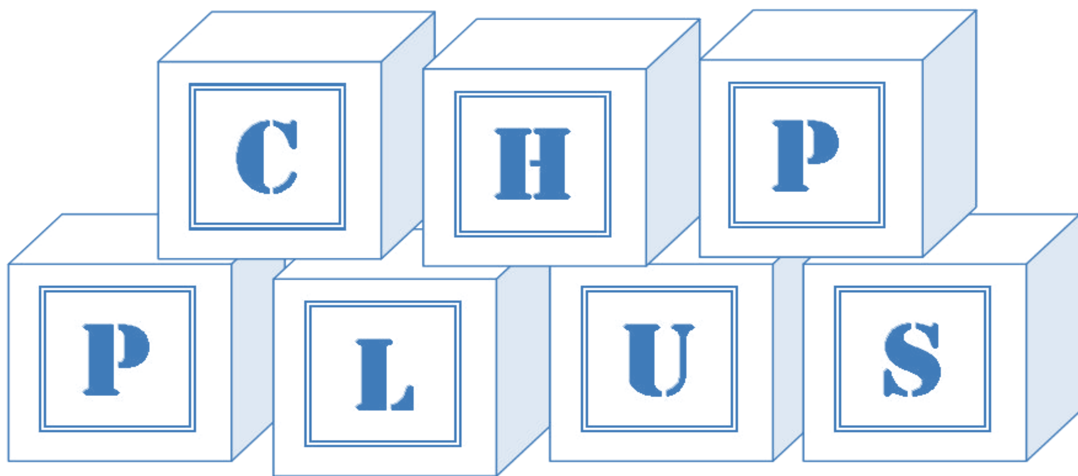
Claims Manual



This Provider Manual was last updated on 01/28/2008. Some policies and procedures may have changed since that time. If you have any questions regarding any of the information found in this manual, please send an email to pns@coaccess.com

Table of Contents

I. **General Information** 1

II. **Colorado Access Addresses** 1

III. **Customer Service/Claim Status** 1

IV. **Timely Filing** 1

V. **Colorado Access Responsibilities** 2

VI. **Provider Responsibilities** 2

VII. **Required Formats** 2

VIII. **Electronic Claims** 3

IX. **CMS 1500 Claims Specification** 3

X. **UB04/CMS 1450 Claim Specifications** 3

XI. **Diagnosis Coding** 3

Confidential Diagnosis Coding 3

XII. **Procedure Coding** 4

XIII. **Specific Billing Instructions & Reimbursements** 4

Anesthesia Billing 4

Immunizations 4

Multiple Occurrences 5

XIV. **Non Clean Claims Process** 5

XV. **Coordination of Benefits** 5

Filing a Claim for a Patient with TPR 5

Secondary Benefit Calculation "Lower of Logic" 6

Authorizations & Coordination of Benefits 6

XIV. **Locum Tenens** 6

XVII. **Out of Area Services** 7

XVIII. **Resubmissions** 7

Resubmission Process 7

Late or Additional Charges 8

XIX. **Provider Carrier Disputes (Claim Appeal)** 8

Submission Process 8

Processing Timeframes 8

XX. **Member Billing or Balance Billing** 10

CHP+ General Rules 10

CHP+ Co-Payment Information 10

Appendix A - CMS 1500

Appendix B - UB04/CMS 1450

Appendix C - Non-clinical Adjustment Request form

I. General Information

Child Health Plan *Plus* is a state health insurance program for children whose families earn too much to qualify for Medicaid but cannot afford health insurance. A family of four can make $41,304 a year ($3,442 per month) and still get CHP+. CHP+ offered by Colorado Access has more benefits than the state's standard CHP+ plan, including coverage of over-the-counter medications when prescribed by a provider, enhanced vision, therapy and hearing aid benefits.

II. Colorado Access Addresses

Claims:
PO Box 17470
Denver, CO 80217-0470

Provider Carrier Disputes (Appeals):
PO Box 17189
Denver, CO 80217-0189

General Correspondence & Provider Network Services:
PO Box 17580
Denver, CO 80217-0580

Customer Service/Complaints & Grievances:
PO Box 17950
Denver, CO 80217

III. Customer Service/Claim Status

Customer Service
Denver Metro Area...(303) 751-9021
Toll Free...(888) 214-1101

The Customer Service Department can answer questions regarding benefits and claims, and can also assist providers with claims status and the status of provider carrier disputes. Customer Service representatives are available Monday through Friday 8:00 AM to 5:00 PM MT.

