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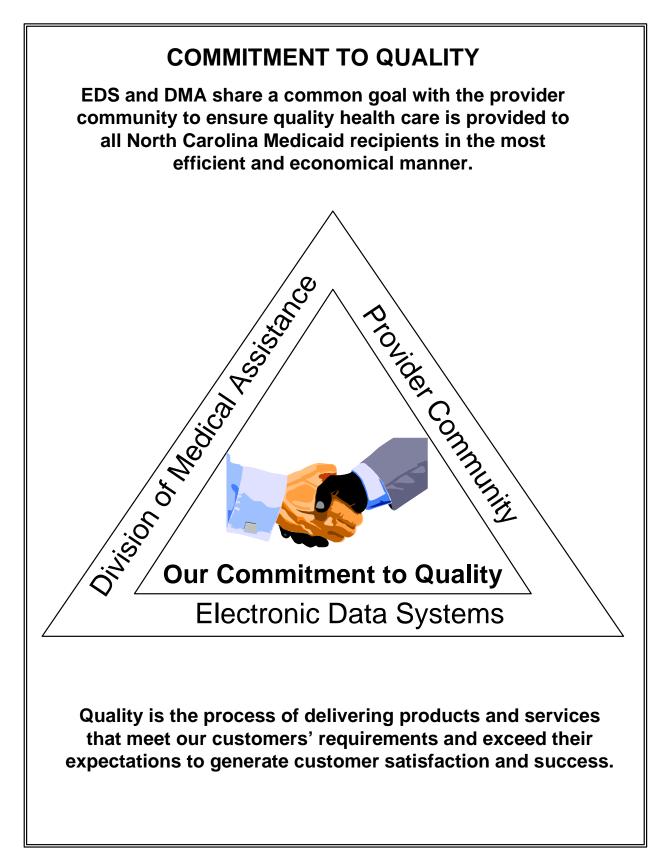
Attention: All Health Check Providers

Effective October 1, 2002



Health Check Billing Guide 2002





www.dhhs.state.nc.us/dma

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Effective with date of services October 1, 2002, changes have been made to the Health Check Program to comply with the implementation of national procedure codes mandated by the Health Insurance Portability and Accountability Act (HIPAA). These changes are outlined in this special bulletin. This special bulletin replaces the Health Check Billing Guide 2001.

HEALTH CHECK SCREENING COMPONENTS

The Health Check Program is a preventive care program for Medicaid-eligible children ages birth through 20. A Health Check screening is the only well child preventive visit reimbursable by Medicaid. All Health Check components are required and are to be documented in the medical record. Each screening component is vital for measuring a child's physical, mental, and developmental growth. Recipients are encouraged to receive their comprehensive health checkups and immunizations on a regular schedule. A complete Health Check screening consists of the following age-appropriate components, which must be performed and documented at each visit <u>unless</u> otherwise noted.

- Comprehensive unclothed physical examination
- Comprehensive health history
- Nutritional assessment
- Anticipatory guidance and health education
- Measurements, blood pressure, and vital signs Blood pressure is recommended to become a part of the exam between ages 3 and 4.
- Developmental screening, including mental, emotional, and behavioral

Perform age-appropriate evaluation at <u>each</u> screening. In addition, three written developmental assessments should be performed: the first by 12 months, the second by 24 months, and the third by 60 months of age.

- **Immunizations** Federal regulations state that immunizations are to be provided at the time of screening if they are needed.
- Vision screenings

A visual assessment must be administered with each periodic screening beginning at age 3.

• Hearing screenings

A hearing assessment must be administered with each periodic screening beginning at age 4.

• Dental screenings

A dental referral is required for every child beginning at 3 years of age. An oral screening performed during a physical examination is not a substitute for examination through direct referral to a dentist. The initial dental referral must be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. When any screening indicates a need for dental services at an earlier age (i.e., baby bottle caries), referrals must be made for needed dental services and documented in the patient's record. The periodicity schedule for dental examinations is not governed by the schedule for regular health screenings.

Note: Dental varnishing is not a requirement of the Health Check screening exam. Providers may bill for dental varnishing and receive reimbursement in addition to the Health Check screening. Providers are to utilize the codes and billing guidelines indicated in the August 2002 general Medicaid bulletin. Bulletins are available on the Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma.

• Laboratory procedures

Includes hemoglobin or hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead screening.

Hemoglobin or hematocrit

Hemoglobin or hematocrit should be measured once during infancy (between the ages of 9 and 12 months) for all children and once during adolescence for menstruating adolescent females. An annual hemoglobin or hematocrit screening for adolescent females (ages 11 to 21 years) should be performed if any of the following risk factors are present: moderate to heavy menses, chronic weight loss, nutritional deficit or athletic activity.

The Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) has specific time frames for hematocrit/hemoglobin testing for recertification for children birth up to 5 years of age and pregnant/postpartum women. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information.

Urinalysis

Urinalysis should be performed during the 5-year-old periodic screening as well as during periodic screenings for all sexually active males and females.

Sickle cell testing

North Carolina hospitals are required to screen all newborns for sickle cell prior to discharge. If a child has been properly tested, this test need not be repeated. **Results must be documented in the child's medical record.** If the test results of the newborn sickle cell screening are not readily available, contact the hospital of birth. An infant not tested at birth should receive a sickle cell test prior to 3 months of age.

Tuberculin testing

Reviewing perinatal histories, family and personal medical histories, significant events in life, and other components of the social history will identify children/adolescents for whom TB screening is indicated. If none of the screening criteria below are present, there is no recommendation for routine TB screening.

The North Carolina TB Control Branch is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local department of health.

Laboratory procedures, continued

Tuberculin testing should be performed as clinically indicated for children/adolescents at increased risk of exposure to tuberculosis, <u>via Purified Protein Derivative (PPD) intradermal injection/Mantoux method</u> – not Tine Test.

