



## Claims Submission Policies and Procedures

Increasingly, local, state and federal governments have sought clinical and cost data to more carefully monitor the use of public health care funds. In order to comply with governmental mandates for information, managed care organizations such as CBH have had to request more detailed and complex claims data from providers.

We recognize that this often poses an arduous task. Nevertheless, submission of accurate claims information in a timely manner is an essential part of the provider's role in delivering care, tracking clinical activity and maintaining fiscal stability.

For this reason, CBH is committed to working with providers to help the process go as smoothly and efficiently as possible. We welcome your comments and suggestions on how to further improve the process. In this chapter, we provide general and specific policy and procedural statements pertaining to the submission of claims to CBH. If we can assist you with any additional information, please contact the Claims Department at (215) 413-7125.

### Submitting Claims to CBH

Provider shall bill CBH for Covered Services rendered to Enrollees, in the manner specified in this section. Provider shall submit "Clean Claims" no more than 180 days following the date of service for Covered Services requiring an authorization number and no more than 90 days following the date of service for Covered Services not requiring an authorization number. In the event Provider is pursuing Coordination of Benefits, provider must obtain a final determination from the primary payor dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of a determination from the primary payor. "Unclean Rejected Claims" must be resubmitted as clean claims within the 180-day and 90-day requirements. CBH reserves the right to make no payments for claims received beyond the time requirements stated herein.

#### Definitions:

**CLEAN CLAIM:** A clean claim shall mean a claim that can be processed without requiring additional information from the provider of the service or from a third party. A clean claim does not include: claims pended or rejected because they require additional information either from a provider or from internal sources (i.e., claims pended for a determination of third-party liability, etc.); a claim under review for medical necessity; or a claim submitted by a provider reported as being under investigation by a governmental agency, the City of Philadelphia or DBH/CBH for fraud or abuse. However, if under investigation by the City or DBH/CBH, the Department of Public Welfare (DPW) must have prior notice of the investigation.

**UNCLEAN REJECTED CLAIMS:** An unclean rejected claim shall mean a claim that is returned to the provider or third party for additional information.

**CLEAN REJECTED CLAIM:** A clean rejected claim shall mean a claim that is returned to the provider or third party due to ineligible recipient or service.

## Verification of Eligibility

In order to receive payment for services rendered, providers must check the member's eligibility. Providers can access the DPW's daily eligibility file by phone by calling (800) 766-5387.

Providers may also use the various methods described on DPW's website:

[www.dpw.state.pa.us/omap/provinf/omapevs.asp](http://www.dpw.state.pa.us/omap/provinf/omapevs.asp)

## Coordinating Claims with Authorizations

The authorization process and the claims process are closely related. (See Authorization section for details on the authorization process.) For all services requiring an authorization, the provider will need to obtain an authorization number **prior** to submitting a claim. A claim form without a required authorization number will be rejected. (If filed manually, the claim will be returned.) Providers must submit separate claims forms for each authorization number given for a particular client within 180 days from the date of service.

## Non-Authorized Services

All laboratory services (600-level services) and most outpatient services do not require an authorization. When completing the claims forms, these non-authorized services must have a Blanket Authorization Number (BAN) placed in the authorization number field. The BAN for all laboratory services is "0" (zero). Please refer to Schedule A of the Provider Agreement to identify the non-authorized outpatient services and the corresponding BAN. There are sample claims forms at the end of this chapter available for reference.

**All other mental health and drug and alcohol outpatient services which do not have a corresponding BAN are authorized services. Continue to follow the authorization process as outlined in the Authorization section of this manual.**

Claims must be submitted for those services not requiring authorization within 90 days from the date of service. Any claims submitted after 90 days from the date of service will be rejected for late submission. **The 90-day timeframe includes billing and rejection clean up.** Please note that providers must follow the Case Open Process outlined in Authorization section of this manual.

## Pricing and Information Modifiers

Certain services (both authorized and non-authorized) require pricing and/or information modifiers. Please refer to Schedule A to identify the services which require modifiers. When completing claims forms, place the pricing modifier in the first modifier field and the information modifier in the second modifier field. There are sample claims forms at the end of this chapter available for reference.

## Entering the Correct Year Format

When completing the UB-92 or CMS 1500 claims forms, the provider must use the complete four-digit year. For example, enter the full year as "2005" rather than "05. Any manual claims submitted without the full year date format will be returned.

## Billing for Consecutive Days —“Span Billing”

When billing for **per diem services** that were provided on consecutive days, the provider does not need to enter each individual date of service on the claim form, but may “span bill” the entire period of service. “Span billing” means that the provider notes on the claim the dates that treatment began and ended and the number of units of service provided. For example, if a patient received 5 consecutive days of inpatient treatment, the provider might note January 5 as the “service begin” date and January 10 as the “service end” date.

**NOTE:** Both the “service begin” date and the “service end” dates must be within the authorization period. The day of discharge from inpatient treatment does not count for units of service.

## Billing for Non-Consecutive Days

When billing for non-consecutive days within a particular authorization period, the provider must note each date of service individually. For example, if a client received one hour of outpatient individual therapy on January 3 and one hour on January 5, the provider must bill:

- ▶ Two units of service on January 3 with a “begin date” of January 3 and an “end date” of January 3.
- ▶ Two units of service on January 5 with a “begin date” of January 5 and an “end date” of January 5.

**NOTE:** Do not span date for non-consecutive days of service or non-per diem services. Such claims will be rejected.

## Requirements for Provider Signature

The provider rendering the service must sign all invoices for claims, whether they are submitted manually or electronically. The signature certifies that the service has been rendered according to Medical Assistance (MA) regulations.

**METHODS OF SIGNING CLAIMS:** The following are acceptable methods of signing claims:

### FOR PAPER CLAIMS:

- 1 An actual handwritten authorization signature of the provider directly on the signature line of the invoice. The provider’s initials or printed name are not acceptable signatures.
- 2 A signature stamp of the provider placed directly over the signature line of the invoice is acceptable, if the provider authorizes its use and assumes responsibility for the information in the invoice.
- 3 An actual handwritten authorization signature of the provider directly on the MA-307 Invoice Transmittal Form, a form used to certify that treatment services have been delivered by the provider.

**FOR CLAIMS SUBMITTED VIA MODEM,** an electronic certification is incorporated into the submission process.

**NON-COMPLIANCE:** All invoices received that do not meet the provider signature requirements will not be processed. These invoices will be returned to the provider for correction.

### Third Party Liability (TPL) Billing

Third Party Liability (TPL) refers to specific entities, such as Medicare, Blue Cross and parties other than CBH that may be liable for all or part of a client's health care expenses. When third-party resources are available to cover behavioral services provided to Medicaid recipients, CBH is the "payor of last resort."

For all services requiring prior authorization, the provider should obtain an authorization number from a DBH/CBH Care Manager prior to submitting a claim. This applies regardless of whether CBH is the primary payor or if it is Medicare or any other insurance carrier. Please also note that providers should obtain authorization numbers at the time clients are admitted to a facility.

Once it is determined that a client has other insurance, the bill should be sent first to the primary insurance carrier(s) for payment consideration. CBH will consider for payment all balances for behavioral health services that are unpaid by the other insurance carriers.

Before CBH can consider a TPL claim for payment, the provider must submit the completed claims form, the Explanation of Benefits (EOB), or the denial letter(s) sent to the provider by any and all other carriers.

The claim must be fully considered and resolved with the primary carrier before it is billed to CBH. If the services are rejected by the primary carrier due to missing, incomplete, or incorrect information, the service must be re-billed to the primary carrier before CBH will consider payment. The EOB, or the denial letter(s) must be the final determination. If the primary carrier rejects the claim, the appeals process must be exhausted with the primary carrier before CBH will consider the claim for payment.

It is important that the provider's bill matches the EOB information. This applies to the billed amount, beginning and ending dates, Medicare approved amount, other insurance paid amount, Medicare deductible and the Medicare co-insurance amount. If the EOB form is larger than letter size, please reduce the EOB to 8-1/2" by 11" in size. Please include a copy of the EOB with each claim. Do not attach several claims to one EOB.

### TPL Medicare Inpatient Claims

When submitting Medicare and other insurance carriers' third-party liability claims for one inpatient stay, CBH requires **separate** claims forms for **each** authorization number issued for the various levels of care during the stay. Be sure to use the appropriate authorization number on each claim.

Once you receive your Medicare or other insurance EOB, complete the UB-92 Claims Form for each authorized period. The total of all the claims should equal the total amount billed to the carrier for the entire stay. Also, the billed charges must be for the authorized period. Attach a copy of the EOB to each claim prior to submitting to CBH. It is essential to submit these claims together to ensure proper processing.

