CMS1500 Billing Manual
CMS 1500 Billing Instructions

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About Billing Instructions

Where can you find help with L&I billing procedures?

Labor & Industries (L&I) provides resources to help you understand and comply with the Industrial Insurance laws in the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC).

L&I publishes the Medical Aid Rules and Fee Schedule (MARFS) which has the payment policies and fees schedule. You can find MARFS online at www.Lni.wa.gov/FeeSchedules.

In additional, L&I publishes a general billing manual and one billing manual for each bill form. Below is a list of the billing manuals L&I provides:

- General Provider Billing Manual.
- Hospital Billing Instructions.
- Miscellaneous Services Billing Instructions.
- Pharmacy Billing Instructions.
- Retraining and Job Modification Billing Instructions.

Each manual includes the following information:

- Information about Industrial Insurance and Crime Victims.
- Electronic and paper billing information.
- How to complete the bill forms.
- Where to send bill forms.
- Billing examples.
- Links to billing forms.
About Labor & Industries (L&I) Industrial Insurance

As administrator of Washington State’s workers’ compensation system, L&I is similar to a large insurance company that provides claim-related coverage to workers who suffer job-related injuries and illnesses.

Two programs cover Washington’s industrially injured/ill workers: the Washington State Fund and the Self Insured Employer Program (SIE). Both programs are governed by the Revised Code of Washington (RCWs) and the Washington Administrative Code (WACs).

State Fund Industrial Insurance

The Washington State Fund is financed by premiums from employers, workers, and income from investments. L&I claim managers oversee State Fund benefits to workers who are injured or become ill on the job. The State Fund covers all employers in the state who are not self-insured or covered by the U.S. Department of Labor.

State Fund claim numbers begin with one letter (B, C, F, G, H, J, K, L, M, N, P, X, Y, or Z) followed by 6 numbers or two letters (AA, AB) followed by 5 numbers. Example state fund claim numbers include: B123456 or AM95370.

Additional information about billing State Fund can be found in this manual or online at www.Lni.wa.gov/ClaimsIns/Providers/Billing or you can call the Provider Hotline at 800-848-0811.

Self-Insured Employer Program

L&I regulates about 400 large, self-insured employers (SIE) who have qualified to provide their own workers’ compensation insurance. Every SIE must authorize medical treatment and pay bills in accordance with Title 51 RCW and the Medical Aid Rules and Fee Schedules of the State of Washington per WAC 296-15-330(1).

Self-Insured claim numbers all start with S, T, or W followed by 6 numbers or 2 letters followed by 5 numbers. Example self-insured claim numbers include T123456 or SG12345.


Additional information about billing for self-insured claims can be directed to the employer or their third party administrator (TPA).

Getting Paid for Services Provided to Washington Workers

Every provider who treats injured workers must have an active provider payment account with L&I to be eligible for payment (WAC 296-20-015). Please visit L&I’s website for detailed information about becoming an L&I provider at www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp.
State Fund Electronic Billing
There are 3 ways to bill electronically for state fund claims:

1. Direct Entry using a free online form.
2. Upload billing files using your own software.
3. Submit bills through a Clearinghouse.

L&I offers free electronic billing through Provider Electronic Billing (PEB). PEB saves time and money and allows for greater control over the payment process, eliminates entry time, and allowing to process payments faster than paper billing. PEB reduces keying errors and decreases bill processing costs.

You can find detailed PEB information on our website at www.Lni.wa.gov/ElectronicBilling.

You can also find a Cost Comparison Estimator for electronic billing at www.Lni.wa.gov/ClaimsIns/Files/Providers/EstimatorFinal042009.xls.

Self-Insurance Electronic Billing
Please contact the employer or their TPA for billing information.

State Fund Paper Billing
The type of service you provide determines which billing form you need to use. See a list of a bill requirements for each provider type in the General Provider Billing Manual – page 7.

You must submit your bills on L&I approved bill forms. Please don’t fax your bills. Mail your bills to the address below:

Department of Labor & Industries
PO Box 44269
Olympia WA 98504-4269

Self-Insurance Paper Billing
You must submit your bills on L&I or self-insured approved forms (WAC 296-20-125(1)).

Mail your bills directly to the SIE or TPA. For a list of SIE/TPAs and their contact information, please visit: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsurance/EmpList.
Crime Victims Compensation Program

The Crime Victims Compensation Program is a secondary insurance program that provides financial, medical, and mental health benefits to victims of crimes.

