*Automated Medical Payments*

# Medicaid Bulletin

## Colorado Title XIX


**Fiscal Agent**

CONSULTEC

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**Suite 600 North**
**Denver, CO 80202**

**Medicaid Provider Services**
**303-534-0146**
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**Mailing Addresses**

**Claims & PARs**
**P.O. Box 30**
**Denver, CO 80201-0030**

**Correspondence, Inquiries & Adjustments**
**P.O Box 90**
**Denver, CO 80201-0090**

**Provider enrollment, Provider Information, Changes, Signature authorization, and Claim requisitions**
**P.O. Box 1100**
**Denver, CO 80201-1100**

**Medicaid Fiscal Agent Information on the Internet**
**WWW.CONSULTEC-GCRO.COM**


Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.


**Distribution: Nursing Facility Providers** **May 2000**

**Reference: B0000065**


**Urgent**
**Read Immediately**

**Contents**



| Replace: | With: |
|---|---|
| Pages 2, 3, 10, 11, 16, & 17, dated 11/99 | Pages 2, 3, 10, 11, 16, & 17, dated 05/00 |

## Provider-submitted Medicare crossover claim completion changes effective May 19, 2000

Medicaid Bulletin B0000064, dated May 2000, is enclosed with this bulletin and announces Medicaid's acceptance of a wider range of Type of Bill values for automatic Medicare crossover claims. Effective May 19, 2000 Medicaid is also revising claim completion requirements for provider-submitted crossover claims for Nursing Facilities. The new billing instructions will help to assure that claims are correctly paid.

**Revenue code 169 (Medicare B, Ancillary service) no longer used for crossover identification.** The most notable billing change is discontinuation of revenue code 169 used in the past to identify ancillary and medical supply crossover services. Effective 5/19/00, providers will use the same revenue codes used to bill Medicare on the Medicaid crossover claim.

- Part A accommodation crossovers will be identified on the claim with accommodation revenue codes, 119 or 129.
- Ancillary charges (Part B of A therapies) will be submitted with the same revenue codes used to bill Medicare.
- Part B supply crossovers will be submitted on the UB-92 claim format using appropriate revenue codes to identify supplies. (Revenue codes are listed in Appendix N of the UB-92 provider manual.)

**To assure proper crossover processing, providers must change billing procedures as soon as possible. Changes must be made no later than July 1, 2000.**

Effective with claims received on or after 7/1/00, claims submitted with revenue code 169 to describe crossover services will be denied. Denied claims must be corrected and resubmitted.

**Claim preparation reference materials.** A summary of the claim preparation changes for provider submitted Medicare crossover claims follows. A Quick Reference for nursing facilities is also included with this bulletin. The quick reference guide may be posted in the provider's office and referred to when completing claim information.