Criteria for screening children/adolescents for TB (per the NC TB Control Branch) are:

- 1. Children/adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.
- 2. Do a **baseline screen** when these children/adolescents present for care.
 - a. Foreign-born individuals arriving within the last five years from Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand, and countries in Western Europe.
 - b. Children/adolescents who are migrants, seasonal farm workers, or are homeless.
 - c. Children/adolescents who are HIV-infected.
 - d. Children who inject illicit drugs or use crack cocaine.

Subsequent TB skin testing is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

In addition to the TB Control Branch criteria:

A TB screening performed as a part of a Health Check screening cannot be billed separately.

Laboratory procedures, continued

Lead Screening

Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should perform a lead screening when it is clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial screening test. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

Blood Lead Concentration	Recommended Response
<10 ug/dL	Rescreen at 24 months of age
10 to 19 ug/dL	Confirmation (venous) testing should be conducted within 3 months. If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on 3 consecutive tests (venous or fingerstick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥ 10 ug/dL, environmental investigation will be offered.
20 to 44 ug/dL	Confirmation (venous) testing should be conducted within 1 week. If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on 3 consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	The child should receive a venous lead test for confirmation as soon as possible. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Screening

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results of specimens from children outside this age group need to contact the State Laboratory of Public Health at 919-733-3937.

Note: When the above laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

HEALTH CHECK SCREENING SCHEDULES

Periodic Screenings

The preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP are used to bill a periodic screening. (Refer to Health Check Billing Requirements on page 9.)

The schedule below outlines the recommended frequency of Health Check screenings dependent upon the age of the child. The intent of this schedule is to assure that a minimum number of screenings occur at critical points in a child's life.

Note: If an illness is detected during a Health Check screening, the provider may continue with the screening or bill a sick visit and reschedule the screening for a later date.

Periodicity	Schedule
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Within the first month	6 months	18 months	4 years
2 months	9 or 15 months	2 years	5 years
4 months	12 months	3 years	6 through 20 years of age
			(One screening every three years for children 6 years of age and older)

Interperiodic Screenings

The preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP are used to bill an interperiodic screening. (Refer to Health Check Billing Requirements on page 9.)

In addition to the periodicity schedule, interperiodic screenings are allowed in the following circumstances:

- When a child requires either a kindergarten or sports physical **outside** the regular schedule.
- When a child's physical, mental or developmental illnesses or conditions have already been diagnosed and have indications that the illness or condition may require closer monitoring.
- When the screening provider has determined there are medical indications that make it necessary to schedule additional screenings in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis, or treatment.
- Upon referral by a health, developmental or educational professional based on their determination of medical necessity. Examples of referral sources may include Head Start, Agricultural Extension Services, Early Intervention Programs or Special Education Programs.

In each of these circumstances, the screening provider must specify and document in the child's medical record the reason necessitating the interperiodic screening.

Hearing and vision assessments are not required for an interperiodic screening. All other Health Check components must be performed during an interperiodic Health Check screening.

IMMUNIZATIONS

Immunization Administration CPT Codes 90471 and 90472; with the EP Modifier

Medicaid reimburses providers for the administration of immunizations to Medicaid enrolled children, birth through 20 years of age, using the following guidelines.

Private Sector Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check screening or an office visit.

- Administration of one immunization is billed with the administration CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at \$13.71.
- Addition immunizations are billed with the administration CPT code 90472 with the EP modifier and are reimbursed at \$13.71.

The maximum reimbursement for two or more immunizations will remain at \$27.42 when using both CPT codes 90471 and 90472. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on billing an immunization administration fee, refer to the chart on page 7.

Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check screening. Health Check screenings and the immunization administration fees are billed under the Medicaid provider number with the "C" suffix.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with an **EP** modifier and is reimbursed at \$13.71.
- Additional immunizations are billed with the administration CPTcode 90472 with the **EP** modifier and are reimbursed at \$13.71.

An immunization fee cannot be billed in conjunction with a core visit. Report the immunization given during the core visit without billing the administration fee. The total reimbursement for two or more immunizations will remain at \$27.42 using both CPT codes. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D. For instructions on billing an immunization administration fee, refer to the chart on page 7.

Local Health Department Providers

An immunization administration fee may not be billed if immunization(s) is provided in addition to a Health Check screening. The immunization administration CPT codes 90471 and 90742 may be billed if immunizations are the only services provided that day or any immunizations are provided in conjunction with an **office visit**.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with an **EP** modifier and is reimbursed at \$20.00.
- Additional immunizations are billed with the administration CPT code 90472 with the **EP** modifier and receive no additional reimbursement.

The immunization administration code is reimbursed at \$20.00 regardless of the number of immunizations given. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on how to bill an immunization administration fee, refer to the chart on page 7.

Immunizations, continued

Billing	Guidelines	for	Immunizations
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Provider Type	Health Check Screening with Immunization(s)	Immunization(s) Only	Office Visit with Immunization(s)	Core Visit with Immunization(s)
Private Sector Providers	For one immunization, bill 90471 with the EP modifier.	For one immunization, bill 90471 with the EP modifier.	For one immunization, bill 90471 with the EP modifier.	N/A
	For additional immunizations, bill 90472 with the EP modifier.	For additional immunizations, bill 90472 with the EP modifier.	For additional immunizations, bill 90472 with the EP modifier.	
	Immunization diagnosis code not required. Immunization procedure code(s) are required.	One immunization diagnosis code is required. Immunization procedure code(s) are required.	Immunization diagnosis code not required. Immunization procedure code(s) are required.	
FQHC/RHC	For one immunization, bill 90471 with the EP modifier.	For one immunization, bill 90471 with the EP modifier.	N/A	Cannot bill 90471 or 90472. Immunization diagnosis
	For additional immunizations, bill 90472 with the EP modifier.	For additional immunizations, bill 90472 with the EP modifier.		immunization diagnosis code is not required. Immunization procedure code(s) are required.
	Immunization diagnosis code not required. Immunization procedure	One immunization diagnosis code is required.		
	code(s) are required.	Immunization procedure code(s) are required.		
Local Health Department Providers	Cannot bill 90471 or 90472. Immunization diagnosis code not required.	For one immunization, bill 90471 with the EP modifier. For additional	For one immunization, bill 90471 with the EP modifier. For additional	N/A
	Immunization procedure code(s) are required.	immunizations, bill 90472 with the EP modifier.	immunizations, bill 90472 with the EP modifier.	
		One immunization diagnosis code is required.	Immunization diagnosis code is not required. Immunization procedure	
		Immunization procedure code(s) are required.	code(s) are required.	

