Milwaukee County Care Management Organization

2010 Provider Handbook

LTC: Let's Take Care

MILWAUKEE COUNTY
INCORPORATED 1835

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Preface

This handbook is issued by the Milwaukee County Care Management Organization (CMO). It provides information and guidance for providers who are affiliated with the Milwaukee County Care Management Organization. This handbook contains general information about the Milwaukee County CMO, our provider network, Family Care and the Family Care Benefit Package. You will also find detailed information about the MIDAS Provider Portal, service authorizations, how to file claims, reasons claims are denied and how to file appeals. The handbook is a good place to begin when you have questions. It can also be very valuable for new provider employees.

Providers should use this handbook in conjunction with other resources, including:

- Family Care Guide For Wisconsin Medicaid-Certified Providers
- Wisconsin Medicaid All-Provider Handbook
- Wisconsin Medicaid service-specific handbooks
- *Wisconsin Medicaid and BadgerCare Updates*
- Wisconsin Administrative Code, Chapters DHS 101-108

For more information, providers may also refer to:

- Milwaukee County Department on Aging **www.milwaukee.gov/county/aging**
- Wisconsin Medicaid's Web site at **www.dhs.wisconsin.gov/medicaid**
- Long-term care Web site at **www.dhs.wisconsin.gov/LTCare**
- Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883

If you have questions or you need help in understanding anything in this handbook, please call your Contract Services Coordinator. (Refer to Appendix 1 of this handbook for Contract Services Coordinator assignments.)

What is Family Care?

Family Care, authorized by the Governor and Legislature in 1998, serves people with physical disabilities, people with developmental disabilities and frail elders, with the specific goals of:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
- Improving access to services.
- Improving quality through a focus on health and social outcomes.
- Creating a cost-effective system for the future.

Family Care has two major organizational components:

1. **Aging and Disability Resource Centers** (ADRCs), designed to be a single entry point where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities.

2. **Care Management Organizations** (CMOs) which manage and deliver the Family Care benefit. The Family Care benefit combines funding and services from a variety of existing programs into one flexible long-term care benefit, tailored to each individual's needs, circumstances and preferences.

The Wisconsin Department of Health Services (DHS) contracts with Care Management Organizations (CMOs) to provide or arrange for services in the Family Care Benefit Package. Each CMO develops a provider network to provide services to Family Care Members who live in their own homes, nursing facilities, or other group living situations.

The Milwaukee County
Care Management Organization

The Milwaukee County Care Management Organization is a department of Milwaukee County contracted with the Wisconsin Department of Health Services to administer the Family Care benefit in Milwaukee County per the Health and Community Supports Contract and Administrative Rule HFS 10.

A significant part of our responsibility is to partner with community organizations able to provide the goods and services funded through our program. This is the role that our providers play in Family Care.

The Milwaukee County CMO is located at 310 W. Wisconsin Avenue, 6th floor East Tower, Milwaukee, WI 53203.

Our Mission Statement

The Milwaukee County CMO respects the dignity and personal autonomy of each Member by honoring choice and promoting the Member's continued participation in the life of their community, by providing a continuum of quality cost-effective long-term care to its Members, and by supporting the families and caregivers of its Members.

Our Core Values

The core values serve as the foundation to guide both the development of the organization's mission and the identification of appropriate behavior and activities in the fulfillment of the mission.

1. **Member-centered** - We acknowledge that our Members are the purpose for our existence. We will always put the best interest of our Members at the center of decision-making.

2. **Care that embraces the whole person** - We are committed to providing quality care that encompasses the body, mind, spirit and social relationships and that preserves the quality of life for our Members.

3. **Dignity** - We will respect the dignity and personal autonomy of each Member.

4. **Collaboration** - We believe in being inclusive and fostering teamwork and collaborative efforts with our Members, their families/support systems, and other organizations.

5. **Justice** - We believe that it is critical for all Members to receive fair equitable treatment that is free from discrimination.

6. **Stewardship** - As a public agency, we have a concern for careful use of our resources and a responsibility to be responsive to the public's input.

7. **Beneficence** - We will strive to provide the best care for our Members.

8. **Cultural Competence** - We are committed to care delivery that is responsive to the cultural values of our Members.

Who is Eligible for Milwaukee County CMO Services?

The Milwaukee County CMO provides services to individuals that meet the following criteria:

- Age and Disability Requirements
    * At least 18 years of age
    * Persons with physical disabilities, developmental disabilities or frail elders

- Financially Eligible - Determined by Economic Support Division

- Functionally Eligible - Determined by screening with Aging and Disability Resource Center

- A resident or responsibility of Milwaukee County

The Aging and Disability Resource Center (ADRC) determines an individual's eligibility for Milwaukee County CMO services. You can contact the ADRC at 414-289-6874.

Enrollment in the Milwaukee County CMO is voluntary. Members choose whether or not they want to be a Member of the program. Once enrolled, an Interdisciplinary Team is assigned to the Member.