# Guide for completing Non-Automatic* Nursing Facility Medicare Crossover Claims Effective May 19, 2000

*Electronic or Paper

| | Part A Accommodations | B of A ancillaries/therapies | Part B - medical supplies |
|---|---|---|---|
| **Type of Bill** | 21X, 22X, 23X, 24X, 28X, 51X, 52X, or 62X | 21X, 22X, 23X, 24X, 28X, 51X, 52X, or 62X | 21X, 22X, 23X, 24X, 28X, 51X, 52X, or 62X |
| **Revenue Codes** | 119 Private<br>129 Semi-Private | As billed to Medicare<br>**Do not use revenue code 169** | Corresponding to the HCPCS billed to Medicare<br>**Do not use revenue code 169** |
| **Medicare Payment Date** | Occurrence code 50 + date<br>Form Locator 32, 33, 34 or 35 | Occurrence code 50 + date<br>Form Locator 32, 33, 34 or 35 | Occurrence code 50 + date<br>Form Locator 32, 33, 34 or 35 |
| **Medicare Payment** | Prior Payments<br>Form Locator 54, Line A | Prior Payments<br>Form Locator 54, Line A | Prior Payments<br>Form Locator 54, Line A |
| **Payer Identification (Payer source Code)** | C-Medicare<br>Form Locator 50, Line A<br>D-Medicaid<br>Form Locator 50, Line B | C-Medicare<br>Form Locator 50, Line A<br>D-Medicaid<br>Form Locator 50, Line B | C-Medicare<br>Form Locator 50, Line A<br>D-Medicaid<br>Form Locator 50, Line B |
| **Medicare Coinsurance or Copayment** | Value code A2<br>Form Locator 39, 40 or 41 | Value Code A2<br>Form Locator 39, 40 or 41 | Value Code A2<br>Form Locator 39, 40 or 41 |
| **Medicare Deductible** | Not applicable | Value Code A1<br>Form Locator 39, 40 or 41 | Value Code A1<br>Form Locator 39, 40 or 41 |
| **Condition Code** | Not required. | Not required. | Not required. |
| **Automatic crossover** | Yes.<br>If automatic crossover does not occur within 30 days of notification by Medicare that the claim has been forwarded to Medicaid, the provider is responsible for submitting the crossover claim. | Yes.<br>If automatic crossover does not occur within 30 days of notification by Medicare that the claim has been forwarded to Medicaid, the provider is responsible for submitting the crossover claim. | No.<br>All automatic crossover claims for supplies and equipment are denied. Claims must be submitted by the provider. Submit crossovers electronically or on paper. Timely filing for crossover claims is 120 days from the date of Medicare processing as shown on the Medicare payment voucher. |

Please direct questions about Medicaid billing or the information in this bulletin to:

Medicaid Provider Services
303-534-0146 or 1-800-237-0757 (toll-free Colorado)

# Quick Reference to Completing Medicare Crossover claims for Nursing Facilities

Type of Bill - 21X, 22X, 23X, 24X, 28X, 51X, 52X, or 62X

Occurrence Code 50 + Medicare Paid Date

Value Codes
A2-Medicare Copayment
B3-Medicaid Estimated Responsibility

Revenue Code - Accommodations -119 or 129
The presence of an accommodation code identifies the claim as a Part A crossover

**Part A Accommodations Days 22-100**

*Medicaid pays Medicaid allowable charges minus Medicare payment or Medicare copayment - whichever is less (Lower-of Payment logic)*

Payer Identification
Line A: C-Medicare
Line B: D-Medicaid

Prior Pavments Medicare Pavment

Insured's Information
Line A: Medicare information
Line B: Medicaid information

Nursing Care Facility
100 Park Avenue
Anytown, CO 80202

623

Smith, Joseph A
128 8th Street, Anytown, CO 80461

3/25/23 M MM/02/YY 05 30

50 MM/15/YY

A2 2619 50 B3 2619 50

| | | | | | |
|---|---|---|---|---|---|
| 129 | Semi-private | 71.87 | | 30 | 2156 10 |
| 001 | Grand Total | | | | 2156 10 |

C-Medicare 7207 50
D-Medicaid 05045004

DUE FROM PATIENT

Smith, Joseph A 521112233A
A123456

358

12345678

Authorized Signature MM/DD/YY

OCR/ORIGINAL

## Completing Medicare Information on the Crossover Claim

| | |
|---|---|
| Medicare Payer identification | FL 50 Payer - Line A |
| Medicare Patient information | FL 58 Insured - Line A |
| Medicare Payment amount - | FL 54 Prior Payments - Line A |
| Medicare Coinsurance amount | FL 39-41 Value Code A2 + Amount |
| Medicare Deductible amount | FL 39-41 Value Code A2 + Amount (Part B Claims) |
| Medicare Payment Date | FL 32 Occurrence Code 50 + Date |

Type of Bill - 21X, 22X, 23X, 24X, 28X, 51X, 52X, or 62X

Occurrence Code 50 + Medicare Paid Date

Value Codes
A1-Medicare Deductible
A2-Medicare Copayment
B3-Medicaid Estimated Responsibility