Immunization procedure code(s) must be listed in block 24D of the CMS-1500 claim form for all immunizations administered.

Universal Childhood Vaccine Distribution Program/Vaccines for Children Program

The Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program provides at no charge all required (and some recommended) vaccines to North Carolina children birth through 18 years of age according to the recommendations of the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Due to the availability of these vaccines, Medicaid does not reimburse for UCVDP/ VFC vaccines for children ages birth through 18. An exception to this is noted below the table.

For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the VFC program vaccines, DMA will continue reimbursement for Medicaid covered vaccines.

Codes	Vaccines	Diagnosis Codes
90645	Hib-4 dose	V03.8 or V05.8
90647	Hib-3 dose	V03.8 or V05.8
90657	Influenza (6 to 35 months of age) High-Risk Only	V04.8
90658	Influenza (3 years of age and above) High-Risk Only	V04.8
90669	Pneumococcal - PCV7 (2 through 59 months of age)	V03.82 or V05.8
90700	DTaP	V06.8
90702	DT	V06.8
90707	MMR	V06.4
90713	IPV	V04.0
90716	Varicella	V05.4
90718	Td	V06.5
90732	Pneumococcal - PPV23 High-Risk Only	V03.82 or V05.8
90744	Hepatitis B Vaccine – Pediatric/Adolescent	V05.8

The following is a list of UCVDP/VFC vaccines:

Note: DMA will reimburse for vaccines required to complete a series of injections when the series was started prior to the recipient's 19th birthday and for **high-risk** individuals 19 years of age and older.

North Carolina Medicaid providers who are not enrolled in the UCVDP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-800-344-0569.

Out-of-state providers (within the 40-mile radius of North Carolina) 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 (1-615-532-8513)
- Virginia (1-804-786-6246)

HEALTH CHECK BILLING REQUIREMENTS

Instructions for billing a Health Check screening on the CMS-1500 claim form are the same as when billing for other medical services except for these six critical requirements. The six billing <u>requirements</u> 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 <u>always</u> be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Periodic Health Check Screening – Use V20.2 as the Primary Diagnosis

Medical diagnoses are listed after the primary diagnosis (V20.2). Medical diagnoses should <u>always</u> be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Interperiodic Health Check Screening – Use V70.3 as the Primary Diagnosis

Medical diagnoses are listed after the primary diagnosis (V70.3). Medical diagnoses should <u>always</u> be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Requirement 2: Identify and Record the Preventive Medicine Code

The preventive medicine CPT codes with the EP modifier for Health Check screenings should be billed as outlined below. In addition to billing the preventive medicine codes, vision and hearing CPT codes must be listed based on the ages outlined in the Health Check Screening Components listed on page 1.

- A Health Check screening is the only well child visit reimbursable by Medicaid and must have V20.2 or V70.3 as the primary diagnosis code.
- Vision and hearing CPT codes must be listed in addition to the preventive CPT codes for a periodic Health Check screening. No additional reimbursement is allowed for these codes.

Use the correct Health Check screening preventive medicine codes with the EP modifier in block 24D of the CMS-1500 claim form:

Screenings	Preventive CPT Codes and Modifier	Diagnoses Codes
Periodic Screening	CPT codes 99381-99385; 99391-99395	V20.2 Primary Diagnosis
	EP Modifier is required in block 24D	
	Vision CPT code 99173; age appropriate	
	Hearing CPT code 92551; age appropriate	
Interperiodic	CPT codes 99381-99385; 99391-99395	V70.3 Primary Diagnosis
Screening	EP Modifier is required in block 24D	

Health Check Billing Requirements, continued

Requirement 3: Health Check CPT Code Modifier - EP

The Health Check screening CPT codes for periodic and interperiodic screenings must have the modifier **EP** listed in block 24D of the CMS-1500 claim form. EP is the only modifier required for Health Check claims.

Requirement 4: Record the Referral Code Indicator

A referral diagnosis indicator is used only when a follow up is necessary for a diagnosis found during a Health Check screening. The indicator "R" should be listed in block 24H of the CMS-1500 claim form when this situation occurs. Refer to pages 19, 20, 28, and 29 for sample claims.

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.

Systematically Entered Next Screening Date

Providers have the following choices for block 15 of the CMS-1500 claim form with a Health Check screening. 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 (11/11/111).

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

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.

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

Refer to the chart on page 7 for guidelines on when to bill the immunization administration CPT codes and EP modifier.

When billing one immunization, use the administration CPT code 90471 (one unit) with the EP modifier listed in block 24D.

When additional immunizations are provided use the administration CPT code 90472 with the EP modifier listed in block 24D.

Refer to pages 20 through 23, 25 through 27, 29, 31, and 32 for sample claims.

NOTE: If the EP modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90471 and 90742 is \$3.41.