## Exhausted Medicare Inpatient Lifetime Psychiatric Days

If the member's lifetime psychiatric days have been exhausted, **manually** submit **both** the Medicare Part A and Part B EOBs with the claims form.

The Medicare Part A EOB must show the Medicare Lifetime Exhaustion rejection code. If you do not have the Medicare Part A EOB, you must submit the Medicare Claims Determination letter or the HIQA Inquiry Form from the Medicare system. However, the Medicare HIQA Inquiry Form will only be accepted if the inquiry date is the admission date or the date on which the benefits exhausted during the stay, or should be covered in the Date of Earliest Billing (DOEBA) or Date of Last Billing (DOLBA) time period.

For Medicare Part B, you must use the appropriate value code in Field 39 on the UB-92 Claim Form to indicate the Medicare Part B payment. **The Part B value amount on each claim must reflect only the portion that applies to the dates of services on each claim.**

## Post-Payment Recoveries

According to the City of Philadelphia's contract with the Commonwealth of Pennsylvania DPW, CBH is required to take all reasonable measures to ensure that CBH is the payor of last resort when other third-party resources are available to cover the cost of medical services.

When CBH becomes aware of payments made on behalf of CBH clients who have valid third-party resources, post-payment recoveries will be pursued. If a provider is identified as having received an inappropriate payment, a post-payment recovery letter will be sent to the provider. Providers who receive such letters are required to bill the primary carrier(s) and resubmit the claim along with a copy of the recovery letter and the final determination for CBH review and processing.

All cases on which CBH is unable to recover will be turned over to the TPL Unit of the Commonwealth of Pennsylvania DPW.

## Member Co-Payment Prohibition

Federal law prohibits treatment providers from requesting co-payments from MA recipients in the Commonwealth of Pennsylvania. Billing CBH members for co-payments for services is also in violation of the CBH Provider Agreement.

## Where to Mail Claims

All manual claims must be sent via the U.S. Postal System or delivery service to: CBH, Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Hand-deliveries **will not** be accepted.

## Filing Electronic Claims

*Filing claims electronically helps providers minimize data entry errors after submission, ensure information is legible, and expedite the processing of their claims. In order to submit claims electronically, the provider must have the appropriate software.*

Please refer to the CBH website, [www.phila-bhs.org](http://www.phila-bhs.org) for the necessary information regarding the submission of electronic claims. On the website under “HIPAA Resources,” you will find the following key information:

- Browser Interface Manual
- CBH Companion Guide 837 Professional
- CBH Companion Guide 837 Institutional
- National Implementation Guides

Prior to any initial electronic claims submission to CBH, contact Provider Relations at (215) 413-7660 for specific information needed to create an electronic file and to coordinate the submission of the test file.

## Filing Manual Claims

*Providers filing manual claims must use one of two printed claims forms designated for that purpose. Please refer to Schedule A for all contractual services and the appropriate CPT codes, pricing and information modifiers, and BANs. This section provides specific information about which forms are to be submitted for the specific types of treatment. It also provides examples of each form.*

**INPATIENT CLAIMS, UB-92 CLAIM FORM** All inpatient hospital or RTF/RCTF-Accredited claims must be submitted using the UB-92 Claim Form. These are the claims forms used in the Pennsylvania MA Program.

**OUTPATIENT CLAIMS, CMS 1500 CLAIM FORM** All other claims must be submitted using the CMS 1500 Claim Form.

## Claims Form Guidelines and Sample Reports

The succeeding section provides specific details on the use of the UB-92 and CMS 1500 Claims Forms. Following is an index:

- ▶ UB-92 Provider Information, Compensable Service and Patient Information.....4.8
- ▶ UB-92 Third Party Liability (TPL) Billing .....4.9
- ▶ CMS 1500 Patient Information, Provider Name and Compensable Medical Services.....4.11
- ▶ CMS 1500 For Patient TPL Billing Information, Provider Name, and Compensable Medical Services .....4.12
- ▶ Common Causes for Claims Rejection and Remedies for Providers .....4.18–4.20

### Claims Reports

- ▶ Payment Detail (Sample) .....4.22
- ▶ Pended Claims Report (Sample) .....4.23
- ▶ Rejected/Denied Claims Report (Sample) .....4.24
- ▶ Rejected Claims Report - Previously Pended (Sample) .....4.25
- ▶ Claims Adjustment Request Form.....4.26

## Specific Claims Submission Information

### Completion of the UB-92 Claim Form

The UB-92 Claim Form is used when an inpatient (hospital inpatient or RTF/RCTF-Accredited) stay has occurred. **Revenue Codes** are used **exclusively** on the UB-92 claim form. **(See sample UB-92 Claim Forms later in this section.)**

Listed below are the specific fields that must be completed on the UB-92 Claim Form before submitting it to CBH for processing. Remember that all services require an authorization number for billing and only one authorization number per claim form is allowed. **When an item is “not applicable,” do not use a zero. Leave it blank.** See the **PROMISE Desk Chart for Assistance in the Completion of the UB-92 Claim Form** in this section.

## UB-92 PROVIDER INFORMATION, COMPENSABLE SERVICE AND PATIENT INFORMATION

Field #	Field Name	Field #	Field Name
1	Provider Name, Address, and Telephone Number	51	Provider Type and Provider MA ID Number (Enter the two-digit Provider Type followed by a slash and the 13-digit Provider MA ID Number)
3	Patient Control Number	54	Prior Payments (if applicable)
4	Type of Bill (See UB-92 PROMISe Desk Chart)	58	Insured's Name (if applicable)
6	Statement Covers Period	59	Client Relationship (if applicable)
7	Covered Days	60	Client's Recipient Number (10-digit MA Number)
8	Non-Covered Days (if applicable)	61	Group Name (if applicable)
9	Coinsurance Days (if applicable)	62	Insurance Group Number (if applicable)
10	Lifetime Reserve Days (if applicable)	63	Treatment Authorization (CBH Authorization Number)
12	Client's Name	67	Principal Diagnosis Code (ICD-9-CM Diagnosis Code)
14	Client's Birthday	76	Admitting Diagnosis (ICD-9-CM Diagnosis Code)
17	Admission Date	82	Attending Physician License Number (Enter the complete license number of the attending physician. This number contains a prefix consisting of two-digit alphabetic characters, the certification number composed of six digits, and a one-letter suffix, or a prefix consisting of two-digit alphabetic characters and the certification number composed of six digits)
18	Admission Hour (See UB-92 PROMISe Desk Chart)	84	CBH Provider Number
19	Type of Admission (See UB-92 PROMISe Desk Chart)	85	Provider Signature or a Signed MA-307 Signature Transmittal Form
21	Discharge Hour (See UB-92 PROMISe Desk Chart)	86	Date Bill Submitted
22	Client Status (See UB-92 PROMISe Desk Chart)		
39-41	Value Codes and Amounts (if applicable)		
42	Revenue Code (See CBH Schedule A)		
43	Revenue Code Description		
46	Units of Service		
47	Total Charges		
50	Payor's Name (Enter the name of each payor organization from which the provider might expect some payment for the bill.)		

**UB-92 INPATIENT THIRD PARTY LIABILITY (TPL) BILLING**

When using the UB-92 Claim Form for inpatient TPL billing, the fields in the chart below must be completed. The standard fields must also be completed. See **Explanation of the Completion of the UB-92**, sample **UB-92 - Inpatient Third Party (TPL) Claim Form** and **Explanation of Benefits (EOB) for Inpatient UB-92 Third Party Liability (TPL)**. See index for specific page numbers of forms and samples.

**UB-92 INPATIENT THIRD PARTY LIABILITY (TPL) BILLING**

Field #	Field Name	Field #	Field Name
9	Coinsurance Days (if applicable)	51	Provider Number
10	Lifetime Reserve Days (if applicable)	54	Prior Payment (Enter the covered charges amount on EOB.)
39-41	Value Codes and Amounts (Deductible and coinsurance values, if applicable)	55	Estimated Amount Due (Enter the estimated amount you expect to be paid by CBH.)
50	Payor's name (Enter the name of each payor organization from which the provider might expect some payment for the bill.)		



**Also Remember:**

*When using the UB-92 Claim Form to bill for inpatient services, the following information must be retrieved from the EOB and indicated on the form:*

Information To Be Retrieved From EOB	Field No. On UB-92 Claim Form
Service From/Thru	6
Covered Days	7
Co-Insurance Days	9
Lifetime Reserve Days	10
Deductibles	39-41
Covered Charges for billed period	54

## Completion of the CMS 1500 Claim Form

The CMS 1500 Claim Form is primarily used for outpatient services.