Revenue Code - Any other than accommodations

**Part B Ancillary Services & Part B Supplies**

*Medicaid pays Medicare Coinsurance & Deductible*

Payer Information
Line A: C-Medicare
Line B: D-Medicaid

Prior Pavments Medicare Pavment

Insured's Information
Line A: Medicare information
Line B: Medicaid information

Nursing Care Facility
100 Park Avenue
Anytown, CO 80202

223

Smith, Joseph A
128 8th Street, Anytown, CO 80461

3/25/98 M MM/DD/YY 05 01

50 MM/DD/YY

A1 80 00 A2 84 00 B3 336 00

| | | | | | |
|---|---|---|---|---|---|
| 420 | Physical therapy | | MM/01/YY | 2 | 100 00 |
| 420 | Physical therapy | | MM/07/YY | 2 | 100 00 |
| 420 | Physical therapy | | MM/13/YY | 2 | 100 00 |
| 420 | Physical therapy | | MM/19/YY | 2 | 100 00 |
| 420 | Physical therapy | | MM/25/YY | 2 | 100 00 |
| 001 | Grand Total | | | | 500 00 |

C-Medicare 336 00
D-Medicaid 05045004

DUE FROM PATIENT

Smith, Joseph A 521113344A
A123456

2900

12345678

Authorized Signature MM/DD/YY

OCR/ORIGINAL

Billing Tip: Always maintain consistent line identification & relationships for *Payer Information, Insured's Information & Value Codes*. Example: Use Line A & Value Codes A1 (Medicare Deductible) & A2 (Medicare Coinsurance) for Medicare information. Use Line B and Value Code B3 (Estimated Responsibility) for Medicaid information.

# General prior authorization requirements

The client's physician completes the physician information on the **U**niform **L**ong **T**erm **C**are (ULTC) 100 form. The physician must sign the ULTC 100. Forms can be obtained from the **C**olorado **F**oundation for **M**edical **C**are (CFMC) and must be completed and submitted to the **P**eer **R**eview **O**rganization (PRO) for approval. When the PRO has approved the care, a confirmation number is assigned, and the approval is electronically submitted to the fiscal agent. The facility will receive a ULTC 100 PAR letter. Submitted claim data is checked against the dates in the MMIS. **Do not** submit a copy of the ULTC 100 form with the claim. The fiscal agent identifies the appropriate ULTC 100 data using patient identification information on the claim.

When the ULTC 100 is approved, submit the nursing facility claim. Nursing facility claims submitted without an approved ULTC 100 in the system will be denied.

Approval of a ULTC 100 does not guarantee Medicaid payment and does not serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a benefit of the Medicaid program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements before payment can be made (e.g., timely filing, Primary Care Physician information completed appropriately, third party resources payments pursued, required attachments included, etc.).

# Special benefits/limitations/exclusions

Nursing facility care is a Medicaid program benefit only after review and certification by the PRO.

## Medicare crossover claims

When the client is dually eligible (Medicare/Medicaid), most claims for nursing facility services are electronically transferred from Medicare to Medicaid. If the claim does not automatically crossover from Medicare to Medicaid, providers are responsible for billing the crossover claim. Nursing facility services are a Medicare Part A benefit if the client is discharged after a hospital stay of at least three days and qualifies for skilled nursing care as defined by Medicare. Some services for nursing facility residents may qualify for Medicare Part B coverage.

### Medicare Part A crossover claims

Medicare Part A reimburses the 1st through the 20th day of the Nursing Facility stay at 100% of the Medicare allowed rate. The 21st through the 100th day are subject to a coinsurance amount per day. Medicaid uses the "lower of" pricing formula to process the coinsurance amount.

Please note the following fields when completing a Medicare Part A crossover claim:

32 – 35 Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.