Providers can also logon to our website at www.coaccess.com to check claim status. If you do not have a provider logon, please complete the Web Based Application Request Form at https://www.coaccess.com/providers/files/WebAccessApplication.pdf

IV. Timely Filing

Claims must be submitted within 120 calendar days from the date of service or the contractual time limit.

Provider Carrier Disputes (claim appeals) must be submitted within 60 calendar days from the date of the voucher on which it appears.

Claims that involve a third party resource (TPR), such as auto insurance, must be submitted within one hundred twenty (120) calendar days from the TPR's denial date or processing date.

V. Colorado Access Responsibilities

Colorado Access has the following responsibilities with respect to the provider:

- ⇨ Provide information about requirements for filing claims
- ⇨ Notify new providers of standard forms, instructions or requirements upon acceptance into the plan
- ⇨ Notify providers of changes in standard forms, instructions or requirements within fifteen (15) calendar days
- ⇨ Determine whether sufficient information has been submitted to allow proper consideration of the claim
- ⇨ Provide appropriate explanations for denied claims
- ⇨ Approve, deny or settle all "clean" paper claims within forty-five (45) calendar days of receipt, or the time period specified in the provider's contract
- ⇨ Approve, deny or settle all "clean" electronic claims within thirty (30) calendar days of receipt, or the time period specified in the provider's contract
- ⇨ Approve, deny or settle all other claims (except fraudulent claims) within ninety (90) calendar days

Note: Colorado Access will not interpret claim information from provider statements or superbills. Colorado Access will not submit fee-for-service claims to the State of Colorado for services rendered to non-Colorado Access members.

VI. Provider Responsibilities

Providers rendering services to Colorado Access members have the following responsibilities in relation to billing for these services:

- ⇨ Verify the member's eligibility and PCP assignment for billed services prior to submitting the claim
- ⇨ Ensure that the appropriate authorization requirements have been met
- ⇨ Verify that place of service codes are correct
- ⇨ Verify that diagnosis and/or procedure codes match the service provided
- ⇨ Complete all required data elements
- ⇨ Leave non-required data fields blank (do not enter N/A)
- ⇨ Use only black or dark red ink on any hand-written paper claims
- ⇨ Use only good quality toner, typewriter or printer ribbons for paper claims
- ⇨ Do not use highlighters to mark claims or attachments
- ⇨ Bill original claims within 120 days or as specified by contract (whichever is less)
- ⇨ Bill third party or Medicare prior to submitting claims to Colorado Access
- ⇨ Attach all required documentation to the claim
- ⇨ If several claims require the same attachment, a photocopy of the attachment must be submitted with each claim
- ⇨ Do not submit "continuation" claims
- ⇨ Submit claims at least weekly to ensure timely payment for services
- ⇨ Submit paper claims to the appropriate address

VII. Required Formats

We require providers to submit complete claims for all services rendered to Colorado Access members, whether the services are capitated or fee-for-service. Electronic submission of claims is preferred. However, Colorado Access will accept paper claims in CMS 1500 or UB04/CMS 1450 formats. In order to process claims in a timely, accurate manner, we ask providers to observe standard reporting requirements.

Providers may also reference the following resources when completing claims submissions:

- ⇨ CMS 1500 Physician's Manual
- ⇨ UB04 Billing Manual
- ⇨ ICD-9-CM Code Book
- ⇨ Physicians' "Current Procedural Terminology" (CPT)
- ⇨ Health Care Financing Administration Common Procedure Coding System (HCPCS)

VIII. Electronic Claims

Registration for Electronic Claim Submissions

Each electronic claim submitter must contact Colorado Access to receive an Electronic Claim Submission (ECS) packet. The information can be obtained via the Colorado Access web site at www.coaccess.com or by contacting Colorado Access at (303) 751-2657 or (877) 441-6032. Once the Enrollment Form has been completed and submitted to Colorado Access, a Submitter ID will be assigned and the ECS submitter will be placed on the testing schedule. For more information regarding electronic claims, please see the Colorado Access 837 Inbound Companion Guide located on our website at https://www.coaccess.com/public/HIPAA/837_Companion_Guide.pdf

IX. CMS 1500 Claims Specifications

Providers must file all claims for professional services, including laboratory services performed by an independent laboratory, on the CMS 1500 Universal Billing form. Please see Appendix A for CMS 1500 field requirements.