### WHEN TO USE THE CMS 1500 CLAIM FORM

The CMS 1500 Claim Form may be used when filing a claim for the following behavioral health services:

- ▶ outpatient psychiatric treatment
- ▶ non-hospital services (3a, 3b, 3c)
- ▶ outpatient drug and alcohol (D&A) treatment services
- ▶ residential treatment facilities (non-accredited)
- ▶ residential continuum treatment facilities (non-accredited)
- ▶ psychiatric partial hospital programs (acute and maintenance)
- ▶ behavioral health rehabilitation services for children
- ▶ intensive outpatient programs (IOP)
- ▶ consultations
- ▶ methadone maintenance
- ▶ laboratory services

Listed on the chart below are the specific fields that must be completed on the CMS 1500 Claim Form before submitting it to CBH for processing. Never use zeros for items that are not applicable. Leave spaces blank. Refer to the **PROMISE Desk Chart for Assistance in the Completion of the UB-92 Claim Form** and sample **CMS 1500 Claim Form** later in this section.

**NOTE:** The CMS 1500 Paper Claim Form has room for 6 lines of service, but CBH's claims system can only accept 4 lines of service per claim. Use no more than 4 lines of service on the CMS 1500 Claim Form.

CMS 1500 PATIENT INFORMATION, PROVIDER NAME AND COMPENSABLE MEDICAL SERVICES

Field #	Field Name	Field #	Field Name
1a	Recipient Number (10-Digit MA Number)	19	Provider type and Provider MA ID Number (enter the two-digit provider type followed by a slash and then 13-digit Provider MA ID Number)
2	Recipient Name	21	ICD-9-CM Diagnosis Code
5	Recipient Address	23	Prior authorization number (CBH authorization number or BAN number)
9	Other insured's name (Another health insurance secondary to insurance in block 11)	24a	Dates of service (please note begin and end date)
9a	Other insured's policy number (if applicable)	24b	Place of service (see PROMISe Desk Chart)
9b	Other insured's date of birth (if applicable)	24d	Procedure code (pricing modifier and/or info modifier, if applicable) (See OBH/CBH Schedule A)
9c	Employer's name or school name	24f	Usual charges
9d	Insurance plan name or program name (other than MA)	24g	Units of Service
11	Primary Insurance (other than MA) policy number (if applicable)	24j	COB/Resource Code (if applicable) (Enter the one-digit resource code, which is found in the PROMISe Desk Chart, if the recipient has another resource available to pay for the service before billing MA)
11a	Insured's date of birth (if applicable)	24k	Other insurance paid or Medicare payment (if applicable)
11b	Employer's name or school name (if applicable)	28	Total charges (Enter the total sum of 24f, 1 thru 4 in dollars and cents)
11c	Insurance plan name or program name (if applicable)	29	Amount paid (Enter the total sum of 24k, 1 thru 4 in dollars and cents)
12	Recipient signature and date (all invoices must have either the recipient's signature or the "signature exception" or "signature on file")	31	Signature of physician, signature stamp or <b>MA-307 Transmittal Form</b>
17	Name of referring/supervising/attending practitioner or prescriber		
17a	Referring practitioner's or prescriber's license number (enter the complete license number of the practitioner noted in 17). This number contains a prefix consisting of two alpha characters, the certification number composed of six digits and one alpha suffix. For provider type 8 (Outpatient D&A Clinic), 11 (Outpatient Psychiatric Clinic), and 11 (Psychiatric Partial Hospital Facility), enter the 13-digit MA ID number of the practitioner noted in 17.		

**CMS 1500 THIRD PARTY LIABILITY (TPL) BILLING**

When completing the CMS 1500 Claim Form for TPL billing, the following fields **must be** completed. The standard fields must also be completed as described above under **Explanation of the Completion of the CMS 1500 Claim Form**. See index for page number of sample **CMS 1500 - Outpatient Third Party Liability (TPL)**.

**CMS 1500 FOR PATIENT TPL BILLING INFORMATION,  
PROVIDER NAME, AND COMPENSABLE MEDICAL SERVICES**

Field #	Field Name	Field #	Field Name
9	Other insured's name (Another health insurance secondary to insurance in block 11)	24f	Usual charges (The amounts should agree with the other plan's EOB)
9a	Other Insured's Policy or Group Number (if applicable) (other than MA)	24j	COB/Resource Code (if applicable) (Enter the one-digit resource code, which is found on the PROMISe Desk Chart, if the recipient has another resource available to pay for the service before billing MA)
9b	Other Insured's Date of Birth (if applicable)		
9c	Employer's Name or School Name (if applicable)		
9d	Insurance Plan Name or Program Name (if applicable) (other than MA)	24k	Medicare or Other Insurance Paid (if applicable) (Enter medicare or the portion of the bill that was paid by another insurance company in this block)
11	Primary Insurance (other than MA) policy number (if applicable)	28	Total Charges (Enter the total sum of 24f 1 thru 4 in dollars and cents)
11a	Insured's date of birth (if applicable)	29	Amount paid (Enter the total sum of 24k in lines 1 thru 4 in dollars and cents)
11b	Employer's name or school name (if applicable)		
11c	Insurance Plan Name or Program Name (other than MA)		

**REMINDER:** *When billing for payment of Medicare deductibles and/or coinsurances for services covered by MA, the provider must use the appropriate MA Procedure Code.*

## Processing Payments

When a provider submits a claim to CBH, it goes through several stages of review and processing, described below:

### Claims Processing Cycle

**ADJUDICATION PROCESS:** CBH will adjudicate 100% of clean claims within 45 days and adjudicate 100% of all claims within 90 days. Adjudicate means to pay or reject a claim.

**PAYMENT OF CLAIMS:** Payment will be mailed in the form of a check to the address designated by the provider in the provider agreement. Changes in address must be reported in writing under the signature of the CEO to CBH, Provider Operations, 801 Market Street, 7th Floor, Philadelphia, PA 19107.

**CLAIMS REPORTS:** Whether a claim is accepted, rejected or pended, claims reports will be made available to the provider explaining the reasons for the action taken on the claim. (Learn more and see samples in the following section under **Claims Reports**.)

### Claims Adjustments

On occasion, after a payment has been issued, either CBH Claims staff or the provider may detect an error in the amount that was paid. The adjustment process deals with the correction of those claims that have been through the adjudication cycle and been paid. If a claim has been rejected and **not yet paid**, it is not subject to an "adjustment." Only those claims that have already been paid can be adjusted. Claims adjustments generally occur for the following reasons:

- ▶ Claim was submitted and paid twice.
- ▶ Claim was paid at wrong rate.
- ▶ Claim was paid for the wrong date(s) of service.
- ▶ Claim was paid at wrong level of care. (Claims Department will only reverse the claim that was paid for the wrong level of care. It is the provider's responsibility to obtain the new authorization and submit the claim.)
- ▶ Claim was submitted with excessive units of service within time period.
- ▶ Services were span billed with overlapping days on more than one claim.
- ▶ A Compliance audit was conducted.

Adjustments must be received within 180 days from the date of service for services requiring an authorization and no more than 90 days from the date of service for services not requiring an authorization. In the event a provider is pursuing coordination of benefits, the provider must obtain a final determination from the primary payor date no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of a determination from the primary payor. See the **Claims Appeal Process** for adjustments that CBH will not accept within these timeframes.

## Submitting Adjustments For Manual Claims

Complete and submit the following:

- ▶ a **Claims Adjustment Request Form**
- ▶ a copy of the corresponding Payment Detail Report, clearly indicating the claim line requiring adjustment.
- ▶ a Corrected Claim(s) Form
- ▶ the EOB for TPL Claims

## Submitting Adjustments For Electronic Claims

Complete and submit the following:

- ▶ a **Claims Adjustment Request Form**
- ▶ a copy of the corresponding Payment Detail Report, clearly indicating the claim line requiring adjustment.

Providers submitting claims electronically via modem must wait to receive a Payment Detail Report containing reversals of the erroneous payments from CBH before resubmitting a claim. This will confirm that the necessary adjustments have been made, allowing the resubmitted claims to be processed correctly.

The top two copies of the Claims Adjustment Request Form must be mailed with the appropriate support documents to: CBH, Claims Department, Attention: Adjustments, 801 Market Street, 7th Floor, Philadelphia, PA 19107.

If you have specific questions regarding an adjustment or need additional copies of the Claims Adjustment Request Form, contact the Provider Claims Hotline at (215) 413-7125.

## Pended Claims

Pended claims are those claims that are put on temporary hold to assure that CBH is the payor of last resort for members that have other primary coverage in addition to MA. It also determines if the services are covered by a third party payor. TPL Claims will pend when:

- 1 The provider indicates on the claims form that the member has another coverage.
- 2 The provider submits an EOB along with the claim.
- 3 During the processing of the claim, CBH's eligibility file, as transmitted by the Pennsylvania DPW, indicates that the client is covered by other insurance.