This Team consists of the individual Member, their families, a case manager, a nurse, and other professionals or consultants as determined necessary by the Member's needs. Upon completion of the eligibility and screen process, this Team assesses the individual needs of the Member and works to develop a Member Centered Plan.

Specific providers are chosen based on their ability to meet the outcomes of the Member.

Provider Network

The network of providers have signed contracts with the Milwaukee County CMO and agreed to adhere to all components of the contract including, but not limited to:

- Agree to Milwaukee County CMO rate.
- Follow contractual requirements related to authorizations and billing.
- Maintain ongoing communications with Milwaukee County CMO staff.
- Meet or exceed quality assurance expectations of Milwaukee County CMO.
- Submit an annual audit as applicable.

The contract specifies the services that an agency is authorized to provide to Milwaukee County CMO Members. As a contracted provider in the Milwaukee County CMO Provider Network, the agency is added to the Provider Directory, which is given to Members. Members and their Interdisciplinary Team choose the Member's service providers from the Provider Directory. All providers are required to be HIPAA compliant.

The Health and Community Supports Contract and HFS 10 requires Milwaukee County CMO to continually monitor the Provider Network to ensure that service capacity and access are managed in accordance with current and anticipated Member service demands. Excess capacity in the Provider Network increases our administrative costs and makes it more difficult to monitor provider quality. Milwaukee County CMO is not required to contract with providers beyond the number necessary to meet the needs of Members.

Ineligible Organizations

The Milwaukee County CMO shall exclude all organizations from participation in the provider network, which can be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*
   Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

   a. Been convicted of the following crimes:

      i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid. (See Section 1128(a)(1) of the Act);
      ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care. (See Section 1128(a)(2) of the Act);
      iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government. (See Section 1128(b)(1) of the Act);
      iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above. (See Section 1128(b)(2) of the Act); or,
      v. Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance. (See Section 1128(b)(3) of the Act).

   b. Been excluded from participation in Medicare or a State Health Care Program. A State Health Care Program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act.)

   c. Been assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)

Out of Network Providers

The Milwaukee County CMO will consider Member requests for providers outside of our network, but the Milwaukee County CMO is not required to add providers to our network simply because they are requested by Members. The requested provider must meet the quality standards set by the Milwaukee County CMO and accept the service rate set by the Milwaukee County CMO. The Milwaukee County CMO will add providers that meet the specific needs of a Member whenever feasible.

Family Care Benefit Package

In general, long-term care services (for example, health services in a Member's home) are included in the Family Care Benefit Package. Acute and primary care services, including physicians, hospital stays and medications, are not included in the Family Care Benefit Package. These medical services will remain fee-for-service for those who are Medicaid eligible. The Family Care Benefit Package also includes services covered by the Community Options Program and the home and community-based waivers program. The following Medicaid Services **are** included in the "Family Care Benefit Package."

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and other Drug Abuse Services, except those provided by a physician or on an inpatient basis
- Assessment and Case Planning
- Case Management
- Communication Aids/Interpreter Services
- Community Support
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services and Treatment
- Durable Medical Equipment and Medical Supplies (except for hearing aids and prosthetics)
- Home Health
- Home Modifications
- Meals delivered to Member's home
- Mental Health Services (except those provided by a physician or on an inpatient basis)
- Nursing Facility
- Nursing Services (except for in-patient hospital stays)
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Personal Emergency Response System Services
- Physical Therapy (in all settings except for inpatient hospital)
- Prevocational Services
- Residential Services: Intermediate Care Facility for People with Mental Retardation (ICF/MR), Residential Care Apartment complex (RCAC), Community Based Residential Facility (CBRF) and Adult Family Home (AFH)
- Respite Care (provided in non-institutional and institutional settings for caregivers of Members)
- Specialized Medical Supplies
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Supported Employment
- Supportive Home Care
- Transportation: all Medicaid covered transportation services (except ambulance)

Providers must obtain **prior authorization** from the Member's Care Manager for **all** services to be rendered or the Milwaukee County CMO may not cover the cost of the service.

The Milwaukee County CMO will not reimburse providers at rates higher than the Medicaid rate for Medicaid services included in the Family Care Benefit Package.

Family Care Benefit Package Exclusions

The following Medicaid Services are **not** included in the "Family Care Benefit Package". Medicaid eligible Members can access these services with their Forward Card.

- Alcohol and other Drug Abuse services provided by a physician or in an inpatient hospital setting
- Audiologist
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital, Inpatient and Outpatient, including emergency room care (except for Outpatient Physical Therapy, Occupational Therapy, Speech, Mental Health services from a non-physician and Alcohol and other Drug Abuse from a non-physician)
- Independent Nurse Practitioner services
- Lab and X-Ray
- Medication
- Mental Health Services provided by a physician or in an inpatient hospital setting
- Optometry
- Physician and Clinic Services (except for Outpatient Physical Therapy, Occupational Therapy, Speech, Mental Health services from a non-physician and Alcohol and other Drug Abuse for a non-physician)
- Podiatry
- Prenatal Care Coordination
- Prosthetics

The Milwaukee County CMO may consider paying for the services listed above on an individual basis even though they are not a Family Care benefit. Providers must obtain **prior authorization** from the Care Manager before rendering the service if they want the Milwaukee County CMO to cover the cost of the service.