Colorado Access providers must, at the very least, include the information marked "yes" in the required field of Appendix A.

X. UB04/CMS1450 Claims Specifications

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, to Colorado Access on the UB04/CMS 1450. Please see Appendix B for UB04/CMS 1450 field requirements. Colorado Access providers must at the very least include the information marked "yes" in the required field of Appendix B.

NOTE: we require providers to bill professional and/or technical components of hospital-based physicians and Certified Registered Nurse Associates separately on an CMS 1500 claim form.

XI. Diagnosis Coding

Colorado Access requires providers to enter the appropriate diagnosis code on each claim submitted. We will only accept those codes published in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 codes). The provider must enter ICD-9 codes clearly on the claim form and include all digits and characters.

- ⇨ Some procedures are appropriate only when specific conditions are present (i.e., 99381- 99387 is valid only with Diagnosis Code V20.2).
- ⇨ Colorado Access requires providers to ensure the diagnosis entered is appropriate for the services provided and is supported by the patient's medical record.

Confidential Diagnosis Coding

Please enter AIDS or AIDS-related diagnosis codes on the claim form as with any other diagnosis or condition. While federal and state statutes provide stringent penalties for failure to keep AIDS related information confidential, these statutes are not intended to prevent accurate and appropriate submission of claims.

Federal and state statutes prohibit disclosure of information regarding application for or receipt of public assistance. However, this information may be disclosed for purposes of administering a public assistance program. Claims submitted for services rendered to our members include information necessary to process claims, calculate costs and project future funding. In sharing information for these purposes, we do not jeopardize the privacy of the recipient.

XII. Procedure Coding

Colorado Access uses the Health Care Financing Administration Common Procedure Codes (HCPCS) to identify services provided to eligible recipients. HCPCS codes include *CPT* codes.

In order to ensure that claims are processed promptly and accurately please follow these guidelines:

- ⇨ Use the most current CPT ("Current Procedural Terminology") revision.
- ⇨ Be aware that not all codes are covered benefits under CHP+ Offered by Colorado Access
- ⇨ When Colorado Access receives billed codes that are considered obsolete the claim will be placed in a pended status and written notification will be sent on a claim voucher.

XIII. Specific Billing Instructions & Reimbursements

Anesthesia Billing

Anesthesia Service Codes (procedure codes 00100-01999) must appear in field 24-D. Time units must be entered in field 24-G – one unit equals fifteen (15) minutes.

When calculating reimbursement on anesthesia claims, Colorado Access does pay for time and units. However, Colorado Access pays for the actual time administered. One unit is equal to 15 minutes. Please see the example below.

Step 1: Actual time divided by 15 equals X
Step 2: The Base Factor is added to X. This total equals Y
Step 3: The Relative Value is multiplied by Y. This total is the payment amount.

Immunizations

Please report all immunizations given to Colorado Access members on the CMS 1500 claim form with the vaccine procedure code. Do not use immunization administration CPT codes 90471 or 90472. Only the CPT codes for the vaccine(s) administered should be reported. A separate vaccine code should be listed for each vaccine administered. For example:

- ⇨ CPT code 90708 for measles, mumps, and rubella (MMRV)
- ⇨ CPT code 90659 for adult influenza injection

Providers should bill an amount for the administration of each vaccine code listed.

Immunization information may be used for tracking and reporting purposes.

Payment on Immunization claims for members of CHP+ Offered by Colorado Access will reflect reimbursement for both the vaccine and administration.

Multiple Occurrences

Report multiple occurrences of the same procedure on the same date on one billing line, using multiple units of service. Charges should equal the unit procedure price times the number of units provided. Providers may refer to the CPT or *HCPCS Bulletin* for more information about unit definitions. DME providers should use the units listed in the Medicaid Fee Schedule.

XIV. Non Clean Claims Process

In accordance with Colorado State Senate bill SB02-013, effective July 1, 2002, if a submitted claim requires additional information in order to be paid, denied, or settled, the claim will not be considered a clean claim. Such claims will be paid, denied, or settled according to the following schedule:

- ⇨ Within 30 calendar days of receiving the claim, Colorado Access will pend/hold the claim in its processing system and include Explanation of Payment (EOP) codes and follow-up instructions on the voucher as to how to resolve the claim.
- ⇨ If, within 30 calendar days of Colorado Access' request, a provider fails to submit requested additional information, Colorado Access may deny the claim.
- ⇨ Where all additional information necessary to resolve the outstanding claim has been provided, during the 30 calendar day period, the clam will be paid, denied or settled by Colorado Access, absent fraud, within 90 calendar days after the date that the claim was first received by Colorado Access.