39 - 41 Value Codes - Enter the appropriate value code and related dollar amount that identifies Medicare Coinsurance and Medicare payment amount.

44 Rates - Enter Nursing Facility's Medicaid rate.

50 Payer - Enter Medicaid on the appropriate payer line.

51 Provider Number - Enter the Nursing Facility's eight digit Medicaid provider number on the line selected for Medicaid.

60 Cert. SSN. HIC Number - Enter the client's Medicaid State ID number on the line selected for Medicaid.

### Medicare Part B crossover claims

Some dually eligible clients do not qualify for comprehensive skilled nursing care as defined by Medicare, but they do qualify for certain Nursing Facility ancillary services (e.g., physical therapy). Medicare part B processes benefit ancillary services. Part B services are subject to the Medicare annual deductible and reimbursed at 80%.

Please note the following fields when completing a part B crossover claim:

32 - 35 Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.

39 - 41 Value Codes - Enter the appropriate value code and related dollar amount that identifies Medicare Deductible, Medicare Coinsurance, and Medicare payment amount.

42 Revenue Code - Enter revenue code billed to Medicare

50 Payer - Enter Medicaid on the appropriate payer line.

51 Provider Number - Enter the Nursing Facility's eight-digit Medicaid provider number on the line selected for Medicaid.

60 Cert. SSN. HIC Number - Enter the client's Medicaid State ID number on the line selected for Medicaid.

## Medical leave days

Medical leave days are days that the client is absent from the nursing facility due to an inpatient hospital stay or admittance to another institution (e.g., skilled bed) payable by Medicare. Medical leave days must be ordered by a physician. Nursing facility medical leave days are not a Medicaid benefit.

## Non-medical leave days

Non-medical leave days are leave days from the nursing facility for non-medical reasons (e.g., visits to the homes of family or friends). The attending physician must approve the leave and certify that the leave is not contrary to the patient's plan of care.

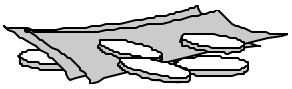
## Programmatic leave days

Programmatic leave days are leave days from the nursing facility prescribed by the physician for therapeutic and/or rehabilitative reasons (e.g., participation in summer camps, or special therapeutic or rehabilitative programs). Programmatic leave days from a facility represent an absence prescribed by a physician.

## Excessive non-medical and programmatic leave days

Medicaid pays for a combined total of 42 non-medical and programmatic leave days per calendar year. With physician approval, clients may pay for room reservations in excess of the combined total 42 non-medical and programmatic leave days per calendar year.

## Patient payment



Patient payment is payment made by the client for nursing facility care after the personal needs allowance is deducted. The personal needs allowance is determined by County Income Maintenance Technicians. This income must be applied to the patient's care.

When reporting patient payment for the entire month, regardless of the number of days in that month, apply the total patient obligation.

When reporting patient payment amounts for less than one full month of care, use the per diem calculation to calculate the correct amount. The per diem calculation is the number of days in the facility times the facility's per diem rate.