Providers should continue to bill Medicaid fee-for-service for Medicaid services that are not included in the Family Care Benefit Package when provided to Medicaid-eligible Milwaukee County CMO Members.

For Members who are not eligible for Medicaid, providers should bill Members or the Members' commercial health insurance for any services that are not included in the Family Care Benefit Package.

Service Authorization

As the sole payment source for Family Care services, the CMO provides our own service authorizations. Prior to delivery of service to a Family Care Member, the provider must obtain a Service Authorization from the Member's Care Manager. To obtain a Care Manager's name and telephone number, contact Family Care Customer Service at (800) 223-6016.

The Care Manager needs the following information in order to consider creating a Service Authorization:

a. Member name
b. service to be provided including HCPC or procedure code
c. units and frequency of service
d. Dates of service
e. service location

Providers who have a contract with Milwaukee CMO may access the MIDAS Provider Portal website at **https://www.mcda-cmo.com** to view and print their Service Authorizations. (If necessary, it is possible for the CMO to arrange for printing Service Authorizations nightly and mailing them to a provider on a daily basis.) If a provider has a question about the Service Authorization or if there is a discrepancy, contact the Care Manager immediately. The Care Manager name, phone number, and e-mail address is on the Service Authorization. (See sample Service Authorization in the Appendix.)

A Service Authorization does not guarantee payment of your services. Benefits are available as long as the Member is eligible at the time service is provided.

Contact your Contract Services Coordinator to obtain your Provider Portal access code. Please see the Appendix of this handbook for a guide to the features available on the Provider Portal.

Third Party Administrator

The Milwaukee County CMO contracts with a Third Party Administrator (TPA) to process provider claims for payment.

The Third Party Administrator is:

Milwaukee County Care Management Organization
c/o **WPS INSURANCE CORP.**
PO Box 7460
Madison, WI 53707-7460
Customer Service Phone #: (800) 223-6016

Provider Training Specialist

The Milwaukee County CMO has a Provider Training Specialist to insure that our providers receive adequate education in all aspects of Family Care billing in order to facilitate timely and accurate payments to their organizations.

The Provider Training Specialist provides training to Milwaukee County CMO service providers regarding use of the Provider Portal, understanding the clean claim and appeal process, electronic submission of claims, and the appropriate use of explanation of benefits (EOB) reports to verify and reconcile payments. This training is available to all existing providers upon request and to all new providers upon acceptance to the network and is performed at your location.

If you would like to set up an appointment with our Provider Training Specialist to discuss any current or ongoing issues, or if you are a new provider in need of assistance, please call: **(414) 289-6249.**

"CLEAN" Claim Submission REQUIREMENTS

5 STEP "CLEAN CLAIM" SUBMISSION PROCESS

1. All Family Care services must be performed by Milwaukee County Care Management Organization (CMO) **Contracted Network Provider.**

2 All Family Care services must be **Pre-Authorized** by the Member's Care Manager, (contact WPS Customer Service **1-800-223-6016**). **In urgent situations, it is possible to obtain a backdated service auth only if requested within 10 days of the date of service**. **No payment** will be made for **un-authorized dates of services.**

Provider is responsible to validate your Family Care service authorization for accuracy.

Dates of service on your claim must match the date span on your service authorization.
Units of Service on your claim may not exceed the number of unit(s) on your service authorization.
Service Code/HCPCS/Revenue Code on your claim must match the code on your service authorization.

If the service you are going to provide does not correspond to your Family Care service authorization, you must contact the Member's Care Manager immediately. A NEW service authorization can be backdated up to 10 days. Untimely requests will cause an un-authorized date of service and your claim payment will deny.

3. **Provider is responsible to submit a** "Clean Claim"

REQUIRED ELEMENTS OF A "CLEAN CLAIM"

- **ONE Member / ONE Service Authorization Number / ONE Service Code, Per ONE CLAIM FORM**
- **ONE Service Authorization Number Per Claim Form:**
  List in Box 23 CMS- 1500, Box 63 UB-04, Box 2 Milw Co Claim Form, listed on your Company Invoice, or listed on the Electronic Format
- **Provider Name, Provider Address, and Provider Number (TIN / EIN / SSN) and National Provider Identifier NPI**
- **Member Full Name, Social Security Number, Date of Birth**
- **Date(s) of Service (date range or individual days)**
- **Service Code /HCPC / Revenue Code / Modifier, if applicable**