TIPS FOR BILLING

All Health Check Providers

- Two screenings on different dates of service cannot be billed on the same claim form.
- Third party insurance must be pursued and reported in block 29 of the CMS-1500 claim form when preventive services (well child screenings) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit a claim to Medicaid.
- When checking claim status on 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 screening and the amount billed for immunizations and any other service billed on the same date of service. Thus, it will be necessary to check claim status for two separate claims.
- When billing immunization administration CPT codes, the EP modifier must be entered in block 24D to receive the reimbursement rate of \$13.71 for 90471 (health departments receive \$20.00) and \$13.71 for 90472 (no additional reimbursement for health departments). If the EP modifier is not entered in block 24D, the reimbursement will be \$3.41 per unit. The reimbursement for these codes is \$3.41 per unit for non-Health Check related services.

Private Sector Health Check Providers Only

- A Health Check screening and an office visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening 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 code 90471 with EP and 90472 with EP can be billed with a Health Check screening, office visit or if it is the only service provided that day. When billing in conjunction with a screening CPT code or an office visit code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with EP and 90472 with EP) as the only service for that day, providers are required to use an immunization diagnosis in block 21 of the claim form. Always list immunization CPT procedure codes when billing 90471 with EP and 90472 with EP. Refer to the chart on page 7 and the sample claim forms beginning on pages 16 through 27.

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

- FQHCs and RHCs must bill Health Check services using their Medicaid provider number with the "C" suffix.
- A Health Check screening and a core 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 code 90471 with EP and 90472 with EP can be billed if it is provided in addition to a Health Check screening CPT code or if it is the only service provided that day. When billing in conjunction with a screening code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with EP and 90472 with EP) as the only service for that day, an immunization diagnosis code is required to be entered in block 21 of the claim form. The administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list immunization procedure codes in the appropriate block on the claim form. <u>Always list immunization procedure codes</u> when billing 90471 with EP and 90742 with EP. Refer to the chart on page 7 and the sample claim forms on pages 28 through 32.

HEALTH CHECK COORDINATORS

Health Check Coordinators (HCCs) are available to assist both **<u>parents</u>** and **<u>providers</u>** in assuring that Medicaid-eligible children have access to Health Check services. The roles of the HCCs 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
- 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 screenings
- promoting Health Check and health prevention with other public and private organizations

Physicians and other primary care providers and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication will significantly enhance recipient participation in Health Check and help make preventive care services more timely and effective.

HCCs are currently located in <u>78</u> North Carolina counties and Qualla Boundary.

HCCs are housed in local health departments, community and rural health centers, and other community agencies.

County	Agency	Telephone Number
Alexander	Alexander County Health Dept.	828-623-9704
Alleghany	Alleghany County Health Dept.	336-372-5641
Ashe	Ashe County Health Dept.	336-246-9449
Avery	Avery County Health Dept.	828-733-6031
Bertie	Bertie County Health Dept.	252-794-5322
Brunswick	Brunswick County Health Dept.	910-253-2250
Buncombe	Buncombe County Health Dept.	828-250-5000
Burke	Burke County Health Dept.	828-439-4400
Cabarrus	Cabarrus Health Alliance	704-920-1000
Caldwell	Caldwell County Health Dept.	828-757-1200
Camden	Albemarle Regional Health Services	252-338-4400
Catawba	Catawba County Health Dept.	828-695-5800
Chatham	Chatham County Health Dept.	919-525-8214
Cherokee	Cherokee County Health Dept.	828-837-7486

Health Check Coordinator Contact List

Health Check Coordinator Contact List, continued

County	Agency	Telephone Number
Chowan	Albemarle Regional Health Services	252-338-4400
Clay	Clay County Health Services	828-389-8052
Cleveland	Cleveland County Health Dept.	704-484-5100
Columbus	Columbus County Health Dept.	910-640-6614
Craven	Craven County Health Dept.	252-636-4960
Cumberland	Cape Fear Valley Health System	910-609-4000
Currituck	Albemarle Regional Health Services	252-232-2271
Dare	Dare County Health Dept.	252-475-1198
Davie	Davie County Health Dept.	336-751-8700
Duplin	Goshen Medical Center	910-267-0421
Durham	Durham County Health Dept.	919-560-7700
Edgecombe	Edgecombe County Health Dept.	252-641-7511
Forsyth	Forsyth County Dept of Health	336-727-8231
Franklin	Franklin County Health Dept.	919-496-2533
Gaston	Gaston Family Health Services	704-853-5079
Gates	Hertford/Gates District Health Dept.	252-357-1380
Graham	Graham County Health Dept.	828-479-7900
Granville	Granville County Health District	919-693-2141
Greene	Greene County Health Care, Inc.	252-747-5841
Guilford	Guilford County Health Dept.	336-333-6001
Halifax	Roanoke Amaranth Community Health Group	252-536-2800
Harnett	Harnett County Health Dept.	910-893-7550
Haywood	Haywood County Health Dept.	828-452-6675
Hertford	Hertford/Gates District Health Dept.	252-358-7833
Hoke	Hoke County Health Dept.	910-875-3717
Hyde	Hyde County Health Dept.	252-926-4200
Jackson	Jackson County Health Dept.	828-586-8994
Jones	Jones County Partnership for Children	252-448-5272
Lenoir	Kinston Community Health Center	252-522-9800
Macon	Macon County Public Health Center	828-349-2081
Madison	Madison County Health Dept.	828-649-3531
McDowell	Rutherford/Polk/McDowell District	828-652-6811
Mitchell	Toe River Health District	828-765-2239
Moore	Moore County Health Dept.	919-947-3300
Nash	Nash County Health Dept.	252-459-9819

