



Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

*Medicaid and Other Medical
Assistance Programs*



September 2007

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My Medicaid Provider ID Number:

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions or issues:

(406) 444-4068 Phone Program Officer
(406) 444-5296 Phone Claim Specialist
(406) 444-1861 Fax

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)

For coding advice and other SADMERC information:

(877) 735-1326

Mon-Fri 9:00 a.m.- 4:00 p.m. Eastern Time

SADMERC
P.O. Box 100143
Columbia, SC 29202-3143

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone

(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

Mountain Pacific Quality Health Foundation

For prior authorization for certain services (see the *Prior Authorization and PASSPORT* chapter in this manual) contact:

Phone:

(406) 457-5887 Local

(877) 443-4021, ext 5887 Long-distance

Fax:

(877) 443-2580 Toll-free local and long-distance

Send written inquiries to:

Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

(800) 201-6308 Client Eligibility Fraud

(800) 362-8312 Medicaid Help Line

(please call this number to report suspected client abuse of Medicaid)

(800) 376-1115 Provider Fraud

Key Websites	
Web Address	Information Available
Provider Information Website www.mtmedicaid.org or http://medicaidprovider.hhs.mt.gov/	<ul style="list-style-type: none"> • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml	<ul style="list-style-type: none"> • Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) http://www.palmettogba.com/index.html	SADMERC information is available under <i>Other Partners</i> . This website assists manufacturers and suppliers with DMEPOS billing and coding information.
Noridian Administrative Services https://www.noridianmedicare.com/	Equipment Regional Carriers (DMERCs) website. DMERC processes Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for Medicare.
ARM Rules http://www.dphhs.mt.gov/legal_section/administrative_rules_montana/arm_title_37/arm_title_37.htm	Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Key Websites (continued)

Web Address	Information Available
<p>CHIP Website www.chip.mt.gov</p>	<ul style="list-style-type: none"> • Information on the Children’s Health Insurance Plan (CHIP)

Office of Management and Budget (OMB), and required by the Centers for Medicare & Medicaid Services (CMS). These forms are available in *Appendix A: Forms*, on the Provider Information website (see *Key Contacts*) and on the following websites:

<http://www.cms.hhs.gov/providers/mr/cmn.asp>

<https://www.noridianmedicare.com/>

The following is a list of items that require a CMN and the corresponding form. This reference list will be updated as changes are made. If any discrepancies exist between these referenced forms and what is published by CMS and Cigna Medicare, then the CMS and Cigna Medicare policy shall take precedence.

CMN Forms		
Item	Form	Date
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	09/05
Osteogenesis Stimulators	CMS-847	09/05
Oxygen	CMS-484	09/05
Seat Lift Mechanisms	CMS-849	09/05
Section C Continuation Form	CMS-854	09/05
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	09/05

DME Information Forms		
Item	Form	Date
External Infusion Pumps	CMS-10125	09/05
Enteral and Parental Nutrition	CMS-10126	09/05

Rental/purchase (ARM 37.86.1801 - 1806)

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 12 months of rental reimbursement. After 12 months of continuous rental, the item is considered owned by the client and the provider must transfer ownership to the client. Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental are limited to 120% of the purchase price for that item. If purchasing the rental item is cost effective, the Department may cover the purchase of the item.

A statement of medical necessity for rental of DME equipment must indicate the length of time the equipment is needed, and all prescriptions must be signed and dated.

Servicing. During the 12-month rental period, Medicaid rental payment includes all supplies, maintenance, repair, components, adjustments and services related to the item during the rental month. Separately billable supply items identified and allowed by Medicare are also separately billable to Medicaid under the same limitations. No additional amounts related to the item may be billed or reimbursed for the item during the 12-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 12-month rental period when ownership of the item is transferred to the client, the provider may bill Medicaid for the supplies, maintenance, repair components, adjustment and services related to the items. Medicaid does not cover repair charges during the manufacturer's warranty period.

Items classified by Medicare as needing frequent and substantial servicing are covered on a monthly rental basis only. The 12-month rental limit does not apply and rental payment may continue as long as the item is medically necessary.

Interruptions in rental period. Interruptions in the rental period of less than 60 days will not result in the start of a new 12-month period or new 120% of purchase price limit. Periods in which service is interrupted do not count toward the 12-month rental limit.

Change in supplier. A change in supplier during the 12-month rental period will not result in the start of a new 12-month period or new 120% of purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the client; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written client statement that another supplier has not been providing the item, unless the provider has knowledge of other facts or information indicating that another supplier

has been providing the item. The supplier providing the item in the twelfth month of the rental period is responsible for transferring ownership to the client.