XV. Coordination of Benefits

NOTE: Qualifying for CHP+ is contingent upon the absence of other insurance coverage excluding Indigent Care and the Health Care Program for Children with Special Needs (HCP). If the subscriber is covered by any other valid coverage, including Medicaid and individual non-group coverage, she or he is not eligible for CHP+.

If the subscriber obtains other coverage, you must notify CHP+ at (800) 359-1991. If the CHP+ member is found to have other insurance, coverage under this program is termed or in some case retro-termed for the time period the other insurance was effective. The exceptions to double coverage are Medicare and Dental.

Filing a Claim for a Patient with TPR

1. Providers must submit a hard copy of the CMS 1500 or UB04/CMS 1450 along with a copy of the Explanation of Benefits (EOB), denial notice (including all denial reason wording), benefits exhausted statement or a copy of the check/voucher used for claim payment from the other insurance/Third Party Resource (TPR)
   - ⇨ Colorado Access does not consider refusals of payment due to claim preparation errors or failure to provide sufficient processing information as proof of denial.
   - ⇨ If an EOB applies to more than one claim, a copy of the EOB must be attached to each claim submission.

2. Complete the appropriate TPR data fields/form locators on the claim form submitted to Colorado Access. Claim TPR data fields/form locators are specific to third party insurance or Medicare; they cannot be used interchangeably.

3. Submit the claim within one hundred twenty (120) calendar days from the TPR's denial date or processing date.

Secondary Benefit Calculation "Lower of Logic"

Colorado Access calculates secondary benefits in the following manner:

- ⇨ Colorado Access' benefit allowance is compared to the primary payment.
- ⇨ If the primary payment is equal to or greater than the Colorado Access benefit allowance, Colorado Access will not make payment.
- ⇨ If the primary payment is less than the Colorado Access benefit allowance, Colorado Access will pay the difference between the two amounts. However, payment will not exceed the other insurance's (including Medicare) co-insurance, deductible and/or co-pay.
- ⇨ Colorado Access does not automatically pay the other insurance's (including Medicare) co-payments, coinsurance and/or deductibles.

NOTE: Providers cannot bill clients for the difference between the primary carrier's health Insurance payments and their billed charges when Colorado Access does not make additional payment.

Authorizations & Coordination of Benefits

Colorado Access authorization rules apply regardless if Colorado Access is the primary or secondary payer. A provider should request authorization for services anytime he/she believes Colorado Access will be responsible for payment of these services. This includes:

- ⇨ When services are not a covered benefit of the primary payer
- ⇨ When benefits are exhausted by the primary payer
- ⇨ When the primary payer does not have an adequate network to provide the covered service

If a claim is submitted to coordinate benefits and an authorization has not been obtained, the claim will deny for no authorization. Colorado Access will perform a retrospective review for medical necessity if the claim is resubmitted on appeal.

XVI. Locum Tenens

A member's regular provider may submit a claim and receive payment for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician if:

- ⇨ The regular physician is unable to provide the visit services;
- ⇨ The member has arranged or seeks to receive the visit services from the regular physician;
- ⇨ The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;
- ⇨ The substitute physician does not provide the visit services to members over a continuous period of longer than 14 days for a reciprocal billing arrangement, or a continuous period of longer than 0 days for a locum tenens arrangement; and
- ⇨ The regular physician identifies the visit services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS 1500 HCPCS Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement), or Q6 modifier (service furnished by a locum tenens physician) after the procedure code. Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to Colorado Access upon request.

A continuous period of covered visit services begins with the first day on which the substitute physician provides covered services to the patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

Example: The regular physician goes on vacation on June 30, 2006 and returns to work on September 4, 2006. A substitute physician provides services to patients of the regular Physician on July 2, 2006 and at various times thereafter, including August 30th and September 2, 2006. The continuous period of covered visit services begins on July 2nd and runs through September 2nd, a period of 63 days. Since the September 2nd services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive payment for them. The regular physician may, however, bill and receive the payment for the services that the substitute physician provides on his/her behalf in the period July 2nd through August 30th.