- **Number of Units (days or units of provided service)**
- **Unit Rate / Billed Amount**
- **Attach Medicare EOMB / Primary Insurer EOB, if applicable**
- **Received by WPS within 120 days from the service start date, or received within 90 days from the date of primary insurer's EOB / Medicare EOMB**

4. **The "Clean Claim" Submission Deadline**: Your **"Clean Claim"** or "**Claim Correction"** must be received by WPS within 120 days from the service start date or within 90 days from the date of Primary Insurer EOB / Medicare EOMB.
   ***NOTE: A claim "CORRECTION" MUST state "CORRECTION" on your paper re-submitted claim, also highlight the correction made to your claim – example: update to units, correction to unit rate, etc.**

   "Clean Claims" must be mailed to:
   WPS Insurance
   C/O Milwaukee County Family Care
   PO BOX 7460
   Madison WI 53707-7460

5. If provider payment has not been received within 30 business days of provider claim submission, please follow-up by contacting **WPS 1-800-223-6016 for payment status**.

   You may submit claims for authorized services using any of the following claim submission options, however, electronic submission is preferred and results in faster payment to the provider.

Claim Submission Options

1. **Electronic Filing**

   - WPS accepts electronic claims in the HIPAA standard format (ANSI X12 837 version 4010A1) for both professional and institutional services.
   - Claims may be submitted direct from a provider's office using vendor-developed or WPS-supplied software, or through an approved clearinghouse or billing service.

   To enroll with WPS for electronic claim submission or to discuss electronic submission options, contact our Electronic Data Services consultant at (608) 223-5858. To obtain access to our WPS plus patient eligibility/claim status application, contact WPS Electronic Data Services at (608) 223-5858.

   - Bill only ***one*** procedure code with the corresponding authorization per claim.

2. **CMS-1500** ***(Please note the additional requirements below.)***

   - Authorization Number(s) in BOX 23
   - One authorization number per code
   - Bill with service code from the Service Authorization Form

3. **UB -04*****(Please note the additional requirements below.)***

   - Authorization number(s) in BOX 63
   - One authorization number per code
   - Bill with service code from service Authorization Form

   Exception - for Medicare Coinsurance claims, the original UB -04submitted to Medicare may be used, however an authorization code for each Family Care covered service must be entered in Box 63.

4. **Milwaukee County Department on Aging billing form** ***(Please note the additional requirements below.)***

   - **One Member** per claim
   - **One authorization number** per claim
   - Dates of service (Date span or individual days)
   - Bill with service code from service Authorization Form

   (Refer to the Appendix for an example of a blank CMS 1500 claim form and a blank UB-4 form.)

5. **If you generate invoices and wish to continue using them, WPS will accept them in lieu of the standard claim form. However, the following information must be included on the invoice bill to avoid delay or denial of payments:**

   - Pre-Service Authorization Number
   - Member Name and Member Number
   - Provider Name, Provider Address, and Provider Number (NPI, TIN, EIN, SSN)
   - Date(s) of Service
   - Bill with service code from service authorization form
   - Charge/Billed Amount
   - Number of Units/Days of service provided

CLAIM DENIAL REASONS

INCLUDING HINTS TO RESOLVE CLAIM DISCREPANCY

WPS	ANSI	
18	**18**	**WE'VE ALREADY PROCESSED THIS CHARGE.**

RESOLUTION: The charge received for processing has already been considered. The denial informs the provider of a duplicate billing for a same date of service has been received and paid. If this claim is for Additional Service Units for a service auth/same date of service, that was already processed (or received a partial payment), a **CORRECTED** claim must be updated and mailed to WPS within 120 days from service start date.

22	**22**	**CLAIM DENIED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS. PLEASE SEND THE OTHER CARRIER'S NOTICE OF PAYMENT OR DENIAL TO WPS PO BOX 8190. IF WE ARE IN ERROR, PLEASE CALL THE WPS CUSTOMER SERVICE DEPARTMENT AT (800) 221-5313.**

RESOLUTION: The Explanation of Benefits (EOB) from the Primary Carrier was missing at the time the claim was submitted for benefit consideration. Please **RE-SUBMIT** the claim with the corresponding explanation of benefits (EOB) for the services being billed. The complete information must be received by WPS within 90 days from the date listed on the EOB.

23	**23**	**CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS, WHICH MAY INCLUDE MEDICARE PAYMENTS. COORDINATION OF BENEFITS WITH YOUR PRIMARY PLAN OF COVERAGE MAY RESULT IN EITHER A REDUCED PAYMENT OR NO PAYMENT.**

The Member's primary carrier, whether it is Medicare or a private health care insurance, has made payment on the claim. The primary carrier allowed a greater fee amount than Family Care's fee schedule. This would result in making a reduced payment or no payment at all. If there is no primary carrier involved, please immediately contact WPS 1-800-223-6016 for processing clarification.