Change in equipment. If rental equipment is changed to different but similar equipment, the change will result in the start of a new 12-month period or new 120% of purchase price limit only when all of the following are met:

- The change in equipment is medically necessary as a result of a substantial change in the client's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

Non-covered services (ARM 37.86.1802)

The following are items and/or categories of items that are not covered through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by the U.S. Department of Health and Human Services, including the Medicare Program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items
- Items/services provided to a client in a nursing facility setting (see the *Nursing Facility Services* manual for details)
- Furniture associated with the use of a seat lift mechanism.
- Scales (covered if monitoring weight is part of any congestive heart failure (CHF) treatment regimen.
- Backup equipment
- Items included in the nursing home per diem



Use the current fee schedule for your provider type to verify coverage for specific services.

Verifying coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are specific criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Apnea Monitors

The rental of an apnea monitor will be covered initially for a six-month period from the date of the physician's order. Apnea monitors are covered under at least one of the following conditions:

- A sibling has died from SIDS
- Infant has symptomatic apnea
- Observation of apparent life-threatening events (ALTE)
- Infant is on oxygen
- Symptomatic apnea due to neurological impairment

For coverage after the initial six-month period, additional months coverage must be prior authorized by the Department and the following conditions must exist and be documented by the physician:

- Infant continues to have significant alarms (log must be kept on file)
- Unresolved symptomatic apnea

Diapers, under pads, liners/shields

Diapers, under pads, liners and shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for clients under three years of age or clients in long term care (nursing facility) settings.

Disposable diapers are limited to 180 diapers per month. Disposable under pads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year.

No more than one month's medical supplies may be provided to a client at one time.



Electric breast pump

The use of an electric breast pump is considered medically appropriate if at least one of the following criteria is met:

- Client has a pre-term infant of 37 weeks or less gestation
- Client's infant has feeding difficulties due to neurological or physical conditions which impairs adequate suckling
- Illness of mother and/or infant that results in their separation
- Mother is on medication that compromises milk supply

Electric breast pump rental is limited for two months unless additional months are prior authorized by the Department. Medicaid covers all supplies, maintenance, repair, components, adjustments and services related to the pump. Payment may not be provided through the infant's eligibility for Medicaid.

Gait trainers

A gait trainer is a device used to support a patient during ambulation. Criteria for coverage of a gait trainer include:

- The client is unable to ambulate independently with a standard front or reverse walker because of the need for postural support, due to a chronic neurological condition including abnormal movement patterns, poor balance, poor endurance, or other clearly documented reasons.
- The anticipated functional benefits of walking are not attainable with the use of a walker.
- Must demonstrate tolerance for standing and weight bearing through the lower extremities.
- Potential benefits to the individual of assisted walking must be clearly documented as follows:
 - The client must be involved in a therapy program established by a physical therapist. The program must include measurable documented objectives and functional goals related to the client and equipment that includes a written carry over plan to be utilized by the client and/or caregiver. The equipment must match the user's needs and ability level.
 - The client has had a trial of the requested gait trainer (GT) and the client shows compliance, willingness, and ability to use the GT in the home.
 - Video of client using the requested GT home demonstrating ability to use GT by showing potential for progress to meet goals and objectives.

Group 2 support surfaces

Rentals will be reviewed on a monthly basis for clients.

In the event that Prior Authorization staff receives additional medical information directly from the care provider, that information will be included in the cover letter to the DME vendor along with a copy of the authorization.

The criteria for “reasonable and necessary” for group 2 support surfaces are defined by the following indications and limitations of coverage and/or medical necessity.

A group 2 support surface is covered if the patient meets:

- Criterion 1 and 2 and 3, or
 - Criterion 4, or
 - Criterion 5 and 6.
1. Multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 - 707.05).
 2. Patient has been on a comprehensive pressure ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.
 3. The pressure ulcers have worsened or remained the same over the past month.
 4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05).
 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 - 707.05).
 6. The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive pressure ulcer treatment described in #2 above should generally include:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
- Appropriate turning and positioning.
- Appropriate wound care (for a stage II, III, or IV ulcer).
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not “bottom out.”

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, ***an authorization will not be issued*** unless there is clear documentation which justifies the medical necessity for the item in the individual case.

Continued use of a group 2 support surface ***is determined on a case by case basis***. It is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management.

A group 2 support surface will be considered for purchase if the following criteria are met:

- Has met the above Indications and Limitations of Coverage and/or Medical Necessity for rental and is necessary for wound management for more than 6 months or
- Has met the above indications of Coverage and/or Medical Necessity for rental and the ulcer (s) have healed. However, the client has a history of previous decubitus ulcers and is at significant risk for recurrent breakdown if the surface is removed.

The purchase of a group 2 support surface will be reviewed on a case by case basis.

It must be determined that:

- The client is compliant with the use of the surface and
- Other factors have been addressed that are/may be contributing to the recurrent breakdown such as infection, nutrition, incontinence management, repositioning etc.