Health Check Coordinator Contact List, continued

County	Agency	Telephone Number
New Hanover	New Hanover County Health Dept.	910-343-6500
Northampton	Roanoke Amaranth Community Health Group	252-536-2800
Onslow	Onslow County Health Dept.	910-347-2154
Orange	Orange County Health Dept.	919-245-2400
Pamlico	Pamlico County Health Dept.	252-745-5111
Pasquotank	Albemarle Regional Health Services	252-338-4400
Pender	Black River Health Services, Inc.	910-259-1230
Perquimans	Albemarle Regional Health Services	252-338-4400
Person	Person County Health Dept.	336-597-2204
Polk	Rutherford/Polk/McDowell District	828-894-8271
Qualla Boundary	Eastern Band of Cherokee Indians	828-497-9163
Richmond	Richmond County Health Dept.	910-997-8300
Robeson	Robeson County Health Dept.	910-671-3200
Rockingham	Rockingham County Health Dept.	336-342-8140
Rutherford	Rutherford/Polk/ McDowell District	828-287-6100
Sampson	Sampson County Health Dept.	910-592-1131
Scotland	Scotland County Health Dept.	910-277-2470
Stanly	Stanly County Health Dept.	704-982-9171
Stokes	Stokes County Health Dept.	336-593-2400
Surry	Surry County Health and Nutrition Center	336-401-8400
Swain	Swain District Health Dept.	828-488-3198
Union	Union County Health Dept.	704-296-4800
Vance	Vance County Health Dept.	252-492-7915
Wake	Wake County Human Services	919-212-7000
Warren	Warren County Health Dept.	252-257-1185
Watauga	Watauga County Health Dept.	828-264-6635
Wayne	Wayne County Health Dept.	919-731-1000
Wilkes	Wilkes County Health Dept.	336-651-7450
Wilson	Wilson Community Health Center	252-243-9800
Yancey	Toe River Health District	828-765-2239

HEALTH CHECK CLAIM FORM SAMPLES

There are 15 CMS-1500 claim form samples, including one split claim and six examples of HSIS screens on the following pages. A copy of the back of the CMS-1500 claim form precedes the first sample. **Note:** Medicaid payment (provider certification) information is shown and specifies that the provider of Medicaid services agrees 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, copayment or similar cost-sharing charge.

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

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 11 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 2(4). 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 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 show 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 CMS, 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 <u>Federal Register</u>, 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," Ederal 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.