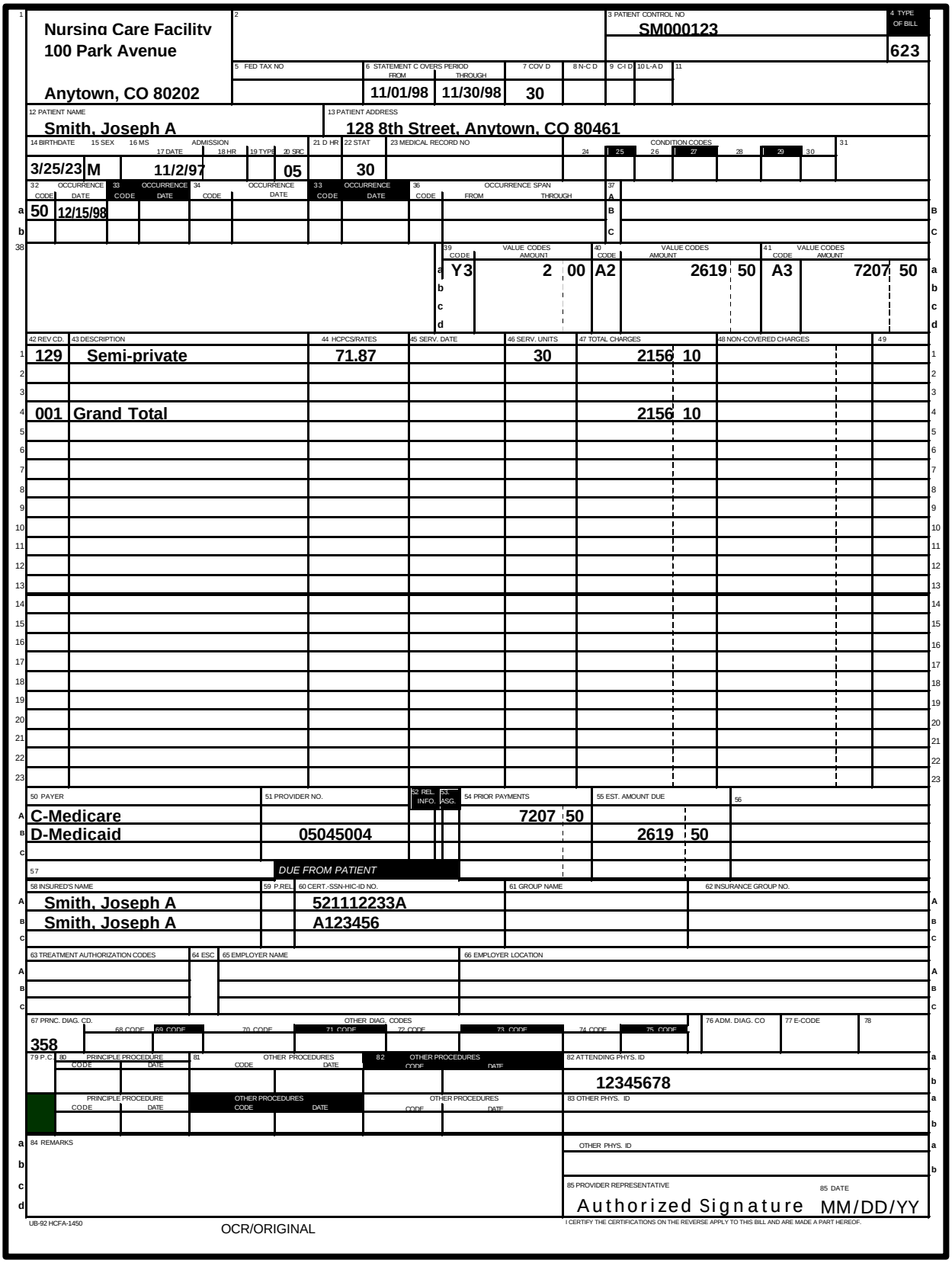
**To calculate patient payment:**

1. Determine the amount of available resident income for the month.
2. Subtract the cost of care provided to the resident during the month.
3. If the cost of care is more than the available resident income, Medicaid will pay the difference. If the cost of care is less than the available resident income, the excess income belongs to the resident.