25	**62**	**THE DATE OF SERVICE IS EITHER BEFORE OR AFTER THE DATE RANGE AUTHORIZED BY FAMILY CARE. AUTHORIZATIONS ARE OBTAINED THROUGH THE CUSTOMER'S CMU CARE MANAGER.**

RESOLUTION: The dates of service billed are not within the Request From – Through date range authorized by Family Care. Check the dates on your original claim vs. your Family Care service authorization, to make sure they are correct. If the dates are incorrect on your claim, **RE-SUBMIT** with the date revision to WPS within 120 days from the service start date or 90 days from the date of the EOB. If your service date is not authorized, contact the Member's care manager to obtain a new

authorization and **SUBMIT** your new claim with the new authorization number should be mailed to WPS within 120 days from service start date.

27	**27**	**EXPENSE(S) INCURRED AFTER COVERAGE TERMINATED. SERVICES PROVIDED AFTER THE TERMINATION DATE, ARE NOT COVERED**. **RESOLUTION**: If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include the copy of your Family Care service authorization that supports the Request From – Through dates covering the timeframe you provided service, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.
28	**26**	**EXPENSE(S) INCURRED PRIOR TO COVERAGE. SERVICES PROVIDED PRIOR TO THE EFFECTIVE DATE, ARE NOT COVERED.** **RESOLUTION:** If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include the copy of your Family Care service authorization that supports the Request From – Through dates covering the timeframe you provided service, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.
29	**29**	**THE TIME LIMIT FOR FILING HAS EXPIRED. CHARGES MUST BE SUBMITTED ON A TIMELY BASIS IN ORDER TO BE CONSIDERED FOR PAYMENT.** **RESOLUTION:** If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include any documentation supporting that your claim was filed within 120 days from start date of service, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.
46	**96**	**THIS SERVICE IS NOT COVERED.** **RESOLUTION:** If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include a copy of your Family Care service authorization, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.
AG	**62**	**THIS SERVICE/SUPPLY REQUIRES PRIOR AUTHORIZATION FROM FAMILY CARE. PLEASE SUBMIT WITH THE AUTH NUMBER WITHIN 120 DAYS FROM THE DATE OF SERVICE OR 90 DAYS FROM MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. CONTACT THE CUSTOMER'S CMU CARE MANAGER WITH QUESTIONS.** **RESOLUTION: FAMILY CARE IS A PRE-AUTHORIZATION BENEFIT PROGRAM. SUBMIT** your claim including the Family Care service

authorization number or contact the care manager to obtain a service authorization, prior to Member servicing. Payment will be considered if you mail your claim to WPS within 120 days from service start date.

B6 171 **THIS SERVICE/PROCEDURE IS DENIED/REDUCED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER, BY THIS TYPE OF PROVIDER IN THIS TYPE OF FACILITY, OR BY A PROVIDER IN THIS SPECIALITY. THIS POLICY DOESN'T COVER SERVICES BY THIS PROVIDER**.

RESOLUTION: If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include a copy of your Family Care service authorization, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.

B7 B7 **THIS PROVIDER WAS NOT CERTIFIED FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE; OR THIS PROVIDER WAS NOT AUTHORIZED TO PERFORM THIS SERVICE.**

RESOLUTION: If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include a copy of your Family Care service authorization, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.

BU 97 **DURING THE PROCESSING OF THIS CLAIM, THIS LINE WAS BUNDLED INTO ANOTHER LINE FOR PROCESSING.**

RESOLUTION: If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial. Please be sure to include any documentation that supports your APPEAL in how the claim was processed. Mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.

CX OA **THE PROCEDURE CODE, DIAGNOSIS CODE, AND/OR REVENUE CODE IS NOT VALID. PLEASE RESUBMIT WITH A VALID CODE.**

RESOLUTION: RE-SUBMIT the claim using the service code / modifier listed on your Family Care service authorization. Your claim **RE-SUBMIT** must be mailed to WPS within 120 days from service start date.

DU 18 **THIS CLAIM IS A DUPLICATE TO A PREVIOUSLY RECEIVED CLAIM THAT IS CURRENTLY BEING REVIEWED FOR PROCESSING.**

RESOLUTION: The charge received for processing has already been considered. The denial informs the provider of a duplicate billing for a same date of service has been received and paid. If this claim is for Additional Service Units for a service auth/same date of service, that was already processed (or received a partial payment), a **CORRECTED** claim

must be updated and mailed to WPS within 120 days from service start date.

EM 22 **WE NEED THE MEDICARE EXPLANATION OF BENEFITS TO PROCESS THIS CHARGE.**
RESOLUTION: **RE-SUBMIT** the claim with the corresponding explanation of benefits (EOMB) for the services being billed. The complete information must be received by WPS within 90 days from the date listed on the EOB.

I3 125 **THESE CHARGES ARE NOT COVERED AS THEY WERE BILLED IN ERROR BY THE PROVIDER OF SERVICE.**

RESOLUTION: If you feel that service should be covered, please submit an **APPEAL** within 60 calendar days from your WPS initial denial**.** Please be sure to include a copy of your Family Care service authorization, and mail your Appeal to WPS c/o Family Care PO Box 7460, Madison WI 53707-7460.