Crime Victims claim number begin the letter V followed by 6 digits or a 2 letters, such as VA, followed by 5 digits.

Additional information about the Crime Victims Compensation Program can be found online at www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources or by calling the Crime Victims Compensation Program at 360-902-5377 or 800-762-3716.

Getting Paid for Services Provided to Crime Victims

You can find Crime Victims billing forms online at: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources.

Please don’t fax your bills to Crime Victims Compensation Program. Mail your bills to:

Department of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520
Use the CMS 1500 Bill Form (Labor and Industries form F245-127-000).

**Which types of providers use the CMS 1500 bill form?**

**Note:** Providers must have an active account with L&I to be eligible for payment.

- Ambulatory Surgery Center (ASC).
- Anesthesiologist.
- Chiropractor.
- Hospital/Emergency Room Professional Services.
- Independent Medical Exam Services.
- Laboratories.
- Naturopath.
- Osteopathic Physician.
- Outpatient Pain Management Program.
- Pathologist.
- Physical Therapist.
- Physician.
- Physician Assistant.
- Physician Clinic.
- Podiatric Physician.
- Psychologist.
- Radiologist.
Instructions by Provider Type

Ambulatory Surgery Center (ASC)

Modifiers affect payments:
- CPT modifiers:
  - –50
  - –51
  - –52
  - –73
  - –74
  - –99

For the purposes of billing for services provided to Washington workers, an ASC is an outpatient facility where surgical services are provided and that meets the following three requirements:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure, and
2. Must have at least one of the following credentials:
   a. Medicare Certification as an ambulatory surgery center, or
   b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS), and
3. Must have an active ASC provider account with L&I.

Procedures not listed in the ASC fee schedule section of Medical Aid Rules and Fee Schedule (MARFS) are not covered in an ASC. Find a list of all procedures covered in an ASC online at: www.Lni.wa.gov/FeeSchedules in the ASC Fee Schedules section.

For more ASC information, please refer to WAC 296-23B and to the Ambulatory Surgery Center section of MARFS at: www.Lni.wa.gov/FeeSchedules in the Billing and Payment Policies section.
Anesthesiologist

Payment for anesthesia services will only be made to:
- Anesthesiologists.
- Certified registered nurse anesthetists.

The insurer does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by L&I.

For a list of non-covered procedures, refer to the Medical Aid Rules and Fee Schedule Appendix F at www.Lni.wa.gov/FeeSchedules in the Billing and Payment Policies section.

The insurer pays most anesthesia services with base and time units. Bill these services with CPT anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier. Bill for services in one (1) minute time units. List only the time in minutes. Do not include base units. L&I’s payment system automatically adds base units.

For more information, please refer to the Anesthesia Services Chapter 4 of the Medical Aid Rules and Fee Schedule at www.Lni.wa.gov/FeeSchedules.

Chiropractor

Chiropractor physicians must bill for chiropractic care visits with the L&I local procedures codes listed in the Chiropractic Services Chapter 7 of the Medical Aid Rules and Fee Schedules at www.Lni.wa.gov/FeeSchedules. They must use the appropriate CPT codes for radiology, office visits, and case management services and HCPCS codes for miscellaneous materials and supplies.

The insurer will not pay chiropractic physicians for codes that are not specifically allowed. Refer to the appendices in the Medical Aid Rules and Fee Schedules www.Lni.wa.gov/FeeSchedules for more information on procedure codes and modifiers.

Evaluation and Management (E/M)

Chiropractic physicians may bill the first four (4) levels of new and established patient office visit codes. L&I uses the CPT definitions for new and established patients.

- New Patient – One who hasn’t received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice within the past three (3) years.

- Established Patient – One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice within the past three (3) years.
The following payment policies apply when chiropractor physicians use E/M office visit codes:

- A new patient E/M office visit code is **payable only once** for the initial visit.
- Established patient E/M office visit codes are **not payable** on the same day as a new patient E/M office visit code.
- Established patient E/M codes are **not payable** in addition to L&I chiropractic care visit codes for follow up visits.
- Office visits in excess of 20 visits or that occur more than 60 days after the first date you treat the worker require **prior authorization**.
- Modifier –22 isn’t payable with E/M codes for chiropractic services.
- For policies about E/M visit with a chiropractic care visit refer to the Chiropractic Services chapter of the Medical Aid Rules and Fee Schedules at [www.Lni.wa.gov/FeeSchedules](http://www.Lni.wa.gov/FeeSchedules).
- Chiropractic consultation requires prior notification to the department or self-insurer. Consultants must be from an approved list of chiropractic consultants.
- The codes and reimbursement levels for chiropractic consultation services are listed in the fee schedules at [www.Lni.wa.gov/FeeSchedules](http://www.Lni.wa.gov/FeeSchedules).
- Also see [WAC 296-23-195](http://www.Lni.wa.gov/FeeSchedules) for additional information on chiropractic consultations.