The provider will receive a Pended Claims Report listing those claims that have pended after the adjudication process. (See page 4.24 for more information about this report and page 4.26 for a sample "Pended Claims Report.")

To avoid disruptions to treatment of children, BHRS claims will first pend, but will be released for payment by CBH within two weeks.

## Rejected/Denied Claims

CBH may reject or deny a claim for a variety of reasons. In some cases, crucial claims information, such as dates, authorization numbers or client information, may be missing or incorrect. In addition, the provider may not have submitted the claim to the primary payor.

When rejecting a claim, CBH will send the provider a Rejected/Denied Claims Report listing those claims that have been rejected/denied after the adjudication process. (See "Claims Report" section for more information and a sample of this report.)

When a claim has first pended and then been rejected, CBH will mail the provider Rejected Claims Previously Pended Report. (See "Claims Report" section for more information and a sample of this report.)

Providers are encouraged to carefully review the original claims, the Rejected/Denied Claims Reports, and the Rejected Claims Previously Pended Reports from CBH and to make any necessary corrections or revisions, and when appropriate, resubmit the claims for payment.



**One of the most common causes for claims to be rejected is entering date information incorrectly. When entering inpatient treatment days, please enter the date of admission as the "begin date" and the day of discharge as the "service end" date, but count the length of the stay according to the number of "nights" of stay. The day of discharge is not counted as a day of treatment.**

## Claims Appeal Process

There are three categories of claims rejections that providers may appeal. The processes for each category are described separately.

### APPEALING REJECTED CLAIMS FOR THIRD PARTY LIABILITY (TPL) CAUSED BY DISCREPANCIES BETWEEN THE ELIGIBILITY VERIFICATION SYSTEM (EVS) AND THE DBH/CBH CLAIMS SYSTEM

If the provider accesses the EVS information and it indicates that the client does not have a TPL coverage, but during processing of the claim, the CBH system detects such coverage and consequently rejects the claim within 180 days from the date of service for services requiring an authorization and within 90 days from the date of service for services not requiring an authorization, the provider must do the following:

- 1 Make a copy of the rejection report that notes the TPL rejection.
- 2 Make a copy of the eligibility information that notes the client does not have TPL coverage.
- 3 Make a copy of the claim along with any other evidence of non-coverage by a third party.
- 4 Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Clearly write on the envelope "TPL Discrepancy."

CBH will then perform a manual review of the client's coverage. If it is determined that the client has no TPL coverage, CBH will reprocess the claim and make the necessary system adjustments. If it is found that the client does have TPL coverage, CBH will return the claim to the provider along with

the name of the primary carrier and policy number. The provider must obtain a final determination from the primary payor dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of the final determination from the primary payor.

#### **APPEALING REJECTED CLAIMS FOR “RECIPIENT NOT ELIGIBLE” CAUSED BY DISCREPANCIES BETWEEN THE EVS AND THE DBH/CBH CLAIMS SYSTEM**

If the provider accesses the eligibility information and it indicates that the client is eligible for treatment on a particular date, but during the processing of the claim CBH does not show the individual to be eligible and rejects the claim, within 180 days from the date of service for services requiring an authorization and within 90 days from the date of service for services not requiring an authorization, the provider must do the following:

- 1 Make a copy of the rejection report that notes the eligibility rejection.
- 2 Make a copy of the eligibility information that notes the client was CBH eligible to receive service on the date(s) indicated on the claim.
- 3 Prepare a new clean claim for the service(s) performed.
- 4 Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Clearly write on the envelope “**Eligibility Rejection Appeal.**”

The claims will be handled by CBH in one of the following ways:

- ▶ If the claim was rejected within the last month, it will be overridden and appear on the next Payment Detail.
- ▶ If the claim rejection is older than one month, it will be re-rejected first. The provider will get another Rejection Report after the next adjudication, indicating the same rejection reason. However, this time, the abbreviated word “Elig”, will appear in the column entitled, “Patient’s Reference Number.” Following the adjudication, the rejection will be overridden and appear on the next Payment Detail. While this process is cumbersome, it is necessary to maintain the integrity of our reporting to the Pennsylvania DPW.

**NOTE:** The override for eligibility applies only to claims that were submitted and rejected for “**Recipient Not Eligible.**” It does not apply to authorization requests that were denied because of ineligibility.

### APPEALING CLAIMS FOR LATE SUBMISSION

If CBH receives a claim or Adjustment Request Form more than 180 days from the date of service for services requiring an authorization, or more than 90 days from the date of service for services not requiring an authorization, the claim or adjustment form will be rejected or returned to provider due to late submission. Claims or adjustments rejected or returned for late submission may be appealed **only** due to processing errors made by CBH. The following requirements are necessary in order to be eligible for appeal:

- 1 Provider had submitted a clean claim within the required timeframes (no more than 180 days from the date of service for services requiring an authorization or no more 90 days from the date of service for services not requiring an authorization).
- 2 CBH had improperly processed the clean claim causing an incorrect payment or a rejection **only** resulting from CBH's processing error.
- 3 Provider resubmits the clean claim (along with an Adjustment Request Form for incorrect payments) within 90 days from the date of the incorrect payment or rejection.

The following information must be submitted with the clean claim (and Adjustment Request Form, if applicable):

- 1 A letter addressed to the Claims Appeals Specialist indicating the specific cause of the rejection or incorrect payment due to CBH's error,
- 2 A copy of the rejection report that notes the rejection reason caused by CBH's error or a copy of the payment detail that notes the incorrect payment made due to CBH's error, and
- 3 A copy of the EOB for TPL claims, if applicable.

Mail the appeal to the attention of the CBH Claims Appeals Specialist, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Clearly write on the envelope "**Claims Appeal.**"

**The following chart lists the most frequent causes for claims to be rejected and the remedies for providers.**

## COMMON CAUSES FOR CLAIMS REJECTION AND REMEDIES FOR PROVIDERS

Rejection Description	Cause	Remedy
Claim line was previously paid.	<p>1. If exact same date(s) of service(s) for same person was previously paid, claim will reject.</p>	Check to ensure no data entry error was made.
	<p>2. When a provider submits two claims for separate units of service within the same billing period, the second claim will reject if the first claim form has referenced the entire billing period. (For example, a provider has authorization for 30 units from 1/1/05 to 1/31/05. Claim #1 is submitted for 15 units used on 1/1 to 1/15, but references 1/1 to 1/31 on the claim form. If a second claim is submitted for the remaining 15 units with service dates 1/16 to 1/31, the second claim will be rejected because it is covering a period that was already paid, and therefore appears to the system to be an overlapping bill.)</p>	Submit a Claims Adjustment Request Form for the initial claim indicating that only a portion of the entire billing period and units of service were used. Also resubmit a corrected claim reflecting the entire billing period.
No units of service left for this authorization	<p>1. This may occur when all authorized units were paid, and the provider submitted a claim for additional units.</p>	Check to see if the additional date(s) of service for additional units are under another authorization number. If so, re-submit the claim using the correct authorization. If additional units are needed for the same individual, the DBH/CBH Care Manager must approve extending the authorization. Then provider can resubmit claim for the added units. Or, new authorization may be issued and provider can re-submit the claim with the correct authorization for payment.
	<p>2. If the initial authorization was zeroed out or canceled, the claim will be rejected for this reason.</p>	
Invalid or unknown recipient ID number.	If a claim was submitted with the wrong recipient number or no number, the claim will reject.	Check to ensure no data entry error was made. Re-submit with the correct CIS number.
Recipient was not eligible for service on a specified date.	These claims have been rejected because, according to DBH/CBH records, the client was not eligible for service on that date.	Re-submit with proof of eligibility. Attach eligibility information for that date of service for correct processing. Send claims to the attention of: "Eligibility Rejections."
Billed dates of service do not match authorized dates of service	If a claim is submitted for service dates outside the authorization period, this error will appear. (For example if the authorization period is for 1/1/05 to 2/1/05 and the claim submitted is for 2/5/05, the claim will be rejected.)	Check the authorization report for the correct authorization number for this date of service. Re-submit the claim for the correct period or obtain a corrected authorization.