BOUTINE 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

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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a. OTHER INSURED'S PO	LICY OR GROUP	NUMBER		a. EMPLOYMENT? (CURREI	NT OR PREVIOUS)	a. INSURED'S DATE	OF BIRTH			SEX
				YES	NO	MM	ID YY	,	м	SEX F
b. OTHER INSURED'S DA MM DD YY		SEX		b. AUTO ACCIDENT?	PLACE (State)) b. EMPLOYER'S NAI	ME OR SCHO	OL NAME		
C. EMPLOYER'S NAME OF	M SCHOOL NAME			c. OTHER ACCIDENT?	NO	C. INSURANCE PLAN		ROGRAM	NAME	
				YES	NO			/		
d. INSURANCE PLAN NAM	E OR PROGRAM	NAME		10d. RESERVED FOR LOCA	IL USE	d. IS THERE ANOTH				
F	EAD BACK OF F	ORM BEFORE	COMPLETIN	G & SIGNING THIS FORM.		13. INSURED'S OR A				TURE I auth
to process this claim. I a	iso request paymen	nt of governmen	t benefits eithe	release of any medical or other i r to myself or to the party who ac	cepts assignment	payment of medic services described	al benefits to t d below.	ne undersk	gned phy	rsician or suj
below.										
SIGNED				DATE		SIGNED				
SIGNED	ILLNESS (First	symptom) OR	15.	DATE		SIGNED	UNABLE TO V	WORK IN (CURREN	T OCCUPA
SIGNED 14. DATE OF CURRENT: MM DD YY	PREGNANCY	lent) OR (LMP)		IF PATIENT HAS HAD SAME C GIVE FIRST DATE MM D		16. DATES PATIENT		WORK IN C		
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Patty, Peppermint			04 17 198	4 ^M X		1000500						
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10 Snoopy Road		STATE	8. PATIENT STATUS		CITY						STATE	
Raleigh		NC	Single Marrie	ed Other								
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27600 COTHER INSURED'S NAME (Last	(919) 555–12 Name, First Name, Middle		10. IS PATIENT'S CONDI		11. INSURED	SPOLICY	GROUP	OR FE	CA NU	MBER		
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MM DD YY			YES	NO								
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READ BA 2. PATIENT'S OR AUTHORIZED P	CK OF FORM BEFORE	COMPLETING	3 & SIGNING THIS FORM. release of any medical or oth	er information necessary							TURE I authoriz sician or supplie	
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10 Bubblegum Road		Self Spouse Chi PATIENT STATUS	ild Other	CITY						STATE
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	CHAMPUS Sponsor's SS	CHAN	APVA GROUP File #) HEALTH PLAN (SSN or ID)	FECA OTHEI BLK LUNG (SSN) (ID)	1a. INSURED'S I.D. 900000000			(FOR	PROGRAM IN ITEM
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Smith, Barbie			02 07 199						
5. PATIENT'S ADDRESS (No., Street) 19 Mattel Lane			6. PATIENT RELATIONS	Child Other	7. INSURED'S ADDR	RESS (No	., Street)		
CITY		ST	ATE 8. PATIENT STATUS	Child	CITY				STATE
Raleigh			C Single Marrie	ed Other					
		- Area Code) 	Employed Full-Tir		ZIP CODE		TELEPH	ONE (IN	CLUDE AREA CODE)
27600 (919 9. OTHER INSURED'S NAME (Last Name,			10. IS PATIENT'S COND		11. INSURED'S POL	ICY GRO	UP OR FECA	NUMBE	R
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MM DD YY M		F	YES	NO					
C. EMPLOYER'S NAME OR SCHOOL NAM	E		c. OTHER ACCIDENT?		C. INSURANCE PLAN	NAME C	R PROGRAM	M NAME	
d. INSURANCE PLAN NAME OR PROGRA	MINAME		10d. RESERVED FOR LO	CAL USE	d. IS THERE ANOTH	ERHEAU	THBENEFIT	PLAN?	
					YES	NO NO			complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON	I'S SIGNATU	RE I authorize	TING & SIGNING THIS FORM.	er information necessary	13. INSURED'S OR A	UTHORIZ	ZED PERSON	'S SIGN	
to process this claim. I also request paym below.	ent of governr	ment benefits e	ither to myself or to the party who	accepts assignment	services described	t below.		aignea pi	
SIGNED			DATE		SIGNED		14117 B. B.		
MM DD YY INJURY (Acc PREGNANC	ident) OR	OR	15. IF PATIENT HAS HAD SAM	E OR SIMILAR ILLNESS.	16. DATES PATIENT MM DE FROM	UNABLE	TO WORK IN		DD YY
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1. MEDICARE MEDICA (Medicare #) X (Medicar		AMPUS onsor's SSN)	CHAMPVA (VA File	#) GROUP HEALTH PLAN (SSN or ID)	FECA OTHE BLK LUNG (SSN) (ID)	R 1a. INSURED'S I.D. 900000000			(FOR	PROGRAM IN IT
2. PATIENT'S NAME (Last Nan	me, First Name,	Middle Initial)		3. PATIENT'S BIRTH DATE		4 INSURED'S NAM		First Name	e, Middle	e Initial)
5. PATIENT'S ADDRESS (No.,				06 11 2001						
12 Mt. Olympus D					hild Other	7. INSURED'S ADDR	RESS (No., Str	eet)		
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				YES	NO	U. INSUMANCE PLAP	THAME UP P		NAME:	
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14 DATE OF CURBENT: 4	LINESS (First	symptom) OB	15	DATE		SIGNED				
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5. PATIENT'S ADDRESS (No	Street)		6	PATIENT RELATIONSH	P TO INSURED	7. INSURED'S ADD	RESS (N	lo., Stree	t)		
46 Iollipop Lar	e			Setf Spouse (child Other						
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27600	(919)	555-1212		Employed Full-Tim Student	Part-Time Student				()	
9. OTHER INSURED'S NAME (I	ast Name, First Na	ame, Middle Initia	H) 1	IO. IS PATIENT'S CONDIT		11. INSURED'S POL	ICY GR	OUP OR	FECAN	UMBER	R
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MM DD YY	м	F		YES	NO						
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d. INSURANCE PLAN NAME OF	R PROGRAM NAM	E	10	VES	AL USE	d. IS THERE ANOTH	ER HE A			14N2	
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READ 12. PATIENT'S OR AUTHORIZE	D PERSON'S SIG	BEFORE COMP	LETING &	SIGNING THIS FORM.	information necessary	13. INSURED'S OR	UTHOR	ZED PE	RSON'S	S SIGN/	
to process this claim. I also re below.	equest payment of g	overnment benefi	ts either to r	myself or to the party who a	ccepts assignment	services describe		its to the	undersi	gneo pri	ysician or supplier
SIGNED				DATE		0101150					
	LNESS (First symp UURY (Accident) C	otom) OR	15. IF P	PATIENT HAS HAD SAME	OR SIMILAR ILLNESS	SIGNED		E TO WO	BK IN (UBBE	
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1. MEDICARE ME		AMPUS	CHAMPVA	HEALTH PLAN BLK LUNG	RED'S I.D. NUMBE		(FOR PI	ROGRAM IN	ITEM 1)
(Medicare #) X (Me		onsor's SSN)	(VA File	(SSN or ID) (SSN) (ID) PATIENT'S BIRTH DATE SEX 4. INSUF	90000000 RED'S NAME (Last N		thoma	Middle	Initial)	
2. PATIENT'S NAME (Last		mode milal)		10 15 2001 м х г	TED S NAME (Last I	ane, riis	a name, i	widdle	(filled)	
Robin, Christ					RED'S ADDRESS (N	o., Street)				
2 Winnie the				Self Spouse Child Other						
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Raleigh			NC	Single Married Other						
ZIP CODE	TELEPHON	NE (Include Area	a Code)	Employed Full-Time Part-Time	E	TEL	EPHONE	E (INCL	UDE AREA C	ODE)
27600	(919)	000		Student Student			()		
9. OTHER INSURED'S NA	ME (Last Name, Fir	st Name, Middle	e Initial)	D. IS PATIENT'S CONDITION RELATED TO: 11. INSU	RED'S POLICY GR	JUP OR F	ECA NU	MBER		
		IL IMPER				ти				
a. OTHER INSURED'S PO	JEICY OR GROUP N	NUMBER		EMPLOYMENT? (CURRENT OR PREVIOUS) a. INSUF	MM DD Y	/	м	[]	SEX F [
b. OTHER INSURED'S DA	TE OF BIRTH	SEX		AUTO ACCIDENT? PLACE (State) b. EMPL	OVER'S NAME OR S	SCHOOL			L	
MM DD YY	M	F F	- 1	YES NO						
C. EMPLOYER'S NAME OF	L.			A start of the sta	ANCE PLAN NAME	OR PRO	GRAM N	AME		
				YES NO						
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13 Lucky Duck I	lane		STATE	Self Spouse Ch 8. PATIENT STATUS	ild Other							67
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1. MEDICARE MEDIC (Medicare #) X (Medic		AMPUS onsor's SSN)	CHAMPV	A GROUP HEALTH PLAN #) (SSN or ID)	FECA OTHE BLK LUNG (SSN) (ID)	R 1a INSURED'S I.D.			(FOR	PROGRAM IN I
2. PATIENT'S NAME (Last Na				3. PATIENT'S BIRTH DATE	(SSN) (IU)	90000000E		me First Na	ne Midd	le Initial)
Menace, Dennis				3 PATIENT'S BIRTH DATE MM DD YY 12 05 2000	M X F		. (603/14	ine, i interna	112, 11100	
5. PATIENT'S ADDRESS (No				6. PATIENT RELATIONSHIP	TOINSURED	7. INSURED'S ADDR	ESS (No	, Street)		
16 Pester Lane	9			Self Spouse Cl	hild Other					
CITY			STATE	8. PATIENT STATUS		CITY				STA
Raleigh			NC	Single Married	Other					
ZIP CODE		NE (Include Al		Employed Full-Time	Part-Time	ZIP CODE	-	TELEPH	ONE (IN	CLUDE AREA CO
27600		555-1		Student	Student			()	
9. OTHER INSURED'S NAME	E (Last Name, Fin	st Name, Midi	dle Initial)	10. IS PATIENT'S CONDITION	ON RELATED TO:	11. INSURED'S POLI	CY GRO	JP OR FEC	NUMBE	:A
a. OTHER INSURED'S POLIC	CY OR GROUP N	UMBER		a. EMPLOYMENT? (CURRE	NT OR PREVIOUS	a INSUBED'S DATE				
				YES	NO NO	a. INSURED'S DATE MM DI	5° °W		м	SEX F
b. OTHER INSURED'S DATE	OFBIRTH	SEX		b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAM	IE OR SO	CHOOL NAM		
MM DD YY	M	F	-	YES	NO					
C. EMPLOYER'S NAME OR S	SCHOOL NAME			C. OTHER ACCIDENT?		C. INSURANCE PLAN	NAME C	R PROGRA	A NAME	
				YES	NO					
d. INSURANCE PLAN NAME	OR PROGRAM	NAME		10d. RESERVED FOR LOCA	LUSE	d. IS THERE ANOTHE	R HEAL	TH BENEFIT	PLAN?	
						YES	NO			complete item 9
	AU BAUK OF FC	VAN BEFURE	COMPLETING	& SIGNING THIS FORM.		13. INSURED'S OR A	UTHORIZ	ED PERSON	'S SIGN	ATURE I authori
12. PATIENT'S OR AUTHORI	IZED PERSON'S	SIGNATURE		release of any medical or other i	nformation necessary	I payment of medics				
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SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN (OPTION 65) FOR LOCAL HEALTH DEPARTMENT'S THAT USE THE NC HEALTH SERVICES INFORMATION SYSTEM (HSIS)