**Hospital Emergency Room/Professional Services**

Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the CMS 1500 bill form using the provider account number(s) assigned by the department specifically for ambulance services and professional services.

Diagnoses codes are not required on the billing form when billing for ambulance services.

For more information, please refer to the Hospital WACs in Chapter 296-23A, the “Hospital Payment Policies section of the Medical Aid Rules and Fee Schedules at [www.Lni.wa.gov/FeeSchedules](http://www.Lni.wa.gov/FeeSchedules) and the Hospital Billing Instructions (Fxxx-xxx-000).
Independent Medical Examination (IME) Providers

For information on the L&I websites, go to:

- Chapter 12 of the Medical Aid Rules and Fee Schedules [www.Lni.wa.gov/FeeSchedules](http://www.Lni.wa.gov/FeeSchedules)

Doctors and/or firms who wish to provide IMEs for the department or self-insures for workers covered under Title 51 RCW must be approved by the department per WAC 296-23-312.

Doctors and/or firms must submit a completed Provider Account Application – IME (F245-046-000) ot the Provider Credentialing and Compliance Unit at the Department of Labor & Industries PO Box 44322 Olympia WA 98504-4322.

- An IME examiner not working through any IME firms will need just 1 IME number, which will also serve as their payee number.
- If an examiner works with multiple IME firms that are identified as the payee, then the examiner will need a different provider number for each IME firm.

Billing State Fund for IME Services Conducted WITHIN Washington State

Billing by non-firm affiliated examiners

If you conduct IMEs in Washington State and you bill the department directly for these services you must enter your IME examiner provider account number and/or your NPI in box 24J “Rendering Provider ID #”. If billing with National Provider Identifier (NPI) only, it must be registered with L&I.

Billing by firms

If your firm conducts IMEs in Washington State, the table below shows which provider account number and/or National Provider Identifier (NPI) to use 24J of the CMS 1500 form based on the IME service provided IN Washington State. If billing with the NPI only, it must be registered with the department.

See table on next page.
<table>
<thead>
<tr>
<th>Use only the IME examiner’s provider account number/NPI for these codes:</th>
<th>Use only the IME firm’s provider account number/NPI for these codes</th>
<th>The following codes may be billed by the IME examiner, the IME firm, or by the performing provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1028M</td>
<td>1118M</td>
<td>1132M IME, document handling fee per page.</td>
</tr>
<tr>
<td>1038M</td>
<td>1120M</td>
<td>1133M IME, CAC document processing fee.</td>
</tr>
<tr>
<td>1048M</td>
<td>1123M</td>
<td>CPT Code 90801</td>
</tr>
<tr>
<td>1066M</td>
<td>1125M</td>
<td>CPT Codes 96101, 96102</td>
</tr>
<tr>
<td>1104M 1105M</td>
<td>1128M</td>
<td>X-ray, diagnostic laboratory tests in conjunction with IME (use modifier –7N).</td>
</tr>
<tr>
<td>1108M</td>
<td>1129M</td>
<td>1045M</td>
</tr>
<tr>
<td>1109M</td>
<td>1130M</td>
<td></td>
</tr>
<tr>
<td>1111M 1112M 1134M 1135M 1136M</td>
<td>1137M 1138M</td>
<td>CPT Codes: 99441 – 99443</td>
</tr>
</tbody>
</table>

**Note:** On the CMS 1500 (F245-127-000), IME firms may use their own provider account numbers (box 33b) and/or NPI (box 33a) as the “payee” although it isn’t required if the same provider account number/NPI is in box 24J.
Billing State Fund for IME Services Conducted OUTSIDE of Washington State

IME providers and IME firms conducting IME services outside of Washington State must comply with the following requirements:

- IME examiners must meet L&I's criteria for approved examiners.
- A separate IME provider account number is required for IMEs conducted outside of Washington State.
- IME examiners must be approved by L&I. To obtain the procedures and an IME provider application, go to www.Lni.wa.gov/ClaimsIns/Providers/Becoming/IME/.
- Firms will not be required to put the examiner provider account number on State Fund bills.
- Bills for out-of-state IMEs must contain the IME firm's provider account number box 33b of the CMS 1500 bill form.
- You must bill your usual and customary fees.