**COMMON CAUSES FOR CLAIMS REJECTION AND REMEDIES FOR PROVIDERS**

Rejection Description	Cause	Remedy
<b>Invalid primary ICD-9 Behavioral Diagnosis Code.</b>	Diagnosis code is not considered valid by DBH/CBH, was not correctly entered, or was missing on the claim.	Use the correct ICD-9 code number for proper payment. Contact Provider Relations if you need assistance at (215) 413-7660.
<b>Invalid or unknown authorization number</b>	The claim was submitted either with no authorization number, an incorrect authorization number, or no BAN.	Check to ensure no data entry error was made. Re-submit with correct authorization number or BAN.
<b>Client is not the same as client referenced in authorization</b>	This rejection will typically appear when the client named in the claim form is not the same as the client named on the authorization. This rejection will also appear with the "Invalid or unknown recipient number," and with "Invalid or unknown authorization number."	Refer to authorization report to check for accuracy of client number or authorization number.
<b>Provider is not the same as provider of authorization referenced</b>	Provider number billed is not the same as the one referenced in the authorization.	Re-submit with the correct provider number that was authorized, or request that the authorization be changed.
<b>Service is not the same as service of authorization referenced</b>	Service is not the same as the service referenced in the authorization. Claim report will indicate wrong service was used. (The claim was submitted with the incorrect authorization or the incorrect cpt or revenue code.) This rejection will also appear with "Invalid or unknown authorization number."	Re-submit with the correct authorization or the correct cpt or revenue code.
<b>Claim is no longer eligible for payment: late submission.</b>	Claim is submitted beyond the 180 days of date of service for Covered Services requiring an authorization and beyond the 90 days of date of service for Covered Services not requiring an authorization.	Refer to Claims Appeals Process section of manual.
<b>Unknown or invalid case number.</b>	Case is not opened.	Reference Case Open Process in Authorization section of this manual.
<b>Cannot match provider to service for specific date</b>	Discrepancy in the contract for that level of care	Contact Claims Department for clarification at (215) 413-7125.

## COMMON CAUSES FOR CLAIMS REJECTION AND REMEDIES FOR PROVIDERS

Rejection Description	Cause	Remedy
<p><b>Cannot find unique service for CPT code (not required authorization)</b></p> <p><b>Incomplete level of care data to determine edit rules</b></p> <p><b>Insufficient information to calculate level of care</b></p>	<p>These three errors result from not following Schedule A, specifically:</p> <ol style="list-style-type: none"> <li>1. Submitting a claim with the wrong CPT code</li> <li>2. Invalid or no BAN</li> <li>3. Invalid or no information modifier</li> <li>4. Invalid or no pricing modifier</li> </ol>	<p>Resubmit claim with the correct information.</p>
<p><b>Units served exceeds maximum allow PAID units per day</b></p>	<p>Primarily results for the following reasons:</p> <ol style="list-style-type: none"> <li>1. When a claim is already paid for that date</li> <li>2. When a claim is submitted with more than the clinically allowable units per day</li> </ol>	<p>Verify the same date of service was already paid. Contact Provider Relations if you need assistance at (215) 413-7660.</p>
<p><b>Unknown HIPPA error CPT code (not in table consmar3)</b></p>	<p>Results from not following Schedule A, specifically when claim is submitted with the incorrect CPT code.</p>	<p>Resubmit with the correct CPT code.</p>

## Claims Reports

The following are brief summaries and examples of reports generated for providers. Samples follow.

- 1 The **Payment Detail Report** lists all paid services with the accompanying check. There are no totals for each individual but there is a grand total for the total number of units paid and the total dollar amount paid.
- 2 The **Pended Claims Report** documents the claims that have been adjudicated and “pended” or held while waiting for review by CBH’s TPL Department. The only reason for a pended claim is the existence of Third Party Liability (TPL). TPL refers to another payor (e.g., Medicare, Blue Shield) having a financial responsibility for payment for all or part of the claim.
- 3 The **Rejected/Denied Claims Report** refers to all claims that will not be paid by CBH as submitted. It lists warnings and the reasons for denials and rejections along with their corresponding amounts. It also lists claims that are shown on the **Rejected Claims Previously Pended Report** but will only show the pended and warning reasons. You must refer to the **Rejected Claims Previously Pended Report** to find out why a pended claim was rejected.  
Some of the claims may be resubmitted with the appropriate information while others will not be paid at all. Please review the reason for the rejection/denial to determine whether or not to resubmit the claim.
- 4 The **Rejected Claims Previously Pended Report** lists those pended claims that were subsequently rejected by CBH. This report also instructs the provider to resubmit the claim with an EOB or to make other corrections before resubmitting the claim. Claims with EOBs attached cannot be processed electronically; send a paper copy of the claims form and EOB.

Payment detail and rejections (including rejected claims previously pended) are available electronically via EDI Browser.

**NOTE:** For help in understanding your rejected claims report, see **Common Causes for Claims Rejection and Remedies for Providers**.

PAYMENT DETAIL (Sample)

Department of Behavioral Health/Community Behavioral Health  
MASTRR-MCARE  
PAYMENT DETAIL

03/10/2005  
02:19:27  
User: OPERATOR, REPORT

Date Paid: 12/12/99  
Selection Criteria: For All Providers  
Provider Name: Get Well Soon, Inc. (123456)

Client Number	Client Name	Service Dates	Procedure Code	Billed Amount	CBH Claim Number	Provider Claim Num	Authorize Number	Level of Care	Paid Units	Amount Paid
0012345678 1/5/2005	JOHN DOE 1/5/2005 90804				123456	DOEA/1		INDIVIDUAL THERAPY W/PSYCHIATRIST	2	90.00
0012345678 1/17/2005	JOHN DOE 1/17/2005 90804				123456	DOEA/1		INDIVIDUAL THERAPY W/PSYCHIATRIST	1	45.00
0087654321 1/7/2005	MARY JONES 1/7/2005 90805				654321	JONES		INDIVIDUAL THERAPY W/PSYCHIATRIST	1	45.00
0087654321 2/2/2005	MARY JONES 2/2/2005 90804				654321	JONES		INDIVIDUAL THERAPY W/PSYCHIATRIST	2	90.00

Provider Name

CBH Assigned Provider Number Used by Providers to Bill for Services

Client's CIS Number

Client's Name

Procedure Code

CBH Claim Number

Provider Claim Reference Number

Number of Units Being Paid

Dollar Amount Paid

Service Date

Procedure Code used to Bill

Description of Service (listed as "Level of Care")

CBH Authorization Number (as listed on the Authorization Letter)

PENDED CLAIMS REPORT (Sample)

Department of Behavioral Health/Community Behavioral Health  
 MASTRR-MCARE  
 PENDED CLAIMS REPORT  
 Reported for period from: 12/02/2005 through 12/03/2005  
 Adjudication Period

12/03/2005  
 06:41:28  
 User: OPERATOR, REPORT

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Provider Name  
 CBH Assigned Provider Number Used by Providers to Bill for Services

Selection Criteria:  
 For All Providers  
 Selection Criteria:  
 Get Well Soon, Inc. (123456)

Authorization Number	Service Dates	Level of Service	Procedure Code	Special Type Attachments	Invoice Number	Line #	TPL Stat	TPL Exp Date	Billed Dollars	Adjudicated Units	Adjud Date	Received Date	
08/26/2005-08/26/2005	INDIV. THERAPY NON-PSYCHIATRIST	90804			153592	1	YES	2/1/2004	125.00	1		12/02/2005	
08/26/2005-08/26/2005	INDIV. THERAPY NON-PSYCHIATRIST	90804			153912	1	YES		125.00	1		12/02/2005	
08/26/2005-08/26/2005	INDIV. THERAPY NON-PSYCHIATRIST	90804			153912	1	YES		125.00	1		12/02/2005	
Totals for Client:										375.00	3		
Client Name: Jones, Mary 0087654321										125.00	1		12/02/2005
08/26/2005-08/26/2005										125.00	1		12/02/2005
INDIV. THERAPY NON-PSYCHIATRIST										250.00	2		
Totals for Client:										625.00	5		

Client Name  
 Doe, John 0012345678  
 INDIV. THERAPY NON-PSYCHIATRIST  
 90804  
 Authorization Number (as listed on the authorization letter)  
 08/26/2005-08/26/2005  
 Client's CIS Number  
 90804  
 Description of Service (listed as "Level of Service")  
 INDIV. THERAPY NON-PSYCHIATRIST  
 90804  
 INDIV. THERAPY NON-PSYCHIATRIST  
 90804

The Amount of the Claim (listed as "Billed Dollars")  
 125.00  
 Number of Adjudicated Units  
 1  
 Date Claim was Received by DBH/CBH  
 12/02/2005

Line Number Referenced (for each line in the Compensable Service section of each claim)  
 2/1/2004

TPL Status (either yes or no to indicate the existence of TPL already in CBH system)  
 YES

TPL Effective /Expiration Date  
 6/1/2005

Procedure Code used to Bill  
 90804

Totals for Provider: Get Well Very Soon, Inc. 123456

Provider Totals



REJECTED CLAIMS REPORT - PREVIOUSLY PENDED (Sample)

Department of Behavioral Health/Community Behavioral Health  
MASTR-MCARE  
Name of Report  
REJECTED CLAIMS REPORT (PREVIOUSLY PENDED CLAIMS)  
Adjudication Period  
Reported for the period from: 11/10/2005 through 11/13/2005