Oral nutrition

Medicaid may cover oral nutritional products for clients under the age of 21 who have had an EPSDT screen resulting in a diagnosed medical condition that impairs absorption of a specific nutrient(s). The client must also have a measurable nutrition plan developed by a nutritionist and the client's primary care provider (PCP).

Phototherapy (bilirubin) light with photometer

The E0202 RR will be reimbursed at 75% of billed charges for infants ages 0-1. One unit of service is to be billed for each day. The capped rental period will be two months. In order to assure correct coding, providers are encouraged to refer to the current HCPCS coding manual. DMEPOS suppliers must

obtain a written prescription in accordance with Administrative Rule of Montana (ARM) 37.86.1802. Suppliers should also maintain supporting documentation showing the client meets the Medicaid coverage criteria.

Services for children and adults over the age of 1 will be reviewed for medical necessity by the DME Program Officer at Health Resources Division.

Pulse oximetry meter

A pulse oximetry meter measures oxygen saturation levels using a noninvasive probe. Pulse oximetry meters provide an estimate of arterial oxyhemoglobin saturation (SaO₂), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO₂).

A pulse oximetry meter is covered for ventilator dependent patients. Continuous read oximetry meters and any meter used for diagnostic purposes are not covered.

A pulse oximetry meter is covered for adult patients when all of the following criteria are met:

- The client has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- A medical need exists in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not immediately treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

A pulse oximetry meter is covered for pediatric patients when all of the following criteria are met:

- The client has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- Oxygen need varies from day to day or per activity (e.g., feeding, sleeping, movement), and a medical need exists to maintain oxygen saturation within a very narrow range in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

Standing frame

A standing frame is used to develop weight bearing through the legs for those who cannot stand independently. Standers may be fixed or adjustable in their design. Accessories must contribute significantly to the therapeutic function of

the device. Designs and accessories primarily for a caregiver's convenience are not considered medically necessary. For the coverage of a standing frame, the following conditions must be met:

- Client can demonstrate tolerance for standing and partial weight bearing
- Client and/or caregivers demonstrate the capability and motivation to be compliant in the use of the standing frame
- Client is unable to stand without the aid of adaptive equipment
- Clients must be involved in a therapy program established by a physical or occupational therapist. The program must include measurable documented objectives related to the client and equipment that includes a written carry over plan to be utilized by the client and/or caregiver. The equipment must match the user's needs and ability level.

Wheelchair seating in the nursing home

Indications and limitations for a wheelchair seating system for an existing wheelchair such as a facility wheelchair, patient owned wheelchair or a donated wheelchair. The seating system would be the least costly alternative that is able to be adapted to meet the positioning needs of a resident in a Nursing Home and will be covered under the following conditions:

There must be a comprehensive written evaluation by a licensed clinician who is not an employee of or otherwise paid by a supplier.

Included in the evaluation referenced above would be the following:

- Seating Systems for increased independence
 - Documentation must support all of the following:
 - The client must be able to self propel to specific destinations, such as to and from the dining room, to and from the activity room, etc.
 - Be able to do a functionally independent task as a result of the seating system such as feed self.
 - The client must be evaluated to determine that he/she is able to safely self propel and does not have the potential cause harm.
 - Be alert and oriented and capable of being completely independent in use of the wheelchair after adapted seating system is placed.

OR

- Seating Systems for positioning purposes
 - Seating for positioning purposes will be reviewed on a case by case basis.
 - Documentation must support that all other less costly alternatives have been ruled out, to include but not be limited to the following:

- Use of geri chairs provided by nursing home and use of standard off-the-shelf seating products have been tried and ruled out; and
- Use of rolled towels, blankets, pillows, wedges or similar devices by facility caregivers to reasonably position and reposition client and
- Documentation that has determined that nursing staff is unable to accomplish repositioning by any other means while resident is up and out of bed and;
- Resident is not incapacitated to the point that he/she is bedridden.

Wheelchairs

In addition to the Medicare, Region D, DMERC Medical Review Policies for wheelchairs, the following also applies. In order to meet the needs of a particular individual, various wheelchair options or accessories are typically selected. The addition of options or accessories does not deem the wheelchair one that is custom.

Wheelchairs in nursing facilities

Nursing facilities are expected to make available wheelchairs with typical options or accessories in a range of sizes to meet the needs of its residents. If a typical option or accessory is not available for a currently owned nursing facility wheelchair, an accommodating wheelchair is expected to be made available by the nursing facility. Only wheelchairs (including power chairs) that cannot be reasonably used by another nursing home resident will be considered for purchase. Wheelchairs must be used primarily for mobility. Roll-about chairs which cannot be self propelled are specifically designed to meet the needs of ill, injured, or otherwise impaired individuals and are considered similar to wheelchairs. Roll-about chairs may be called by other names such as *transport* or *mobile geriatric* chairs (Geri-Chairs). Roll-about chairs are not wheelchairs; however, many of the same options and accessories can be found for use on them. Like standard wheelchairs, roll-about chairs are expected to be available to residents by the nursing facility.

Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

To request prior authorization for an item/service:

- Submit a completed *DMEPOS Prior Authorization Request Form* (see *Appendix A: Forms*)
- Include appropriate supporting documentation with the request (see the following *PA Criteria* table).
- Fax or mail the request and supporting documentation to the Mountain Pacific Quality Health Foundation (see the following *PA Criteria* table).
- Upon completion of the review, the client and the requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations (see *Key Contacts*).

PA Criteria		
Covered Service	PA Contact	Requirements
<ul style="list-style-type: none"> • Item/Service over \$1,000 (when the Department fee for any single line item is greater than or equal to \$1,000) • Item/Service shown on the Department fee schedule with a PA indicator • Items/services that are unique in their function/use in comparison to other items/services in the same category 	<p>Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (406) 457-5887 Local (877) 443-4021, ext 5887 Long-distance</p> <p>Fax: (877) 443-2580 Toll-free local and long-distance</p>	<p>Medical necessity documentation must include all of the following:</p> <ul style="list-style-type: none"> • Completed DMEPOS Prior Authorization Request form • Supporting documentation, which must include at a minimum: <ul style="list-style-type: none"> • Prescription • Certificate of medical need (if required for the item) • Narrative summary from the prescribing authority detailing the need for the item • A manufacturers retail price sheet and product warranty information • For clients being treated by a licensed therapist, a copy of the client’s plan of care in relation to the item/service is required • Video, if applicable

Submitting a Claim

Electronic Claims

Professional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **ACS field software WINASAP 2003.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing electronically with paper attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	888888888	-	11182003
Medicaid Provider ID		Client ID Number		Date of Service (mmdyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.

Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
---	--	--

Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
 P.O. Box 8000
 Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
Client Information		
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
1a, 9a, 11**	Client's Medicaid ID	If client's ID is not located in 10d these three fields are searched for the number
Provider Information		
17a**	Referring Provider's Medicaid/Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
24j*	Taxonomy Code	Enter the taxonomy code for the rendering provider
24j*	NPI Number, Rendering Provider	Enter NPI number for the rendering provider.
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid Coverage Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky										3. PATIENT'S BIRTH DATE 04 28 92					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1										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)																			
CITY Anytown					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																			
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																			
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 Medicaid																			
d. INSURANCE PLAN NAME OR PROGRAM NAME 999999999										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 07 19 08										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 PROVIDER OR OTHER SOURCE Great Gazoo, M.D.										17a. ID 9954321										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI 1234567890										19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 357 0 2. 349 9 3. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 999999999																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																			
1 07 19 08 07 19 08		12 0		K0005						1,2		2,050 00		1		ZZ		36LP000X																					
2 07 19 08 07 19 08		12 0		K0040						1,2		105 00		2		ZZ		36LP000X																					
3 07 19 08 07 19 08		12 0		K0075						1,2		65 00		2		ZZ		36LP000X																					
4																NPI																							
5																NPI																							
6																NPI																							
25. FEDERAL TAX I.D. NUMBER 99-9999999					SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 99999					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 2,220 00					29. AMOUNT PAID \$ 0 00					30. BALANCE DUE \$ 2,220 00									
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.) Mary Bender 08/02/08 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X																			

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
11d*	Is there another health benefit plan?	Check "NO."
9a, 11**	Client's Medicaid ID	If client's ID is not located in 10d these fields are searched for the number
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
24j*	Taxonomy Code	Enter the taxonomy code for the rendering provider
24j*	NPI Number, Rendering Provider	Enter NPI number for the rendering provider.
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
23**	Prior Authorization Number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
24h**	EPSDT/Family Planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table in this chapter)
28*	Total Charges	Enter total charges from all line items.

* = Required Field ** = Conditional (required if applicable)