For more information on becoming an approved IME provider or performing impairment ratings, please see the Medical Examiners’ Handbook or go www.Lni.wa.gov/ClaimsIns/Providers/Becoming/IME/.

For general information regarding Washington State IMEs (including finding a medical examiners how to receive a Medical Examiners’ Handbook, etc), go to www.Lni.wa.gov/IMES.

Laboratory

Please refer to the Pathology and Laboratory Services Chapter 22 of the Professional Services section of the Medical Aid Rules and Fee Schedules at www.Lni.wa.gov/FeeSchedules.
Naturopath

When billing for services, naturopathic physicians should use:

- The local codes listed in the Fee Schedule Chapter 18 Naturopathic Physicians for office visit services.
- CPT codes 99367 and 99441 – 99444 to bill case management services, and
- The appropriate HCPCS codes to bill for miscellaneous materials and supplies.

For details about payment criteria and documentation requirement for case management services, see the payment policies for “Case Management Services” in Chapter 10 Evaluation and Management.

The department will not pay naturopathic physicians for services that are not specifically allowed including consultations. Refer to WAC 296-23-205 and WAC 296-23-215 and the Naturopathic Physicians chapter of the Medical Aid Rules and Fee Schedules www.Lni.wa.gov/FeeSchedules.

Osteopathic Physician

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT code 97140 isn’t covered for osteopathic physicians.

OMT includes pre- and post-service work (for example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT only when all of the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient’s record supporting the level of E/M billing, and
- The E/M service is billed using the –25 modifier.

The insurer won’t pay for E/M codes billed on the same day as OMT without the –25 modifier.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

For more information, please refer to the Professional Services section in the Medical Aid Rules and Fee Schedules at www.Lni.wa.gov/FeeSchedules.
Outpatient Pain Management

Please refer to the Chronic Pain Management chapter 34 in the Facility Services section of the Medical Aid Rules and Fee Schedules www.Lni.wa.gov/FeeSchedules for additional information.

Pathologist

Please refer to the Pathology and Laboratory Services Chapter 22 of the Professional Services section in the Medical Aid Rules and Fee Schedules www.Lni.wa.gov/FeeSchedules.

Physical Therapist

Physical therapy services must be ordered by the worker’s:

- Attending doctor, or
- Nurse practitioner, or
- By the physician assistant for the attending doctor.

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant servicing under the supervision of a license physical therapist (see WAC 296-23-220).

For more information, please refer to the Physical Medicine Services chapter 24 of the Professional Services section of the Medical Aid Rules and Fee Schedule at www.Lni.wa.gov/FeeSchedules.

Physician and Physician Clinic

Please refer to the Professional Services section in the Medical Aid Rules and Fee Schedule at www.Lni.wa.gov/FeeSchedules.

Physician Assistant

Physician assistants (PAs) must be certified and have valid individual L&I provider account numbers to be paid for services. PAs should use billing modifiers outlined in the RBRVS Payment Policies sections of the Medical Aid Rules and Fee Schedules. For example, to bill for assistant at surgery, the PA would use the modifier –80; –81; or –82 as appropriate.

Physician assistants may sign any documentation required by the department. Consultations and impairment ratings services related to workers’ compensation benefits determinations are not payable to physician assistants as specified in RCW 51.28.100 and WAC 296-20-01501.

Physician assistant services are paid to the supervising physician at a maximum of 90% of the allowed fee. For more information about physician assistant services and payment, see WAC 296-20-12501 and WAC 296-20-01501.
Podiatric Physician

Please refer to the Professional Services section in the Medical Aid Rules and Fee Schedule at www.Lni.wa.gov/FeeSchedules.

Psychologist

Authorized psychiatric services must be performed by a psychiatrist (MD or DO), psychiatric Advance Registered Nurse Practitioner (ARNP), or a licensed clinical PhD or PsyD psychologist (see WAC 296-21-270).

Licensed clinical psychologists and psychiatrist are paid at the same rate when performing the same service. Psychiatric ARNPs are paid at 90% of the values listed in the fee schedule.

A psychiatric or psychiatric ARNP can only be a worker’s attending provider when the insurer has accepted a psychiatric condition and it is the only condition being treated. A psychiatrist or psychiatric ARNP may certify a worker’s time loss from work if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychiatric ARNP may not rate permanent partial disability.

Prior authorization is required for all psychiatric care referral (see WAC 296-21-270).