Example #1 - Health Check Periodic Screening for a 1 month old child and two immunizations.

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R	CH	90700				Α_			RUS		/1						

Example #2 – Health Check Periodic Screening for an 18 year old with an additional procedure, plus Vision and Hearing Screenings. Diagnosis warrants a <u>referral for a followup</u> visit, designated with a "R" entered in the HLTH CHK/EPSDT REFERRAL data field.

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R CH R CH	99173 92551			A	ROS ROS		71 71				·	9999	

Example #3 - Health Check Interperiodic Screening for a child age 4 with two

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NEXT MESS		CORD:	COUN	ΤY	999	SC	REEN	1 65	ID 4	44444	444	DATE	1209	902 AG	CTION	A
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Local Health Departments using HSIS - Continued

Example #4 – Health Check Periodic Screening and immunizations for child age 1 with referral/followup indicator.

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1	२ (СН	90471	EP	_		A		_	ROS	01	71					99999	
	2 (СН	90472	EP			A		_	ROS	01	71					99999	
	2 0	CH	90645				A			ROS	01	71					99999	
1		СН	90669				A			ROS	01	71					99999	

Example #5 – Immunization Administration fee ONLY for child age 3.

	r reg Sage	CORD:	COUL	YTY	999		S	CR	EEI	1 65	ID 55	55555	5555	DATE	11220	02 2	ACTION A
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в	IM	90471	EP	_		A	_			NURSE	01	71				-	99999
R	тм	90472	EP			A	_		_	NURSE	01	71				-	99999
R	IM	90700				A				NURSE	01	71				_	99999
R	TM	90713				A		_		NURSE	01	71				_	99999
R	IM	90744				A	-		-	NURSE	01	71				_	99999
R	IM	90647	_			A	_		_	NURSE	01	71					99999

Example #6 – Office Visit with one immunization for a child age 2.

NEXT MESS		CORD:	COUNT	Y 999	SCREEN	65	ID 6	66666	666	DATE	1114()2 1	ACTION A
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в	CH	99212			A	PHY	01	71					99999
в	CH	90471	EP _		A	NURSE	01	71					99999
R	CH	90716			A	NURSE	01	71					99999

TIPS FOR DECREASING DENIALS

EOB	Message	Тір
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 ID (MID) number, DOB, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and Remittance and Status Report to the DMA Claims Analysis Unit, 2519 Mail Service Center, Raleigh, NC 27699-2519.
024	Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill detail as a new claim.	Verify procedure code, modifier and/or procedure code/modifier combination is valid according to the billing guidelines on pages 9 and 10. Correct claim and resubmit.
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 according to the billing guidelines on page 9. Correct claim and resubmit.
349	Health Check screening and related service not allowed same day, same provider or member of same group. Resubmit as an adjustment with documentation supporting related services.	Verify if related services billed on same or different claim as the Health Check screening are Health Check components. Health Check screening and related services will not be paid for same date of service initially. Resubmit as an adjustment with medical documentation supporting the need for related 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 program services.
1035	This EOB is for internal tracking of Health Check visits. To determine if claim paid or denied, look in the screening section of your RA.	This EOB is for reporting purposes only. To determine if the claim paid or denied, look under the screening section of the RA
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Immunizations(s) are free through the UCVDP/VFC Program.
1058	The only well child exam billable through the Medicaid program is a Health Check screening. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic screening with V20.2 and interperiodic screenings with V70.3. Check the preventive medicine code entered in block 24D of the claim form.
1174	Thanks for reporting vaccine to our database. This vaccine is available at no charge through the VFC program and therefore is not reimbursable through Medicaid.	No payment allowed.