Client Has Medicaid and Medicare Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky										3. PATIENT'S BIRTH DATE MM DD YY 04 28 92 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1																																																	
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)																																																	
CITY Anytown					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																							
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
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																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 999999999										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT: MM DD YY 07 19 08 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.										17a. ID 9954321										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
17b. NPI 1234567890										19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 357 0										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																																							
2. 349 9										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																																	
1 07 19 08 07 19 08 12 0 K0005 1,2 2,050 00 1 ZZ 36LP000X NPI 1234567890										2 07 19 08 07 19 08 12 0 K0040 1,2 105 00 2 ZZ 36LP000X NPI 1234567890										3 07 19 08 07 19 08 12 0 K0075 1,2 65 00 2 ZZ 36LP000X NPI 1234567890																																							
4										5										6																																							
25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 99999										27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 2,220 00										29. AMOUNT PAID \$										30. BALANCE DUE \$ 2,220 00									
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.) Mary Bender 08/02/08										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X																																							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
Client Information		
1a**	Insured's ID Number	Enter the client's ID number for the primary carrier.
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
9a**	Other Insured's Information	Enter the client's ID number if there are two or more third-party insurance carriers.
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
11*	Insured's Policy Number	Enter the client's ID number for the primary payer
11c*	Insured's Plan	Enter primary payer's name
11d*	Another health plan benefit besides Medicaid	Check "YES."
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	Enter 1D as the atypical qualifier or ZZ for the taxonomy qualifier
24j shaded*	Medicaid/Taxonomy	Enter atypical provider number or taxonomy number
24j*	NPI Number	Enter NPI number
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number if applicable
33b*	Atypical/Taxonomy #	Enter the 1D qualifier and atypical provider number or the ZZ qualifier and the provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Enter emergency code if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA	PICA																				
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky				3. PATIENT'S BIRTH DATE MM DD YY 04 28 92			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1				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)			CITY											
CITY Anytown		STATE MT		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE											
ZIP CODE 59999		TELEPHONE (Include Area Code) (406) 555-5555		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B			a. INSURED'S DATE OF BIRTH MM DD YY											
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME											
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			PLACE (State)			c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance											
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			10d. RESERVED FOR LOCAL USE 999999999			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>											
d. INSURANCE PLAN NAME OR PROGRAM NAME				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			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											
SIGNED				DATE			SIGNED			DATE											
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 07 19 08				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 PROVIDER OR OTHER SOURCE Great Gazoo, M.D.											
17a. ID 9954321				17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
19. RESERVED FOR LOCAL USE				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 490			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1		07 19 08		07 19 08		12 0		E0570		RR		1		25:00		1		ZZ		36LP000X	
2																		NPI			
3																		NPI			
4																		NPI			
5																		NPI			
6																		NPI			
25. FEDERAL TAX I.D. NUMBER 99-9999999				SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 123456789				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 25:00		29. AMOUNT PAID \$ 20:00		30. BALANCE DUE \$ 5:00		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.) <i>Mary Bender</i> 08/02/08			
32. SERVICE FACILITY LOCATION INFORMATION a. NPI				b. ZZ 400RT001X				33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999				a. 9876543210				b. ZZ 400RT001X					

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number..
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Reserved for Local Use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's Policy Group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance Plan or Program	Enter of the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES."
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
24j*	Taxonomy Code	Enter the taxonomy code for the rendering provider
24j*	NPI Number, Rendering Provider	Enter NPI number for the rendering provider.
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
23**	Prior Authorization Number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
24h**	EPSDT/Family Planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table in this chapter)
28*	Total Charges	Enter total charges from all line items.
29*	Amount Paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance Due	Enter the balance due (the amount in field 28 less the amount in field 29).

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid, Medicare, and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky					3. PATIENT'S BIRTH DATE MM DD YY 04 28 92 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1					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)									
CITY Anytown			STATE MT		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE						
ZIP CODE 59999			TELEPHONE (Include Area Code) (406) 555-5555		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE			TELEPHONE (Include Area Code) ()						
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999A									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE 999999999					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 07 19 08					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 PROVIDER OR OTHER SOURCE Great Gazoo, M.D.					17a. ID 9954321					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
					17b. NPI 1234567890														
19. RESERVED FOR LOCAL USE										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. L 496										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
2. _____										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE									
C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER									
E. DIAGNOSIS POINTER										F. \$ CHARGES									
										G. DAYS OR UNITS									
										H. EPSDT Family Plan									
										I. ID. QUAL.									
										J. RENDERING PROVIDER ID. #									
1 07 19 08 07 19 08 12 0 A7015 1,2 5:00 1 ZZ 36LP000X										NPI 1234567890									
2 07 19 08 07 19 08 12 0 E1390 RR 1,2 325:00 1 ZZ 36LP000X										NPI 1234567890									
3 07 19 08 07 19 08 12 0 E0431 RR 1,2 50:00 1 ZZ 36LP000X										NPI 1234567890									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 99-9999999					SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 123456789					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ 380:00					29. AMOUNT PAID \$ 304:00					30. BALANCE DUE \$ 76:00									
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.) <i>Mary Bender</i> 08/02/08										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. ZZ 400RT001X									
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH# (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
11*	Insured's Policy Group	Enter the client's ID number for the primary payer.
11c*	Insurance Plan or Program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.)
11d*	Is there another health benefit plan?	Check "YES."
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
24j*	Taxonomy Code	Enter the taxonomy code for the rendering provider
24j*	NPI Number, Rendering Provider	Enter NPI number for the rendering provider.
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
23**	Prior Authorization Number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
24h**	EPSDT/Family Planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table in this chapter)
28*	Total Charges	Enter total charges from all line items.
29*	Amount Paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the Medicare EOMB attached to the claim.
30*	Balance Due	Enter balance due (amount in field 28 less the amount in field 29).