12/15/2005  
13 : 42 : 51  
User: OPERATOR REPORT  
Provider Name  
CBH Assigned Provider Number Used by Providers to Bill for Services  
Selection Criteria: For All Providers For All Clients  
Provider Name: Get Well Very Soon, Inc. 123456

Authorization Number  
Level of Service  
Description  
Invoice Number  
Line #  
TPL Stat  
Billed Dollars  
Units  
Adjudicated Date  
Provider Ref #  
Received Date

Client Name	Client's CIS Number	Authorization Number (as listed on the authorization letter)	Description of Service (listed as "Level of Service")	CBH Invoice Number	TPL Stat	Billed Dollars	Units	Adjudicated Date	Provider Ref #	Received Date
Client Name: Doe, John 00112345678 201010 41	Resubmit other ins. EOB	IOP		1366302 3	No	85.00	1.00	10/12/2005	Doe90	10/27/2005
201010 41	Resubmit other ins. EOB	IOP		1366302 4	No	85.00	1.00	10/12/2005	Doe90	10/27/2005
Totals for Client:						170.00	2.00			
Client Name: Jones, Mary 0087654321 69	INDIV. THERAPY NON-PSYCHIATRIST COB payment>CBH max allowance			153931 2	Yes	125.00	1.00	10/12/2005	Jones47	10/27/2005
Totals for Client:	INDIV. THERAPY NON-PSYCHIATRIST COB payment>CBH max allowance	Jones, Mary 0087654321		153986 1	Yes	125.00	1.00	10/12/2005	Jones47	10/02/2005
Totals for Provider:						420.00	4.00			

**CLAIMS ADJUSTMENT REQUEST FORM**

Please Print

Requestor's name \_\_\_\_\_ Date submitted \_\_\_\_\_

Provider name \_\_\_\_\_

MA ID # \_\_\_\_\_ Authorization # \_\_\_\_\_

Recipient Name \_\_\_\_\_ Recipient ID # \_\_\_\_\_

Corrected Claim (check one box)  paper (attach)  diskette (attach)  via modem

**Reason for Adjustment:** (please check applicable box(es), attach payment detail and corrected claims)

- Duplicate authorization (claims submitted and paid twice)
- Payment made at wrong rate
- Payment made for incorrect level of care
- Payment made for excessive units of service within a time period
- Service was span billed with overlapping days on more than one claim, resulting in payment for the first claim submitted, but rejections for subsequent claims
- Other (please explain) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ADJUSTMENT DETAIL**

	Current	Should Be
Level of Care Code	_____	_____
Date(s) of Service	_____	_____
Units Paid	_____	_____
Rate Paid	_____	_____

(completed by CBH only)

**Adjustment Request is being returned because:**

- Units exhausted  Missing or incomplete claim form  Missing Payment detail
- Other \_\_\_\_\_  
 \_\_\_\_\_

**Return the top two copies of this form with required support materials to:**

CBH Claims Department (Attention: Adjustments) • Community Behavioral Health  
 801 Market Street, 7th Floor • Philadelphia, PA 19107

For more information or additional copies of this form, call CBH Provider Relations at (215) 413-7660



## Sample Forms

The succeeding section provides reference materials as well as samples of claims forms and reports:

- ▶ **PROMISe Desk Chart for Assistance in the Completion of the UB-92 Claim Form** .....4.28–4.29
  - ▶ UB-92 – Inpatient Claim Form .....4.30
  - ▶ UB-92 – Inpatient Third Party Liability (TPL) Claim Form .....4.31
  - ▶ Explanation of Benefits (EOB) for Inpatient UB-92 Third Party Liability (TPL) .....4.32
  
- ▶ **Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) Desk Reference**.....4.33–4.35
  - ▶ OMHSAS Desk Reference - Provider Types .....4.33–4.34
  - ▶ OMHSAS Desk Reference - Modifiers.....4.34
  - ▶ OMHSAS Desk Reference - HIPAA Place of Service Codes .....4.35
  
- ▶ **Assistance in the Completion of the Outpatient and CMS 1500 Claim Forms** ....4.10–4.12
  - ▶ CMS 1500 - Outpatient Claim Form .....4.36
  - ▶ CMS 1500 - Outpatient Third Party Liability (TPL) Claim Form.....4.37
  - ▶ Explanation of Benefits (EOB) for CMS 1500 Outpatient Third Party Liability (TPL) .....4.38

PROMISE DESK CHART FOR ASSISTANCE IN THE COMPLETION OF THE UB-92 CLAIM FORM

Code	Code	Code
<b>PROVIDER TYPE FIELD #2</b>		
1 General hospital	1 Private psychiatric hospital or psychiatric unit	1 Accredited residential treatment facility or extended acute psychiatric care unit (inpatient)
1 Medical rehab hospital, medical rehab unit, D&A hospital or D&A unit	1 Public psychiatric hospital	
<b>TYPE OF BILL Field #4</b>		
1 Admit through discharge	7 Replacement of prior claim	8 Void/cancel prior claim
2 Interim—first claim		
<b>ADMISSION AND DISCHARGE HOURS Field #18, 21</b>		
00 12:00 midnight–12:59 am	TO	23 11:00 pm–11:59 pm
<b>TYPES OF ADMISSION Field #19</b>		
1 Emergency	3 Elective	2 Urgent
<b>SOURCE OF ADMISSION Field #20</b>		
5 Transfer from LTC facility		
<b>PATIENT STATUS Field #22</b>		
01 Routine discharge	04 Discharge/transfer to ICF	07 Left against medical advice or discontinued care
02 Discharge/transfer to another general hospital for inpatient care	05 Discharge/transfer to another type of institution for inpatient care or referred for outpatient services to another institution	20 Expired
03 Discharge/transfer to SNF		30 Still a patient
<b>CONDITION CODES Field #24-30</b>		
02 Condition is employment related	X2 Medicare EOMB on file	Y0 Newborn eligibility
03 Patient covered by insurance not reflected here	X3 Hysterectomy acknowledgement form	Y1 Family planning
05 Lien has been filed	X4 Medicare denial form	Y2 Pregnancy
60 Day outlier	X5 Third-party payment on file	Y3 Co-pay not collected
77 Provider accepts or is obligated/required due to contractual arrangement or law to accept payment by a primary payor as payment in full	X6 Restricted recipient referral form	Y4 Medicare benefits exhausted
	X7 Medical documentation for hysterectomy	
X0 Abortion physician certification	X8 Administrative waiver	Y6 Third-party denial on file
X1 Sterilization patient consent form	X9 Patient pay applied to previous claim	

(continued on next page)

PROMIS<sub>e</sub> DESK CHART FOR ASSISTANCE IN THE COMPLETION OF THE UB-92 CLAIM FORM (continued)

Code	Code	Code
<b>OCCURRENCE CODES Field #32-35</b>		
01 Auto accident	05 Other accident	25 Date benefits terminated by primary payor
02 No-fault insurance involved—including auto accident/other	06 Crime victim	A3 Benefits exhausted
03 Accident/tort liability	24 Date insurance denied	B3 Benefits exhausted
04 Accident/employment related		
<b>OCCURRENCE SPAN CODES Field #32-35</b>		
71 Prior stay dates	74 Non-covered level of care	
<b>VALUE CODES Field #39-41</b>		
06 Medicare blood deductible	A1 Deductible payor A	B2 Coinsurance payor B
38 Blood deductible pints	B1 Deductible payor B	X0 Medicare part B payment
39 Pints of blood replaced	A2 Coinsurance payor A	
<b>REVENUE CODE Field #42</b>		
001 Total charges		
<b>REVENUE CODES REQUIRING UNITS OF SERVICE Field #42</b>		
32X Radiology diagnostic	61X Magnetic resonance imaging	81X Organ acquisition
35X CT scan	73X EKG/ECG—electrocardiogram	91X Psychiatric/psychological services—nursing care
42X Physical therapy	74X EEG—electroencephalogram	94X Other therapeutic services
43X Occupational therapy		
<b>PAYOR IDENTIFICATION Field #50</b>		
A Primary payor	C Tertiary payor (always MA)	
B Secondary payor	P Due from patient	
<b>PATIENT'S RELATIONSHIP TO INSURED Field #59</b>		
01 Patient is insuree	06 Foster child	14 Niece/nephew
02 Spouse	07 Ward of court	15 Injured plaintiff
03 Natural child/insured financial responsibility	08 Employee	16 Sponsored dependent
04 Natural child/insured does not have financial responsibility	09 Unknown	17 Minor dependent of a minor dependent
05 Stepchild	10 Handicapped dependent	18 Parent
	13 Grandchild	19 Grandparent
<b>EMPLOYMENT STATUS CODE Field #64</b>		
1 Employed full-time	4 Self employed	6 On active military duty
2 Employed part-time	5 Retired	9 Unknown
3 Not employed		