Tips For Decreasing Denials, continued

EOB	Message	Тір
1422	Immunization administration not allowed without the appropriate immunization. Refer to the July 2002 Special Health Check 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.
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 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 V250.9.
1771	All components were not rendered for this Health Check screening.	For periodic screenings, verify all required components, such as vision and or hearing assessments were performed and reported on the claim form. Make corrections and resubmit as a new day claim.

HEALTH CHECK BILLING WORKSHEET

The Health Check Billing Worksheet (see page 38) may be used in your practice to facilitate Health Check billing.

For additional billing questions please contact EDS at 1-800-688-6696 or 919-851-8888.

HEALTH CHECK BILLING WORKSHEET

Date of Service _____

Patient's Name	Next Screening Date (optional)
Medicaid ID number	Date of Birth

Health Check Diagnosis Code	
Periodic Health Check Screening	Periodic Health Check Screening V20.2
Interperiodic Health Check Screening	Interperiodic Health Check Screening V70.3

Health Check Screening Code						
Description	Preventive Medicine Codes	Diagnosis Code	✓			
Regular Periodic Screening - Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V20.2				
Vision Assessment based on age	Vision Assessment CPT Code 99173					
Hearing Assessment based on age	Hearing Assessment CPT Code 92551					
Interperiodic Screening - Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V70.3				

Second Diagnosis (if applicable)		
Description	Indicator	✓
Follow-up with screening provider or another provider	R	

Indicator	✓
R	
	Indicator R

Fourth Diagnosis (if applicable)		
Description	Indicator	✓
Follow-up with screening provider or another provider	R	

Description	CPT Codes	Unit	
Immunization Administration Fee	90471 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 EP Modifier	Additional	
		immunizations	

Code	Description	Diagnosis	VFC	Dose Given					
90371	Hepatitis B Immune Globulin	V07.2		1	2	3	4	5	6
90375	Rabies Immune Globulin	V07.2		1	2	3	4	5	6
90376	Rabies Immune Globulin – Heat treated (RIG-HT)	V07.2		1	2	3	4	5	6
90384	Rho (D) Immune Globulin Full Dose	V07.2		1	2	3	4	5	6
90385	Rho (D) Immune Globulin Mini Dose	V07.2		1	2	3	4	5	6
90389	Tetanus Immune Globulin	V07.2		1	2	3	4	5	6
90396	Varicella-Zoster Immune Globulin	V07.2		1	2	3	4	5	6
90585	BCG	V03.2		1	2	3	4	5	6
90632	Hepatitis A Vaccine – Age 18 & up	V05.8		1	2	3	4	5	6
90633	Hepatitis A Vaccine – Age 2 & up	V05.8		1	2	3	4	5	6
90645	Hib – 4 dose (Brand name – Hib Titer)	V03.8 or V05.8	VFC 2 mo – 5 yrs	1	2	3	4	5	6
90646	Hib – booster	V03.8 or V05.8		1	2	3	4	5	6
90647	Hib – 3 dose (Brand name – PedVax)	V03.8 or V05.8	VFC 2 mo – 5 yrs	1	2	3	4	5	6
90648	Hib – 4 dose (Brand name – ActHib)	V03.8 or V05.8	VFC 2 mo – 5 yrs	1	2	3	4	5	6
90657	Influenza (6-35 months of age)	V04.8	VFC 6 mo – 35 mo	1	2	3	4	5	6
90658	Influenza (3 years and above)	V04.8	VFC 3 yrs – 18 yrs	1	2	3	4	5	6
90669	Pneumococcal PCV7 (2-59 months)	V03.82 or V05.8	VFC 2 mo – 59 mo	1	2	3	4	5	6
90675	Rabies – IM	V04.5		1	2	3	4	5	6
90676	Rabies Vaccine – Intradermal use	V07.2		1	2	3	4	5	6
90700	DTaP	V06.8	VFC 2 mo – 7 yrs	1	2	3	4	5	6
90702	DT	V06.8	VFC 2 mo – 6 yrs	1	2	3	4	5	6
90703	Tetanus Toxoid	V03.7		1	2	3	4	5	6
90704	Mumps	V04.6		1	2	3	4	5	6
90705	Measles	V04.2		1	2	3	4	5	6
90706	Rubella	V04.3		1	2	3	4	5	6
90707	MMR	V06.4	VFC 12 mo - 18 yrs	1	2	3	4	5	6
90708	MR	V06.8		1	2	3	4	5	6
90709	Rubella and Mumps	V06.8							
90713	IPV (Injectable Polio Vaccine)	V04.0	VFC 2 mo – 18 yrs	1	2	3	4	5	6
90716	Varicella	V05.4	VFC 12 mo - 18 yrs	1	2	3	4	5	6
90718	Td	V06.5	VFC 7 yrs – 18 yrs	1	2	3	4	5	6
90719	Diptheria Toxoid	V03.5							
90721	DTaP/HIB	V06.8		1	2	3	4	5	6
90725	Cholera	V03.0		1	2	3	4	5	6
90732	Pneumococcal PPV23 (High Risk Only)	V03.82 or V05.8	VFC 2 yrs – 18 yrs						
90733	Meningococcal	V03.89		1	2	3	4	5	6
90744	Hepatitis B Vaccine – Pediatric/adol	V05.8	VFC 0 through 18 yrs	1	2	3	4	5	6
90746	Hepatitis B Vaccine – Age 19 and above	V05.8		1	2	3	4	5	6
90747	Hepatitis B Vaccine - Dialysis Pt./immunosuppressed	585		1	2	3	4	5	6
90281	Immune Globulin	V07.2		1	2	3	4	5	6

IMMUNIZATION BILLING WORKSHEET*

* This list is subject to change.

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Nina M. Yeager, Director Division of Medical Assistance Department of Health and Human Services

Ricky Pope Executive Director EDS

Presorted Standard U.S. POSTAGE PAID Raleigh, N.C. Permit No. 1087

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