NM 15 **THE AUTHORIZATION NUMBER IS INVALID WITH THE SERVICE/SUPPLY BILLED. PLEASE SUBMIT USING THE CORRECT FAMILY CARE AUTHORIZATION NUMBER WITHIN 120 DAYS FROM THE DATE OF SERVICE OR 90 DAYS FROM MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. CONTACT THE CUSTOMER'S CMU CARE MANAGER WITH QUESTIONS.**
RESOLUTION: **SUBMIT** a new claim using a **Valid** Family Care service authorization number. Verify that the Member's social security number is accurately reported on your claim, also the service code/hcpcs was authorized and reported correctly. This claim must be updated and mailed to WPS within 120 days from service start date.

NO 119 **THE CLAIM EXCEEDED THE NUMBER OF AUTHORIZED UNITS FOR THIS SERVICE.**

RESOLUTION: Contact the Member's Care Manager to obtain a NEW Family Care Service authorization number. All available units are exhausted, a NEW authorization is needed. **SUBMIT** a new claim with the new service authorization number to WPS within 120 days from service start date.

NP B18 **THE PROCEDURE CODE IS MISSING OR DOES NOT MATCH THOSE AUTHORIZED BY FAMILY CARE. PLEASE SUBMIT WITH THE CORRECT CODE WITHIN 120 DAYS FROM THE DATE OF SERVICE OR 90 DAYS FROM MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. CONTACT THE CUSTOMER'S CMU CARE MANAGER WITH QUESTIONS.**
RESOLUTION: **SUBMIT** a new claim using the correct procedure code that is listed on your Family Care service authorization. This claim must be mailed to WPS within 120 days from service start date.

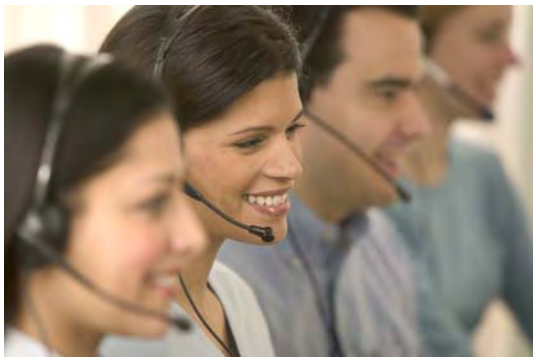
SU	**97**	**IN ORDER TO PROCESS BENEFITS CORRECTLY, THIS LINE WAS SPLIT FOR PROCESSING.** If your claim was not paid in full, it is possible that all units are exhausted or part of your claim was billed out of date range. An Extended end date or a New service authorization may be needed. Contact the Member's listed Care Manager, or WPS Customer Service 1-800-223-6016 may be able to provide you with additional assistance.
WS	**125**	**THESE CHARGES WERE SUBMITTED UNDER AN INCORRECT CUSTOMER NUMBER. WE WILL PROCESS THESE CHARGES UNDER THE VALID NUMBER. TO AVOID DELAYS IN THE FUTURE, PLEASE USE THE CORRECT NUMBER AND VERIFY THAT THE PROVIDER HAS THE CORRECT NUMBER.** No action needed, informational only.

Contacting WPS

If a provider has a billing or claims question they may contact WPS as follows:

Call Center:

- 800-223-6016 (8:00AM - 4:30PM, Monday - Friday)



Automated Response System to check claim status:

- 800-221-7049

WPS Web site (www.wpsic.com):

- To view the status of claims and eligibility of Members on-line:
  ~ Contact WPS Electronic Data Services at (608) 223-5858 to get an account established.
  ~ Once you have an account you can view your claims and eligibility by clicking on Provider Corner and choosing claims or eligibility.

Provider Appeal Process

(Printed on the back of every EOB)

A provider has the right to appeal a "Clean Claim" denial or partial claims payment to Milwaukee County Family Care c/o WPS Insurance Corp.

To determine if the formal Appeal Process is required for your claim denial or partial claims payment, contact WPS Customer Service at (800) 223-6016. Representatives are available between 8:00 a.m. and 4:30 p.m. (CST) Monday through Friday.

A Customer Service Representative will review and advise you on the necessary steps to take in order to resolve your case. Sometimes all that is necessary is a telephone call to WPS Insurance Corporation.