This requirement includes referrals for psychiatric consultation and evaluations. Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

Psychologists may not bill the E/M codes for office visits.

Psychiatrists and psychiatric ARNPs may only bill the E/M codes for office visits on the same day psychotherapy is provided if it’s medically necessary to provide E/M service for a condition other than that for which psychotherapy has been authorized. The provider must submit documentation of the event and request a review before payments can be made.

Please refer to WAC 296-21-270, WAC 296-21-280 and the Professional Services section of the Medical Aid Rules and Fee Schedules at www.Lni.wa.gov/FeeSchedules.
Radiologist

RT and LT Modifiers

HCPCS modifiers –RT (right side) and –LT (left side) don’t affect payment. They may be used with CPT radiologist codes 70010 – 79999 to identify duplicate procedures performed on opposite sides of the body.

Consultation Services

CPT code 76140 isn’t covered. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier –26. The insurer won’t pay separately for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the X-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed. Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the consultation is required.

Radiology Reporting Requirements

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier –26 or as part of the global service. Documentation refers to charting of justification, findings, diagnoses, and test result integration.

Any provider who produces and interprets his/her own imaging studies, and any radiologist who overreads imaging studies must produce a report of radiology findings to bill for the professional component.

Chart notes such as “X-rays are negative” or “X-rays are normal” don’t fulfill the reporting requirements outlined in the Radiology chapter of the Professional Services section of the Medical Aid Rules and Fee Schedules www.Lni.wa.gov/FeeSchedules, and the insurer will not pay for the professional component in these circumstances.

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes.

For more information, please refer to the Radiology section of WAC Chapter 296-23 and the Professional Services section of the Medical Aid Rules and Fee Schedule at www.Lni.wa.gov/FeeSchedules.
Completing the CMS 1500 Form

The CMS 1500 bill form (F245-127-000) is available on the L&I website www.Lni.wa.gov/FormPub/Detail.asp?DocId=1630.

Completed bill forms must be typed or printed and be clearly legible. All of the following boxes must be completed to ensure correct bill adjudication. Use the instructions below to complete the CMS 1500 Health Insurance Claim Form.

The CMS 1500 is a universal claim form used by many agencies nationwide; a number of fields on the form do not apply when billing for workers’ compensation services. Only the fields that pertain to billing Labor & Industries, self-insured employers and Crime Victims claims are addressed below.

Required fields are underlined. Complete the fields not underlined if the information is available or if they apply to the bill.

<table>
<thead>
<tr>
<th>Box 2</th>
<th>Worker’s Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Box 11</td>
<td>Claim Number</td>
</tr>
<tr>
<td>Box 24A</td>
<td>Date of Service</td>
</tr>
<tr>
<td>Box 24D</td>
<td>Procedure Code</td>
</tr>
<tr>
<td>Box 24F</td>
<td>Charge Amount</td>
</tr>
<tr>
<td>Box 24G</td>
<td>Unit</td>
</tr>
<tr>
<td>Box 24J</td>
<td>Rendering physician L&amp;I number (this is optional beginning May 23, 2008) Rendering physician NPI number (bottom portion of 24J)</td>
</tr>
<tr>
<td>Box 28</td>
<td>Total Charge</td>
</tr>
<tr>
<td>Box 33</td>
<td>Performing Provider Name</td>
</tr>
<tr>
<td>Box 33a</td>
<td>Group NPI Number – Refer to page 1 for Injured Worker</td>
</tr>
<tr>
<td>Box 1</td>
<td>Social Security Number or Claim Number can be accepted in this box</td>
</tr>
<tr>
<td>Box 21</td>
<td>Diagnosis or Description</td>
</tr>
<tr>
<td>Box 24E</td>
<td>Diagnosis Pointer</td>
</tr>
<tr>
<td>Box 23</td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td>Box 24D</td>
<td>Modifier Code</td>
</tr>
<tr>
<td>Box 25</td>
<td>Federal Tax ID Number</td>
</tr>
<tr>
<td>Box 26</td>
<td>Patient’s Account Number</td>
</tr>
<tr>
<td>Box 32A</td>
<td>Provider NPI Number (Service Facility Location)</td>
</tr>
<tr>
<td>Box 33b</td>
<td>Group L&amp;I Number</td>
</tr>
</tbody>
</table>
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

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

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by me 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 ensure 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 those Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

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


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

ROUTINE USES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their 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 PL. 100-503, the “Computer Matching and Privacy Protection Act of 1988”, permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)
I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human 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.