| FIELD LABEL | Special Instructions |
|---|---|
| **20. SRC** | Required<br>Complete if the client has been admitted or readmitted during the billing period.<br>Use one of the following codes:<br>1 - Physician referral<br>2 - Clinic referral<br>3 - Referred from HMO<br>4* -Transfer from a hospital<br>5**-Transfer from a skilled Nursing Facility<br>6 - Transfer from another health care facility<br>7 - Emergency Room<br>8 - Court/Law Enforcement<br>9 - Information Not Available<br>* Use code 4 when a PPS hospital receives a transfer patient from another PPS hospital.<br>Use a valid code other than 4 for a PPS hospital receiving a patient from either an exempt hospital or rehabilitation distinct part unit. Code 1, Physician Referral, is the most appropriate code. Use any appropriate code as above when completing this field for exempt hospitals and rehabilitation distinct part units.<br>** Use code 5 if the client is a nursing facility resident transfer or is changing from private pay to Medicaid. |
| **22. STAT (PATIENT STATUS)** | Required<br>Enter the appropriate patient status code as of discharge date or the "THROUGH" date in the "STATEMENT COVERS PERIOD."<br>Use one of the following codes:<br>01 - Discharged to Home<br>03 - Discharged/Transferred to SNF<br>04 - Discharged/Transferred to ICF<br>05 - Discharged/Transferred to Another Type of Institution<br>06 - Discharged/Transferred to organized Home Health Care Program (HCBS)<br>07 - Left Against Medical Advice<br>08 - Discharged/Transferred to Home Under Care of Home Health Provider<br>20 - Deceased<br>30 - Still a Patient |
| **24.- CONDITION CODES 30.** | Conditional<br>If the client has other reimbursement resources, complete with the code that corresponds to the client's other resources.<br>Use one of the following codes:<br>01 - Military Service Related<br>02 - Employment Related<br>04 - HMO Medicare Enrollee<br>05 - Lien Has Been Filed<br>06 - ESRD Patient - First Year Entitlement |

| FIELD LABEL | Special Instructions |
|---|---|
| **32.- OCCURRENCE CODE AND DATE 35.** | Conditional<br>Complete both the code and date of occurrence when applicable.<br>Use one of the following for Medicare crossover claims:<br>50 - Medicare Pay Date<br>51 - Medicare Denial Date<br>53 - Late Bill Override Date<br>See the main UB-92 provider manual for additional codes that may apply. |
| **36. OCCURRENCE SPAN CODE/ FROM AND THROUGH DATES** | Conditional<br>Complete if nursing facility bills PETI revenue code(s) on the claim.<br>Enter occurrence span code 80 for PETI services.<br>Enter the "FROM and THROUGH" dates for the PETI services in MM/DD/YY format. The occurrence span must encompass the dates for all PETI services submitted on this claim. Use the *earliest* "FROM" date and the *latest* "THROUGH" date approved on the PETI PAR(s). |
| **39.- VALUE CODES AND AMOUNT 41.** | Conditional<br>Complete when there is an applicable value code. If a value code is entered, a dollar amount or related numeric value must be entered.<br><u>Days</u><br>Y1 - Medical Leave Days - See explanation in the Special benefits/limitations/exclusions section.<br>Y2 - Non-Medical Leave Days - See explanation in the Special benefits/limitations/exclusions section.<br>Y3 - Programmatic Leave Days - See explanation in the Special benefits/limitations/exclusions section.<br><u>TPL</u><br>A1 - Deductible Payer A \<br>B1 - Deductible Payer B } The amount applied to the patient's<br>C1 - Deductible Payer C / deductible for the indicated payer<br>A2 - Co-Insurance Payer A \<br>B2 - Co-Insurance Payer B } The amount applied to the patient's<br>C2 - Co-Insurance Payer C / coinsurance for the indicated payer<br>A3 - Estimated Responsibility Payer A \<br>B3 - Estimated Responsibility Payer B } The amount paid by<br>C3 - Estimated Responsibility Payer C / the indicated payer |
| **42. REV CD (REVENUE CODE)** | Required<br>Use only the revenue codes listed in this supplement for nursing facility claims.<br>For Medicare part A crossover claims use:<br>119 - Private<br>129 – Semi-private<br>For Medicare part B crossover claims use:<br>Revenue code billed to Medicare |