1. Written Appeal to the CMO

If you wish to file an appeal you must submit a separate letter or form that is clearly marked "**Appeal**" and include the following:

- **a. Provider's Name and ID Number**
- **b. Member Name and Social Security Number**
- **c. Date of Service, Procedure Code, Units billed, and Dollar Amount Billed**
- **d. Copy of the Family Care Service Authorization**
- **e. Copy of WPS Explanation of Benefit (EOB) Rejection,**
- **f. Copy of Explanation of Medicare Benefit (EOMB) or Other Insurance EOB**
- **g. Reason(s) your claim merits reconsideration**

Your appeal must be submitted within **60** calendar days of **the initial** denial or partial payment to:

Milwaukee County-CMO c/o WPS Insurance Corp.
PO Box 7460
Madison, WI 53707-7460
Phone: 800-223-6016

2. Written Appeal to Department of Health Services

A provider has the right to appeal to the Department of Health Services (DHS) if the CMO fails to respond to the appeal within 45 calendar days, or if the provider is not satisfied with the CMO's response to the request for reconsideration.

a. All appeals to DHS must be submitted in writing within **60** calendar days from the **CMO's Final Decision** as follows:

CMO Contract Administrator
Center for Delivery Systems Development
1 West Wilson Street, Room 518
PO Box 7851
Madison, WI 53707-7851

b. DHS will accept written comments from all parties to the dispute prior to making the decision.

c. DHS has 45 calendar days from the date of receipt of all written comments to respond to these appeals.

d. The Milwaukee County-CMO shall pay the provider within 45 calendar days of receipt of a DHS final determination found in favor of the provider.

Concerns/Complaints

Provider Complaints

Providers should direct their concerns, complaints, and questions to the Contract Services Coordinator assigned to work with them. See Appendix 1 for the service areas managed by each Contract Services Coordinator.

Member Complaints

If a Provider becomes aware of concerns or dissatisfaction expressed by a Member, or on behalf of a Member, related to the Member's care or needs, then the Provider should inform the Member's Care Manager of the concerns. The Care Manager's name, phone number, and email address is printed on every Provider Service Authorization. Care Managers are available Monday through Friday from 8:00am to 4:30pm.

Members' Right to Fair Hearing

Providers should contact the Milwaukee County-CMO Member/Provider Liaison, if a Member requests assistance in preparing a written grievance, or fair hearing request, or information about the availability of advocacy services to assist the Member.

The Member/Provider Liaison can be reached Monday through Friday from 8:00am to 4:30pm at 414-289-6034.

Appendix

1) Contract Services Coordinator Assignments
2) Provider Portal Guide
3) Sample Service Authorizations
4) Blank Claim Form
5) Sample UB-4 Form
6) Sample CMS 1500

CONTRACT SERVICES COORDINATORS			
Contract Administrator	Jim Hennen	289-6832	James.hennen@milwcnty.com
CBRFs (5-8 beds), AFH (3-4 beds)	Diane Baumbach	289-6104	diane.baumbach@milwaukeecounty.com
CMUs, HDM, Interpreters, Financial Services, Home & Vehicle Mod, Lawn Care/ Snow, Moving, PERS, PC/SHC	Kelly Burt	289-6458	Kelly.burt@milwcnty.com
NH, AFH (1-2 bed), RCAC, ILAs, CBRF's-9 beds and over	Topczewski, Sara	289-6281	Sara.topczewski@milwcnty.com
HHC/, DME/ DMS, PT/OT/SPL, Daily Living Skills, Communication Aids, Fiscal Agent, Medicare Consultant	Sharon Murphy	289-5795	sharon.murphy@milwaukeecounty.com
ADC, Transportation, Mental Health/ AODA, Vocational Services	Dennis Ryan	289-6409	dennis.ryan@milwaukeecounty.com
Quality Surveyor	Jefferlyn Harper-Harris	289-6371	Jefferlyn.Harper-Harris@milwcnty.com
AFH (1-2) Bed Certification	Melvin Mattox	289-6197	Melvin.mattox@Milwaukeecounty.com

Contract Services and Provider Network Development website:
http://www.milwaukee.gov/BecomingaServProv23226.htm

MILWAUKEE COUNTY (MCO) FAMILY CARE
SERVICE AUTHORIZATION

Authorization Number: 3793

Provider ID: 391753XXX
Phone: 4144760025
Fax: 4144760347

NPI # / Payee Tax Id#
Phone: 4144760025
Fax: 4144760347

Provider Name and Address:
VISITING FRIENDS
7231 W. GREENFIELD AVE.,
WEST ALLIS, WI 53214

Checks will be made payable to:
VISITING FRIENDS
7231 W. GREENFIELD AVE., SUITE 206
WEST ALLIS, WI 53214

MEMBER: JONES, A M
Patient ID: 254XXXXX
Date of Birth: 03/14/1920
Service Type: SHC - Supportive Home Care
Service Code: S5121 - SHC/Companion MOD U3
Modifier Codes: Info=U3
Location: Other Unlisted Facility
SERVICE START : 12/01/2006 **SERVICE END** 12/31/2009
UNITS 16.00 (per 15 min units)
Frequency: Monthly
UNIT RATE: $5.25
Status: Approved by RN
CMU: CMO FAMILY CARE
Care Manager: **SUE SMITH** Phone Number: **414-964-5151 Fax: 414-964-050 Email: xxxx@wi.rro**
SUPERVISOR TOM JONES **Phone Number 414-999-8000**

Please submit ALL CLEAN CLAIMS to: **Milwaukee County Family Care**
c/o WPS
PO Box 7460
Madison WI 53707-7460
Claims Status / Customer Service: 1 800 223 6016

This "APPROVED" service authorization is required before providing any service and must be validated for accuracy. If this service authorization requires a revision, a prompt request for a NEW service authorization must be made within 10 day of the service start date, by contacting the listed care manager above.