UB-92 - INPATIENT (Sample)

Provider Name Address Telephone Number		2		3 PATIENT CONTROL NO. 09 876543		APPROVED OMB NO. 0938-027		4 TYPE OF BILL 111	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 03/01/2005 THROUGH 03/09/2005		7 COV D. 8		8 N-C D.		9 C-I D.	
10 L-R D.		11		12 PATIENT NAME Smith, Delia		13 PATIENT ADDRESS 1234 Maple Lane, Phila., PA 19121			
14 BIRTHDATE 01/01/1947		15 SEX		16 MS		17 DATE 03/01/2005		18 HPT	
19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO. JD12X34YZ	
24		25		26		27		28	
29		30		31		32		33	
34		35		36		37		38	
39		40		41		42		43	
44		45		46		47		48	
49		50		51		52		53	
54		55		56		57		58	
59		60		61		62		63	
64		65		66		67		68	
69		70		71		72		73	
74		75		76		77		78	
79		80		81		82		83	
84		85		86		87		88	
89		90		91		92		93	
94		95		96		97		98	
99		100		101		102		103	
104		105		106		107		108	
109		110		111		112		113	
114		115		116		117		118	
119		120		121		122		123	
124		125		126		127		128	
129		130		131		132		133	
134		135		136		137		138	
139		140		141		142		143	
144		145		146		147		148	
149		150		151		152		153	
154		155		156		157		158	
159		160		161		162		163	
164		165		166		167		168	
169		170		171		172		173	
174		175		176		177		178	
179		180		181		182		183	
184		185		186		187		188	
189		190		191		192		193	
194		195		196		197		198	
199		200		201		202		203	
204		205		206		207		208	
209		210		211		212		213	
214		215		216		217		218	
219		220		221		222		223	
224		225		226		227		228	
229		230		231		232		233	
234		235		236		237		238	
239		240		241		242		243	
244		245		246		247		248	
249		250		251		252		253	
254		255		256		257		258	
259		260		261		262		263	
264		265		266		267		268	
269		270		271		272		273	
274		275		276		277		278	
279		280		281		282		283	
284		285		286		287		288	
289		290		291		292		293	
294		295		296		297		298	
299		300		301		302		303	
304		305		306		307		308	
309		310		311		312		313	
314		315		316		317		318	
319		320		321		322		323	
324		325		326		327		328	
329		330		331		332		333	
334		335		336		337		338	
339		340		341		342		343	
344		345		346		347		348	
349		350		351		352		353	
354		355		356		357		358	
359		360		361		362		363	
364		365		366		367		368	
369		370		371		372		373	
374		375		376		377		378	
379		380		381		382		383	
384		385		386		387		388	
389		390		391		392		393	
394		395		396		397		398	
399		400		401		402		403	
404		405		406		407		408	
409		410		411		412		413	
414		415		416		417		418	
419		420		421		422		423	
424		425		426		427		428	
429		430		431		432		433	
434		435		436		437		438	
439		440		441		442		443	
444		445		446		447		448	
449		450		451		452		453	
454		455		456		457		458	
459		460		461		462		463	
464		465		466		467		468	
469		470		471		472		473	
474		475		476		477		478	
479		480		481		482		483	
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UB-92 -INPATIENT THIRD PARTY LIABILITY (TPL) (Sample)

APPROVED OMB NO. 0938-027

Feel Good Hospital 651 Jenkins Road Philadelphia, PA 19178 Phone: (215) 999-1010				2		3 PATIENT CONTROL NO. 1571579				4 TYPE OF BILL 111																							
5 FED. TAX NO. 123456789		8 STATEMENT COVERS PERIOD FROM 05/22/2005 THROUGH 05/30/2005		7 COV. ID. 8		8 N-C.D.		9 C-I.D.		10 L-R.G. 11																							
12 PATIENT NAME Brown, David				13 PATIENT ADDRESS 1234 Oak Lane, Phila., PA 19121																													
14 BIRTHDATE 02/05/1959		15 SEX M	16 MS		17 DATE 5/22/2005		18 ADMISSION 18 NP 19 TYPE 20 SRC 09 2		21 D HR 19		22 STAT 01		23 MEDICAL RECORD NO. 22771		24		25		26		27		28		29		30		31				
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37		38		39		40		41		42		43		44		45		46		47		48	
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42 REV. CD. 001 124		43 DESCRIPTION Total Charges Room and Board				44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS 8		47 TOTAL CHARGES 7202 00 7040 00		48 NON-COVERED CHARGES		49																	
50 PAYER Medicare CBH/MAPA				51 PROVIDER NO. 123456 01/01234567890004				52 REL. INFO Y Y		53 ASG. DEN. Y Y		54 PRIOR PAYMENTS 1,996 00		55 EST. AMOUNT DUE 764 00		56																	
57 <b>DUE FROM PATIENT</b>																																	
58 INSURED'S NAME Brown, David				59 P. REL. 01		60 CERT. - SSN - HIC - ID NO. 123456789A 99999999999				61 GROUP NAME				62 INSURANCE GROUP NO.																			
63 TREATMENT AUTHORIZATION CODES 505425				64 ICD-9-CM 505425				65 EMPLOYER NAME				66 EMPLOYER LOCATION																					
67 PRIN. DIAG. CD. 296.00		68 CODE 30480		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD. 296.00		77 E-CODE		78											
79 P.C. 9		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 OTHER PROCEDURE CODE DATE		83 OTHER PROCEDURE CODE DATE		84 OTHER PROCEDURE CODE DATE		85 OTHER PROCEDURE CODE DATE		86 OTHER PROCEDURE CODE DATE		87 OTHER PROCEDURE CODE DATE		88 OTHER PROCEDURE CODE DATE		89 OTHER PROCEDURE CODE DATE		90 OTHER PROCEDURE CODE DATE											
91 ATTENDING PHYS. ID MD123456E Dr. Mercy																																	
92 OTHER PHYS. ID																																	
93 OTHER PHYS. ID																																	
94 REMARKS 123456																																	
95 PROVIDER REPRESENTATIVE Mary Jones														96 DATE 07/14/2005																			

**EXPLANATION OF BENEFITS (EOB) FOR INPATIENT UB-92 THIRD PARTY LIABILITY (TPL) (Sample)**

VERITUS MEDICARE SERVICES FEEL GOOD HOSPITAL		FIFTH AVENUE PLACE, PITTSBURGH, PA 15222 TEL#412-255-7000										PAGE 1											
PART A		PAID DATE: 6/18/05 REMITIN: 147																					
Patient Name	Patient Cntrl Number	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ	HIC Number	ICN Number	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ						
FROM DT	THRU DT	NACHG	HICHG	TOB	NCOVY	RC	REM	DRG#	DRG OUT AMT	DRG CAP AMT	MSP PAYMT	INTEREST	HCPCS AMOUNT	CLM STATUS	COVDY	NCOVY	DRG OPR AMT	DEDUCTIBLES	COVD CHGS	COVD DENIED CHGS	ESRD NET ADJ	PER DIEM RTE	
Brown, David	1575179	A2	HAO2						.00	.00	.00	.00	4442.05	123456789A	19815609540204	01	B3		.00	7202.00	.00	.00	345.00
05/22/2005	05/30/2005	<div style="display: flex; justify-content: space-between; align-items: center;"> <span>Service from/thru</span> <span>Co-insurance</span> <span>Covered charges</span> </div>																					
1	QC	N	111	1					.00	.00	.00	.00	.00	8	8			764.00	.00	.00	.00	.00	1996.00
Subtotal Fiscal Year 2005		<div style="display: flex; justify-content: space-between; align-items: center;"> <span>Covered days</span> <span>Deductible</span> <span>Net reimbursement</span> </div>																					
		8	8						.00	.00	.00	.00	4442.05			7202.00	.00	.00	.00	.00	.00	.00	.00
Subtotal Part A		<div style="display: flex; justify-content: space-between; align-items: center;"> <span></span> <span></span> <span></span> </div>																					
		8	8						.00	.00	.00	.00	4442.05			7202.00	.00	.00	.00	.00	.00	.00	.00
		8	8						.00	.00	.00	.00	1996.00				.00	.00	.00	.00	.00	.00	.00

