCINE...				NURSE,ROST...	Rostered Nurs...	

Example #8 – Immunizations Only for two-month old child
Administration Fee for Oral Vaccine without physician counseling
Administration Fee for Vaccine Injection without physician counseling


PHTRAIN (803) - INFANT,JOHNNY (949824169)/Encounter Recording

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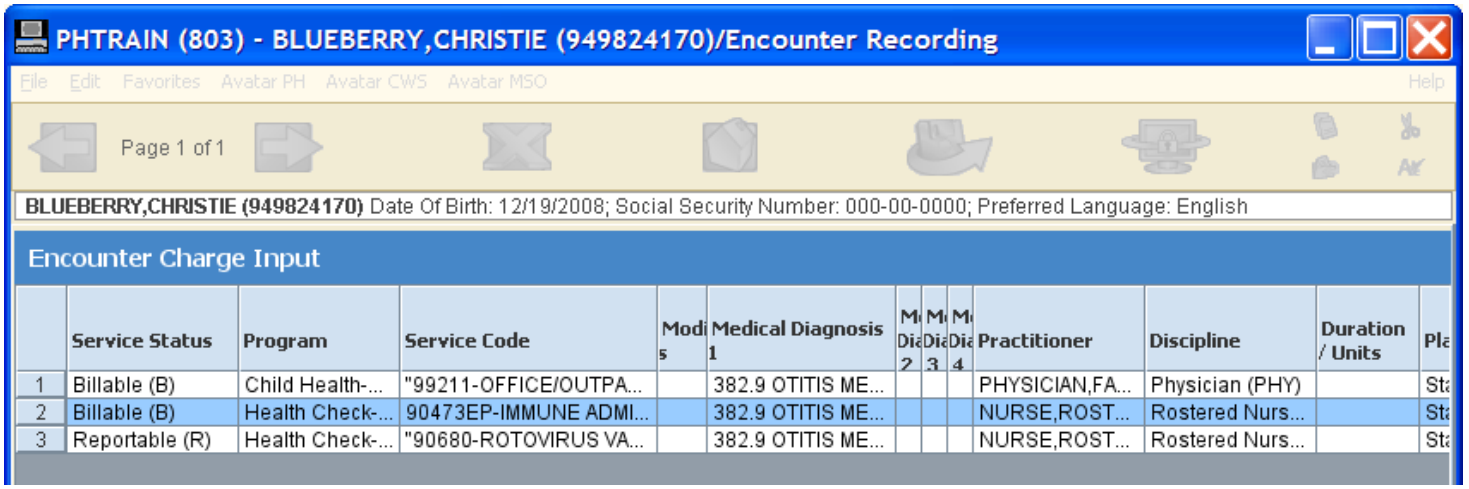
INFANT,JOHNNY (949824169)

Encounter Charge Input

	Service Status	Program	Service Code	Modis	Medical Diagnosis 1	Medical Diagnosis 2	Dia 3	Dia 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Immunization...	90474EP-IMMUNE ADM...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
2	Reportable (R)	Immunization...	"90680-ROTOVIRUS VA...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
3	Billable (B)	Immunization...	90471-IMMUNIZATION ...	EP	VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
4	Reportable (R)	Immunization...	90744-HEPB VACC PE...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
5	Billable (B)	Immunization...	"90472EP-IMMUNIZATI...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	4
6	Reportable (R)	Immunization...	"90700-DTAP VACCINE...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
7	Reportable (R)	Immunization...	"90648-HIB VACCINE, ...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
8	Reportable (R)	Immunization...	"90669-PNEUMOCOCC...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1
9	Reportable (R)	Immunization...	"90713-POLIOVIRUS, I...		VACCINE FOR OT...	VACCINE OT...			NURSE,ROS...	Rostered...	1

Example #9 – Office Visit at which Oral Vaccine for two-month old child was provided without physician counseling



	Service Status	Program	Service Code	Mods	Medical Diagnosis 1	Dia 2	Dia 3	Dia 4	Practitioner	Discipline	Duration / Units	Pla
1	Billable (B)	Child Health-...	"99211-OFFICE/OUTPA...		382.9 OTITIS ME...				PHYSICIAN,FA...	Physician (PHY)		Sta
2	Billable (B)	Health Check-...	90473EP-IMMUNE ADMI...		382.9 OTITIS ME...				NURSE,ROST...	Rostered Nurs...		Sta
3	Reportable (R)	Health Check-...	"90680-ROTOVIRUS VA...		382.9 OTITIS ME...				NURSE,ROST...	Rostered Nurs...		Sta

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Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services