# Nursing Facility claim - Medicare part A crossover



1 Nursing Care Facility
100 Park Avenue
Anytown, CO 80202

2

3 PATIENT CONTROL NO: SM000123

4 TYPE OF BILL: 623

5 FED TAX NO

6 STATEMENT COVERS PERIOD: FROM 11/01/98 THROUGH 11/30/98

7 COV D: 30

8 N-C D

9 C-I D

10 L-A D

11

12 PATIENT NAME: Smith, Joseph A

13 PATIENT ADDRESS: 128 8th Street, Anytown, CO 80461

| 14 BIRTHDATE | 15 SEX | 16 MS | 17 ADMISSION DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3/25/23 | M | | 11/2/97 | | | 05 | | 30 | | | | | | | | | |

| | 32 OCCURRENCE CODE | 32 OCCURRENCE DATE | 33 OCCURRENCE CODE | 33 OCCURRENCE DATE | 34 OCCURRENCE CODE | 34 OCCURRENCE DATE | 35 OCCURRENCE CODE | 35 OCCURRENCE DATE | 36 OCCURRENCE SPAN CODE | FROM | THROUGH | 37 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | 50 | 12/15/98 | | | | | | | | | | A |
| b | | | | | | | | | | | | B |
| | | | | | | | | | | | | C |

38

| | 39 VALUE CODES CODE | 39 VALUE CODES AMOUNT | 40 VALUE CODES CODE | 40 VALUE CODES AMOUNT | 41 VALUE CODES CODE | 41 VALUE CODES AMOUNT |
|---|---|---|---|---|---|---|
| a | Y3 | 2 00 | A2 | 2619 50 | A3 | 7207 50 |
| b | | | | | | |
| c | | | | | | |
| d | | | | | | |

| | 42 REV CD. | 43 DESCRIPTION | 44 HCPCS/RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|---|
| 1 | 129 | Semi-private | 71.87 | | 30 | 2156 10 | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | 001 | Grand Total | | | | 2156 10 | | |
| 5 | | | | | | | | |
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| 23 | | | | | | | | |

| | 50 PAYER | 51 PROVIDER NO. | 52 REL. INFO. | 53 ASG. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 |
|---|---|---|---|---|---|---|---|
| A | C-Medicare | | | | 7207 50 | | |
| B | D-Medicaid | 05045004 | | | | 2619 50 | |
| c | | | | | | | |

57 DUE FROM PATIENT

| | 58 INSURED'S NAME | 59 P.REL | 60 CERT.-SSN-HIC-ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|---|
| A | Smith, Joseph A | | 521112233A | | |
| B | Smith, Joseph A | | A123456 | | |
| c | | | | | |

| | 63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION |
|---|---|---|---|---|
| A | | | | |
| B | | | | |
| c | | | | |

67 PRNC. DIAG. CD.: 358

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

76 ADM. DIAG. CO | 77 E-CODE | 78

| | 79 P.C | 80 PRINCIPLE PROCEDURE CODE | 80 PRINCIPLE PROCEDURE DATE | 81 OTHER PROCEDURES CODE | 81 OTHER PROCEDURES DATE | 82 OTHER PROCEDURES CODE | 82 OTHER PROCEDURES DATE | 82 ATTENDING PHYS. ID |
|---|---|---|---|---|---|---|---|---|
| a | | | | | | | | |
| b | | | | | | | | 12345678 |

| | PRINCIPLE PROCEDURE CODE | PRINCIPLE PROCEDURE DATE | OTHER PROCEDURES CODE | OTHER PROCEDURES DATE | OTHER PROCEDURES CODE | OTHER PROCEDURES DATE | 83 OTHER PHYS. ID |
|---|---|---|---|---|---|---|---|
| a | | | | | | | |
| b | | | | | | | |

| | 84 REMARKS | OTHER PHYS. ID |
|---|---|---|
| a | | |
| b | | |
| c | | 85 PROVIDER REPRESENTATIVE: Authorized Signature — 85 DATE: MM/DD/YY |
| d | | |