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky										3. PATIENT'S BIRTH DATE MM DD YY 04 28 92					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1										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)																			
CITY Anytown					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																			
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																			
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 Paywell Supplemental Insurance																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 999999999										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>SIGNED _____ DATE _____</p>																				<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>																			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 07 19 08										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 PROVIDER OR OTHER SOURCE Great Gazoo, M.D.										17a. ID 9954321					17b. NPI 1234567890					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 496										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #																			
1 07 19 08 07 19 08		12 0		E1390		RR				1		325 00		1		ZZ		36LP000X		NPI 1234567890																			
2 07 19 08 07 19 08		12 0		E0431		RR				1		50 00		1		ZZ		36LP000X		NPI 1234567890																			
3 07 19 08 07 19 08		12 0		A7003						1		8 00		1		ZZ		36LP000X		NPI 1234567890																			
4																		NPI																					
5																		NPI																					
6																		NPI																					
25. FEDERAL TAX I.D. NUMBER 99-9999999					SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 123456789					27. ACCEPT ASSIGNMENT? (If for govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 393 00					29. AMOUNT PAID \$ 314 40					30. BALANCE DUE \$ 78 60									
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.) <i>Mary Bender</i> 08/02/08										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. ZZ 400RT01X										33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999																			
SIGNED _____ DATE _____										a. 9876543210 b. ZZ 400RT01X																													

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

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

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG AND FECA CLAIMS

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

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

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

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

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

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

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

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by 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 6101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have internet access, and be registered for the Montana Access to Health Web Portal. You can access your electronic RA through the Web Portal on the internet by going to the Provider Information Web Portal (see *Key Contacts*) and selecting Log In to Montana Access to Health. In order to access the Montana Access to Health Web Portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

After these forms have been processed, you will receive a user ID and password that you can use to log on to the Web Portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Web Portal home page. Due to space limitations, each RA is only available for 90 days.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.



Electronic RAs are available for only 90 days on the web portal.



If a claim was denied, read the reason and remark code description before taking any action on the claim.

Sections of the Paper RA	
Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see <i>Adjustments</i> later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending claims	<p>All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.</p>
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a “4” (see *Key to the Paper RA* in this chapter).

Payment and the RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider’s bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider’s account, all Medicaid payments will be made through EFT. To arrange for EFT, call the number listed under *Direct Deposit Arrangements* in *Key Contacts*.



Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

<p align="center">Required Forms for EFT and/or Electronic RA All four forms are required for a provider to receive weekly payment</p>			
Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health Web Portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement)	<ul style="list-style-type: none"> • Provider Information Web Portal • Provider Relations (see <i>Key Contacts</i>) 	Provider Relations (see <i>Key Contacts</i>)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider Information Web Portal (see <i>Key Contacts</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form)	<ul style="list-style-type: none"> • Provider Information Web Portal • ACS EDI Gateway website (see <i>Key Contacts</i>) 	ACS address on the form

Appendix A: Forms

- ***Montana Medicaid /MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***
- ***Certificates of Medical Necessity***
 - *Lymphedema Pumps (Pneumatic Compression Devices) (CMS-846)*
 - *Osteogenesis Stimulators (CMS-847)*
 - *Oxygen (CMS-484)*
 - *Seat Lift Mechanisms (CMS-849)*
 - *Section C Continuation Form (CMS-854)*
 - *Transcutaneous Electrical Nerve Stimulators (TENS) (CMS-848)*
- ***DME Information Forms***
 - *External Infusion Pumps DME 09.03 (CMS 10125)*
 - *Enteral and Parenteral Nutrition DME 10.03 (CMS 10126)*
- ***DMEPOS Medical Review Request Form***
- ***Request for Blanket Denial Letter***

CERTIFICATE OF MEDICAL NECESSITY

CMS-846 — PNEUMATIC COMPRESSION DEVICES

DME 04.04B

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (___) ___ - ___ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (___) ___ - ___ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i>	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (___) ___ - ___ UPIN or NPI # _____
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1-5 FOR PNEUMATIC COMPRESSION DEVICES (Circle Y for Yes, N for No, Unless Otherwise Noted)	
Y N	1. Does the patient have chronic venous insufficiency with venous stasis ulcers?	
Y N	2. If the patient has venous stasis ulcers, have you seen the patient regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?	
Y N	3. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?	
Y N	4. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?	
Y N	5. Has the patient had lymphedema since childhood or adolescence?	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)		
SECTION D PHYSICIAN Attestation and Signature/Date		
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____		DATE ___/___/___

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR PNEUMATIC COMPRESSION DEVICES (CMS-846)

SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the PHYSICIAN'S name and complete mailing address.

PHYSICIAN INFORMATION: Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)

PHYSICIAN'S TELEPHONE NO.: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).