All claims for this authorized service must be submitted as a CLEAN CLAIM and must be received by our Third Party Administrator (WPS) within 120 days of the service start date or within 90 days of the Medicare EOMB date. (see website: https://www.cmo-mcda.com) for a PROVIDER HANDBOOK – 5 STEP TO CLEAN CLAIM SUBMISSION PROCESS.) Untimely claims will DENY.

Provider claim payment will be made within 30 days of your submission receipt date, from our Third Party Administrator (WPS). If payment is not received after 30 days, immediately contact WPS for Claim Status 1-800-223-6016.

Family Care payment is not guaranteed if the member's eligibility is not valid. Your claim payment will DENY if claims are incomplete, inaccurate, or untimely. Your Claim APPEAL Rights are listed on the back of your WPS Explanation of Benefits (EOB).

Printed: 9/26/2008

MILWAUKEE COUNTY FAMILY CARE CLAIM FORM

FAMILY CARE MEMBER CLAIM INFORMATION	PROVIDER PAYMENT ADDRESS
1. CLAIM TYPE: NEW CLAIM SUBMISSION / RE-SUBMISSION / CORRECTED	5. Provider TAX/EIN/SSN:
(circle one - claim description below)	6. MCDA REF ID #:
	7. PROVIDER NPI#:
2. Member's Social Security:	8. Provider Payment Name:
3. Member's Name:	9. Provider Payment Address:
4. Member's Birth Date:	10. City/State/Zip:
	11. Provider Telephone#:

12. DATE OF SERVICE (MM/DD/YY) *(Date Span or List Individual Days)*	13. Authorization Number	14. Procedure (HCPCS) Code	15. Modifier *(optional)*	16. Units	17. Rate	18. Billed Amount
					19. Total	

I certify that all services indicated above have been provided.

20. Provider Signature: **Date: / /** **21. Print Name:** **Date:**

CLAIM DESCRIPTIONS:

First Claim Submission=1st time original claim is being submitted, first time sent to WPS within 120 days of service start date.

Re-Submission=original claim was **FULLY DENIED, for reason reference WPS EOB**. Revisions must be made to claim form (claim info must correspond with Family Care Service Auth), re-submit to WPS within 120 days of start date. ***A NEW FAMILY CARE service authorization** may be needed, please contact your care manager.

Corrected=original claim was **PARTIALLY PAID, for reason, reference WPS EOB.** Provider identified errors (ex:dos range/frequency/unit/procedure) on claim form. Correction must reflect the EXACT original amount of what should have been billed. Correction must be sent to WPS within 120 days of service start date.

***A NEW Family Care service authorization may be needed, contact the listed care manager immediately, to prevent payment delay.**

CLAIM REMINDERS:

If claim payment is not received after 30 days billed, contact WPS Customer Service 1-800-223-6016, for claim status

All claims must be received by WPS within 120 days of service start date.

If you wish to dispute your payment, please follow the APPEAL PROCESS listed on the back of your WPS EOB or reference your Provider Handbook at https://www.mcda-cmo.com

MAIL CLAIM FORM TO:

WPS INSURANCE
C/O Milwaukee County Family Care
PO BOX 7460
MADISON WI 53707-7460

CLAIM STATUS: 1-800-223-6016

Revised 2009

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7 COV D.

8 N-C D.

9 C-I D.

10 L-R D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC

21 D HR

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES 24 25 26 27 28 29 30

31

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE CODE DATE

36 OCCURRENCE SPAN CODE FROM THROUGH

37 A B C

38

39 VALUE CODES CODE AMOUNT

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
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19									19
20									20
21									21
22									22
23									23

50 PAYER

51 PROVIDER NO.

52 REL INFO

53 ASG BEN

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

57

DUE FROM PATIENT ▶

58 INSURED'S NAME

59 P. REL

60 CERT. - SSN - HIC. - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.

OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE

76 ADM. DIAG. CD.

77 E-CODE

78

79 P.C.

80 PRINCIPAL PROCEDURE CODE DATE

81 OTHER PROCEDURE CODE DATE A

OTHER PROCEDURE CODE DATE B

OTHER PROCEDURE CODE DATE C

OTHER PROCEDURE CODE DATE D

OTHER PROCEDURE CODE DATE E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

85 PROVIDER REPRESENTATIVE X

86 DATE

UB-92 HCFA-1450

OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

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

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

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

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

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

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

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

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

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

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

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

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

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

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

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.