UB-92 HCFA-1450 OCR/ORIGINAL

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

# Nursing Facility claim - Medicare part B crossover

1 Nursing Care Facility
100 Park Avenue
Anytown, CO 80202

2

3 PATIENT CONTROL NO: SM000123

4 TYPE OF BILL: 223

5 FED TAX NO

6 STATEMENT COVERS PERIOD: FROM MM/01/YY THROUGH MM/30/YY

7 COV D | 8 N-C D | 9 C-I D | 10 L-A C | 11

12 PATIENT NAME: Smith, Joseph A

13 PATIENT ADDRESS: 128 8th Street, Anytown, CO 80461

| 14 BIRTHDATE | 15 SEX | 16 MS | 17 ADMISSION DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO | 24 | CONDITION CODES 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3/25/98 | M | | MM/DD/YY | | | 05 | | 01 | | | | | | | | | |

| 32 OCCURRENCE CODE | DATE | 33 OCCURRENCE CODE | DATE | 34 OCCURRENCE CODE | DATE | 35 OCCURRENCE CODE | DATE | 36 OCCURRENCE SPAN CODE | FROM | THROUGH | 37 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a 50 | MM/DD/YY | | | | | | | | | | A |
| b | | | | | | | | | | | B |
| | | | | | | | | | | | C |

38

| 39 VALUE CODES CODE | AMOUNT | 40 VALUE CODES CODE | AMOUNT | 41 VALUE CODES CODE | AMOUNT |
|---|---|---|---|---|---|
| a A1 | 80 00 | A2 | 84 00 | B3 | 336 00 |
| b | | | | | |
| c | | | | | |
| d | | | | | |

| | 42 REV CD. | 43 DESCRIPTION | 44 HCPCS/RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|---|
| 1 | 420 | Physical therapy | | MM/01/YY | 2 | 100 00 | | |
| 2 | 420 | Physical therapy | | MM/07/YY | 2 | 100 00 | | |
| 3 | 420 | Physical therapy | | MM/13/YY | 2 | 100 00 | | |
| 4 | 420 | Physical therapy | | MM/19/YY | 2 | 100 00 | | |
| 5 | 420 | Physical therapy | | MM/25/YY | 2 | 100 00 | | |
| 6 | | | | | | | | |
| 7 | 001 | Grand Total | | | | 500 00 | | |
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| | 50 PAYER | 51 PROVIDER NO. | 52 REL. INFO. | 53 ASG. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 |
|---|---|---|---|---|---|---|---|
| A | C-Medicare | | | | 336 00 | | |
| B | D-Medicaid | 05045004 | | | | 164 00 | |
| C | | | | | | | |
| 57 | | DUE FROM PATIENT | | | | | |

| | 58 INSURED'S NAME | 59 P.REL | 60 CERT.-SSN-HIC-ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|---|
| A | Smith, Joseph A | | 521113344A | | |
| B | Smith, Joseph A | | A123456 | | |
| C | | | | | |

| | 63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION |
|---|---|---|---|---|
| A | | | | |
| B | | | | |
| C | | | | |

67 PRNC. DIAG. CD. 2900

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

76 ADM. DIAG. CO | 77 E-CODE | 78

| 79 P.C. | PRINCIPLE PROCEDURE CODE | DATE | 81 OTHER PROCEDURES CODE | DATE | 82 OTHER PROCEDURES CODE | DATE | 82 ATTENDING PHYS. ID |
|---|---|---|---|---|---|---|---|
| | | | | | | | 12345678 |
| | PRINCIPLE PROCEDURE CODE | DATE | OTHER PROCEDURES CODE | DATE | OTHER PROCEDURES CODE | DATE | 83 OTHER PHYS. ID |

| | 84 REMARKS | OTHER PHYS. ID |
|---|---|---|
| a | | |
| b | | |
| c | | 85 PROVIDER REPRESENTATIVE: Authorized Signature — 85 DATE: MM/DD/YY |
| d | | |

UB-92 HCFA-1450 OCR/ORIGINAL

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