QUESTION SECTION: This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

CERTIFICATE OF MEDICAL NECESSITY CMS-847 — OSTEOGENESIS STIMULATORS

DME 04.04C

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (___) ___ - ___ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (___) ___ - ___ NSC or NPI # _____
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i> _____ _____ _____		PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (___) ___ - ___ UPIN or NPI # _____

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.	
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)	DIAGNOSIS CODES (ICD-9): _____
ANSWERS	QUESTIONS 1-5 ARE BLANK. ANSWER QUESTIONS 6-8 FOR NONSPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 9-11 FOR SPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 6 AND 12 FOR ULTRASONIC OSTEOGENESIS STIMULATOR (Circle Y for Yes, N for No, or D for Does Not Apply. For questions about months, enter 1-99 or D. If less than one month, enter 1.)
a) Y N D	6. In a fracture, has there been no clinically significant radiographic evidence of healing for a minimum of 90 days?
a) Y N D b) _____	7. (a) Does the patient have a failed fusion of a joint other than the spine? (b) How many months prior to ordering the device did the patient have the fusion?
Y N D	8. Does the patient have a congenital pseudoarthrosis?
a) Y N D b) _____	9. (a) Is the device being ordered as a treatment of a failed single level spinal fusion surgery in a patient who has not had a recent repeat fusion? (b) How many months prior to ordering the device did the patient have the fusion?
a) Y N D b) _____ c) _____	10. (a) Is the device being ordered as an adjunct to repeat single level spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s)? (b) How many months prior to ordering the device did the patient have the repeat fusion? (c) How many months prior to ordering the device did the patient have the previously failed fusion?
Y N D	11. Is the device being ordered following multi-level spinal fusion surgery?
Y N D	12. Has there been at least one open surgical intervention for treatment of the fracture?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D PHYSICIAN Attestation and Signature/Date
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.
PHYSICIAN'S SIGNATURE _____ DATE ___/___/___

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OSTEOGENESIS STIMULATORS (CMS-847)

SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxx)

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the PHYSICIAN'S name and complete mailing address.

PHYSICIAN INFORMATION: Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)

PHYSICIAN'S TELEPHONE NO.: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).

QUESTION SECTION: This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

CERTIFICATE OF MEDICAL NECESSITY CMS-484 — OXYGEN

DME 484.03

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) _____ - _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (____) _____ - _____ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i>	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (____) _____ - _____ UPIN or NPI # _____
SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)	
a) _____ mm Hg b) _____ % c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO ₂ and/or (b) oxygen saturation test; (c) date of test.	
1 2 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?	
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep	
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.	
_____ LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".	
a) _____ mm Hg b) _____ % c) ___/___/___	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO ₂ and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).	
ANSWER QUESTIONS 7-9 ONLY IF PO₂ = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1		
Y N	7. Does the patient have dependent edema due to congestive heart failure?	
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?	
Y N	9. Does the patient have a hematocrit greater than 56%?	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)		
SECTION D Physician Attestation and Signature/Date		
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____		DATE ___/___/___

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN (CMS-484)

SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxx)

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the PHYSICIAN'S name and complete mailing address.

PHYSICIAN INFORMATION: Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).

QUESTION SECTION: This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0534. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

CERTIFICATE OF MEDICAL NECESSITY CMS-849 — SEAT LIFT MECHANISMS

DME 07.03A

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (___) ___ - ___ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (___) ___ - ___ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i> _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (___) ___ - ___ UPIN or NPI # _____	
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Circle Y for Yes, N for No, or D for Does Not Apply)	
Y N D	1. Does the patient have severe arthritis of the hip or knee?	
Y N D	2. Does the patient have a severe neuromuscular disease?	
Y N D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?	
Y N D	4. Once standing, does the patient have the ability to ambulate?	
Y N D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)		
SECTION D PHYSICIAN Attestation and Signature/Date		
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____		DATE ___/___/___

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR SEAT LIFT MECHANISMS (CMS-849)

SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxx)

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the PHYSICIAN'S name and complete mailing address.

PHYSICIAN INFORMATION: Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)

PHYSICIAN'S TELEPHONE NO.: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).

QUESTION SECTION: This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

SECTION C CONTINUATION FORM (CMS-854)

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Provide (1) a narrative description of the item(s) ordered, as well as all options, accessories; (2) the product, model and serial number of the product being delivered (if applicable); (3) the supplier's charge for each item, option, accessory; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies(1) the CMN which he/she is reviewing includes Sections A, B, C and D;; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd, Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