OMHSAS DESK REFERENCE - PROVIDER TYPES

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Inpatient Facility	010	Acute Care Hospital
		011	Private Psychiatric Hospital
		013	RTF (Accredited) Hospital
		018	Extended Acute Psychiatric Inpatient Unit
		019	D&A Rehabilitation Hospital/Unit
		022	Private Psychiatric Unit
		027	RTF (Accredited) Unit
		183	Hospital-Based Medical Clinic
07	Capitation	072	Managed Care Organization - Behavioral Health
08	Clinic	080	Federally Qualified Health Center
		081	Rural Health Clinic
		082	Independent Medical/Surgical Clinic
		084	Methadone Maintenance
		110	Psychiatric Outpatient
		184	D&A Outpatient
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
		09	CRNP
548	Therapeutic Staff Support		
549	Mobile Therapy		
559	Behavioral Specialist Consultant		
11	Mental Health/Substance Abuse	110	Psychiatric Outpatient
		111	Community Mental Health
		112	Outpatient Practitioner - Mental Health
		113	Partial Psychiatric Hospital - Children
		114	Partial Psychiatric Hospital - Adult
		115	Family Based Mental Health
		116	Licensed Clinical Social Worker
		117	Licensed Social Worker
		118	Mental Health Crisis Intervention
		119	Mental Health - OMHSAS
		123	Psychiatric Rehabilitation
		127	D&A Outpatient
		128	D&A Intensive Outpatient
		129	D&A Partial Hospitalization
		131	D&A Medically Monitored Halfway House
		132	D&A Medically Monitored Detox
		133	D&A Medically Monitored Residential, Short Term
		134	D&A Medically Monitored Residential, Long Term
		184	Outpatient D&A
		548	Therapeutic Staff Support
549	Mobile Therapy		
559	Behavioral Specialist Consultant		

OMHSAS DESK REFERENCE - PROVIDER TYPES

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
16	Nurse	162	Psychiatric Nurse
17	Therapist	174	Art Therapist
		175	Music Therapist
19	Psychologist	190	General Psychologist
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
21	Case Manager	138	D&A Targeted Case Management
		212	MA Case Management
		221	Mental Health TCM - Resource Coordination
		222	Mental Health TCM - Intensive
28	Laboratory	280	Independent Laboratory
31	Physician	339	Psychiatry & Neurology
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
34	Program Exception	340	Program Exception
52	Community Residential Rehabilitation	520	Child Residential Service - 3800 (Group Home)
		523	Community Residential Rehabilitaton - Mental Health (Host Home)
56	Residential Treatment Facility	560	Residential Treatment Facility (Non-Accredited)

OMHSAS DESK REFERENCE - MODIFIERS

Modifiers	Modifier Descriptions	Modifiers	Modifier Descriptions
AH	Clinical Psychologist	TF	Intermediate Level of Care
EP	Services Provided as Part of Medicaid EPSDT Program	TG	Complex/High-Tech Level of Care
HA	Child/Adolescent Program	TJ	Program Group, Child and/or Adolescent
HB	Adult Program, Non-Geriatric	TS	Follow-up Service
HE	Mental Health Program	TT	Individualized Service Provided to More than One Patient in Same Setting
HF	Substance Abuse Program	UA	Licensed Children's Program
HG	Opioid Addiction Treatment Program	UB	Behavioral Health Pricing Modifier
HK	Specialized Mental Health Programs for High-Risk Populations	UC	Pilot Program
HO	Masters Degree Level	UK	Someone Other than the Client (Collateral)
HP	Doctoral Level	U1	Psychiatric
HQ	Group Setting	U2	Medicare/TPL Contractual Disallowance
HT	Multi-Disciplinary Team	U7	Pricing Modifier
HW	Funded by State Mental Health Agency	U8	Pricing Modifier
SC	Medically Necessary Service or Supply		

**OMHSAS DESK REFERENCE - HIPAA PLACE OF SERVICE CODES**

Use only the HIPAA Place of Service (POS) Codes listed below when submitting claims to DBH/CBH. These are the codes expected by DPW for DBH/CBH services. Do not use any other codes listed in the 837 Professional Billing Guide from the Commonwealth of Pennsylvania.

POS	Place of Service Description	POS	Place of Service Description
11	Office	50	Federally Qualified Health Center
12	Home	52	Psychiatric Facility Partial Hospital
15	Mobile Unit	54	ICF/MR
21	Inpatient Hospital	56	Psychiatric Residential Treatment Facility
22	Outpatient Hospital	57	Non-Residential Substance Abuse Treatment Facility
23	Emergency Room - Hospital	65	End-Stage Renal Disease Treatment Facility
24	Ambulatory Surgical Center	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other POS
34	Hospice		
49	Independent Clinic		

CMS 1500 - OUTPATIENT (Sample)

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																															
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>																																																																																																																																																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Brown, Lilly					3. PATIENT'S BIRTH DATE MM DD YY 03 28 53 M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																																																																																																																																																																																										
5. PATIENT'S ADDRESS (No., Street) 625 Daisy Street CITY: Philadelphia STATE: PA ZIP CODE: 19122 TELEPHONE (Include Area Code): (215) 222-0000					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same																																																																																																																																																																																																										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																																																																																																																																																										
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. SIGNED: Signature on file DATE: 06 / 17 / 05					11. INSURED'S POLICY GROUP OR FECA NUMBER 0987654321 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: Signature on file																																																																																																																																																																																																										
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 05 24 2005					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 05 26 2005																																																																																																																																																																																																										
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE John, Pity, MD					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 11/0012345670501																																																																																																																																																																																																										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 304.0					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 123456																																																																																																																																																																																																										
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25. FEDERAL TAX I.D. NUMBER 23-0987654					26. PATIENT'S ACCOUNT NO. 1234					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																					
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: Mary Jones DATE: 06/17/2005					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) DNA Center Philadelphia, PA 19111					28. TOTAL CHARGE \$ 160 00 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$																																																																																																																																																																																																					
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					PIN#					GRP#																																																																																																																																																																																																					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)  
FORM OWCP-1500 FORM RRB-1500

CMS 1500 - OUTPATIENT THIRD PARTY LIABILITY (TPL) (Sample)

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lee, Betty					3. PATIENT'S BIRTH DATE MM DD YY 07 06 35			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 0213456789			
5. PATIENT'S ADDRESS (No., Street) 800 Rose Lane					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) Same		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same			
CITY Philadelphia			STATE PA		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY Same		STATE			
ZIP CODE 19122		TELEPHONE (Include Area Code) (215) 222-0000			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE Same		TELEPHONE (INCLUDE AREA CODE) ( ) Same			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) None					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER 123456789A		a. INSURED'S DATE OF BIRTH MM DD YY 07 06 35			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME None		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME Medicare		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO // yes, return to and complete item 9 a-d.			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			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. SIGNED: Signature on file		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: Signature on file			
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Brinks, Daniel, MD			
17a. I.D. NUMBER OF REFERRING PHYSICIAN MD213456X					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 12 15 2004 TO 12 27 2004			19. RESERVED FOR LOCAL USE 11/0012345670501		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 304.0					22. MEDICAID RESUBMISSION CODE			23. PRIOR AUTHORIZATION NUMBER 213456		24. TABLE OF SERVICES			
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
12 27 2004 12 27 2004		21		99242			1	70 00	1			1	28.14
25. FEDERAL TAX I.D. NUMBER 23-3456789					26. PATIENT'S ACCOUNT NO. 128027			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 12 86		29. AMOUNT PAID \$ 28 14	30. BALANCE DUE \$ 7 03
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: Mary Jones					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) XXY Mental Health 1234 N. 100th Street Philadelphia, PA 19121			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # XXY Mental Health 1234 N. 100th Street Philadelphia, PA 19121					
DATE: 06/22/2005					PIN#			GRP#					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)  
FORM OWCP-1500 FORM RRB-1500

**EXPLANATION OF BENEFITS (EOB) FOR CMS 1500 OUTPATIENT THIRD PARTY LIABILITY (TPL) (Sample)**

XACT Medicare Services

**EXPLANATION OF MEDICARE BENEFITS**



Patient Name	Health Insurance Claim Number/Control No.	Proced. Code	No. Svcs.	2		3	4	5	6	7	8	9	10	11	12
				When From Mo./Day	To Mo./Day										
B. Lee	Acct. #493848 123456789A 36736321446-00	99231	1	12/27	12/27	7	51/1	70.00	35.17	7.03	35.17	0.00	0.00	0.00	28.14

\*CLAIM TOTALS

Total	Number of Claims	Amount Billed	Amount Apprv'd	Amount Applied to Deductible	Medicare Pays 80% of this Amt.	Co-ins	Amount of 80% of Payment	Svcs. Pd. in Full	Withheld Medicare for Offset	Medicare Paid Patient	Medicare Paid Provider
1	1	70.00	35.17	0.00	35.17	7.03	35.17	0.00	0.00	0.00	28.14

**SUMMARY**      Provider Number: 111111      Week Ending: 1/24/05      Check Number: 034432427      Date Paid: 1/24/05      Page: 1

XXY Mental Health  
1234 N. 100th Street  
Philadelphia, PA 19121