CERTIFICATE OF MEDICAL NECESSITY

DME 06.03B

CMS-848 — TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) _____ - _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (____) _____ - _____ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i>	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (____) _____ - _____ UPIN or NPI # _____
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1-6 for purchase of TENS (Circle Y for Yes, N for No.)	
Y N	1. Does the patient have chronic, intractable pain?	
_____ Months	2. How long has the patient had intractable pain? (Enter number of months, 1 - 99.)	
1 2 3 4 5	3. Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above	
Y N	4. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?	
Y N	5. Has the patient received a TENS trial of at least 30 days?	
___/___/___	6. What is the date that you reevaluated the patient at the end of the trial period?	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):		
NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)		
SECTION D PHYSICIAN Attestation and Signature/Date		
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____		DATE ___/___/___

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) (CMS-848)

SECTION A:	(May be completed by the supplier)
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES: on the CMN.	List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the PHYSICIAN'S name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	(To be completed by the supplier)
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.
SECTION D:	(To be completed by the physician)
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

DME INFORMATION FORM

CMS-10125 — EXTERNAL INFUSION PUMPS

DME 09.03

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) _____ - _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (____) _____ - _____ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i> _____ _____ _____	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (____) _____ - _____ UPIN or NPI # _____
ANSWERS		ANSWER QUESTIONS 1 - 4 FOR EXTERNAL INFUSION PUMP.
HCPCS CODE: a) _____ b) _____ c) _____		1. Provide the HCPCS code(s) for the drug(s) that requires the use of the pump.
a) _____ b) _____ c) _____		2. If a NOC (not otherwise classified) HCPCS code is listed in question 1, print name of drug.
1 2 3 4		3. Circle number for route of administration? 1 — Intravenous 2 — Subcutaneous 3 — Epidural 4 — Other
1 2		4. Circle number for method of administration? 1 – Continuous 2 – Intermittent
Supplier Attestation and Signature/Date		
I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.		
SUPPLIER SIGNATURE _____		DATE ___/___/___

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR EXTERNAL INFUSION PUMPS (CMS-10125)

CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
SUPPLIER ATTESTATION:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
SUPPLIER SIGNATURE AND DATE:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

DME INFORMATION FORM

CMS-10126 — ENTERAL AND PARENTERAL NUTRITION

DME 10.03

All INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER		
Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) _____ - _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (____) _____ - _____ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___ (in) Wt. ___ (lbs.)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i> _____ _____ _____	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (____) _____ - _____ UPIN or NPI # _____
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1-6 FOR ENTERAL NUTRITION, AND 6 - 9 FOR PARENTERAL NUTRITION (Circle Y for Yes, N for No, Unless Otherwise Noted)	
Y N	1. Is there documentation in the medical record that supports the patient having a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?	
Y N	2. Is the enteral nutrition being provided for administration via tube? (i.e., gastrostomy tube, jejunostomy tube, nasogastric tube)	
A) _____ B) _____	3. Print HCPCS code(s) of product.	
A) _____ B) _____	4. Calories per day for each corresponding HCPCS code(s).	
1 2 3 4	5. Circle the number for method of administration? 1 – Syringe 2 – Gravity 3 – Pump 4 – Oral (i.e. drinking)	
_____	6. Days per week administered or infused (Enter 1 – 7)	
Y N	7. Is there documentation in the medical record that supports the patient having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?	
	8. Formula components: Amino Acid _____ (ml/day) _____ concentration % _____ gms protein/day Dextrose _____ (ml/day) _____ concentration % Lipids _____ (ml/day) _____ days/week _____ concentration %	
1 2 3	9. Circle the number for the route of administration. 1 – Central Line (Including PICC) 2 – Hemodialysis Access Line 3 – Peritoneal Catheter	
Supplier Attestation and Signature/Date		
I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.		
SUPPLIER SIGNATURE _____ DATE ___/___/___		

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR ENTERAL AND PARENTERAL NUTRITION (CMS-10126)

CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO.:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
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REQUEST FOR BLANKET DENIAL LETTER

DATE REQUESTED _____ **PROVIDER #** _____

RECIPIENT NAME _____

MEDICAID ID # _____

INSURANCE COMPANY NAME ON FILE _____

PROCEDURE CODES NEEDED:

1. _____

2. _____

3. _____

4. _____

5. _____

CONTACT _____

PHONE NUMBER _____

FAX NUMBER _____

PLEASE FAX ALL REQUESTS TO 406-442-0357

Cost Sharing

The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers

Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles

Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or

unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental

A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Frequently Maintained Rental

Rentals that need frequent and substantial servicing are not subject to a cap and the provider may continue to rent the item as long as it is medically necessary. All supplies needed to operate the equipment are included in the rental fee.

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

A non-covered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Maximum Allowable

The maximum dollar amount for which a provider may be reimbursed as established by Montana Medicaid for specific services, supplies and/or equipment.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or mal-function. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Montana Access to Health (MATH)**Web Portal**

A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Montana Breast and Cervical Cancer Treatment Program

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

PASSPORT To Health

A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay

When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)

QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit

The numerical value given to each service in a relative value scale.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)

SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down

Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care

A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact the EDI Technical Help Desk (see *Key Contacts*).

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