NOTE: A physician who has left a group and for whom the group has engaged a locum tenens physician as a temporary replacement may still be considered a member of the group until a permanent replacement is obtained. Practitioners who provide services under a substitute physician's agreement must enroll, or be enrolled, in the Colorado Medicaid program.

XVII. Out of Area Services

Colorado Access is financially responsible for all emergency services and urgent care services provided by out-of-area medical and hospital facilities. Please refer any out-of-area provider contacts regarding a Colorado Access member to the Customer Service Department at (888) 214-1101. Any out-of-area provider should forward their bills to the Colorado Access Claims Department for processing.

XVIII. Resubmissions

Providers may resubmit denied claims for reprocessing within 120 days of the date of service or the time frames outlined in the provider's contract or 60 days from the date of the last denial recorded on a voucher.

Resubmission Process

1. Send a photocopy of the original claim, clearly marked "Resubmission" on the face of the claim or newly completed claim form. The resubmission must be newly dated and signed with an authorized signature. Attach a copy of the voucher listing the originally submitted claim as denied.
2. If one or more items on an original claim have been paid and other items denied, a legible photocopy of the original claim may be used to resubmit denied lines.
3. Correct the appropriate information clearly and accurately.
4. Adjust total charges to reflect the amount being resubmitted.
5. Mail all resubmitted claims the Colorado Access claims address (see address section of this manual)

Colorado Access will research the resubmission and adjudicate the claim according to the newly resubmitted information. Once adjudicated, the claim will appear on the provider's voucher with a corresponding remark code outlining the reason for payment or denial.

Late or Additional Charges

Providers billing late or additional charges for previously submitted claims must resubmit the entire claim. Do not submit the missing lines or additional lines separately. For example, if an inpatient claims was submitted without the laboratory fees, the new/corrected claim must include the laboratory fees AND the original claim lines.

XIX. Provider Carrier Disputes (Claim Appeal)

A provider or a provider representative may access the Provider Carrier Dispute process to submit a written request for a resolution of a dispute regarding an administrative, payment or other issue not related to an action.

Submission Process

Colorado Access will only accept Provider-Carrier disputes that are submitted in writing. Information may be submitted in a brief letter or on Colorado Access' Non-clinical Adjustment Request form (Appendix C).

All necessary information should be submitted **60 calendar days** from the date of the voucher on which the disputed claim appears to the following address:

Colorado Access
Provider-Carrier Disputes
PO Box 17189
Denver, CO 80217-0189

Necessary information for purposes of a Provider-Carrier dispute includes the following:

1. Each applicable date of service;
2. Member name;
3. Patient name;
4. Member identification number;
5. Provider name;
6. Provider tax identification number;
7. Dollar amount in dispute, if applicable;
8. Provider position statement explaining the nature of the dispute; and
9. Supporting documentation where necessary, (e.g., medical records, proof of timely filing, State Web Portal eligibility screen prints verifying reasonable attempts to capture member eligibility on date of service).

After Colorado Access receives a dispute in writing, providers or their representatives may present the rationale for a dispute in person. When a face-to-face meeting is not practical, Colorado Access will provide alternative methods of communication such as teleconference.

Processing Timeframes

Upon receipt of a Provider-Carrier dispute, Colorado Access will review, record, investigate, resolve and provide appropriate and timely notifications in accordance with applicable state and federal rules and regulations.

Colorado Access will issue a written confirmation to the provider or the provider's representative within thirty (30) calendar days of receiving a complete dispute resolution request. Colorado Access will resolve Provider-Carrier disputes and issue written notification of the outcome within sixty (60) calendar days of receipt of the initial request for resolution and upon receiving all necessary information. Colorado Access may choose to use electronic means to send required notification to providers including e-mail or facsimile. Both parties may agree in writing to an extension beyond the (60) calendar days from receipt of all necessary information time frames established by this policy in order to resolve a dispute.

Please use the following table to assist in submitting complete documentation with your dispute.

Situation	Appropriate Dispute Documentation	Incomplete Dispute Documentation
Billed incorrect codes and/or amounts	⇨ Letter/Adjustment Form detailing the situation ⇨ Correct claim sent with the words *"corrected claim"* written at the top of the claim	⇨ Letter stating "not paid correctly" ⇨ Provider computer generated system notes
Incorrect payment received	⇨ Letter/Adjustment Form detailing the situation ⇨ Specific dollar amounts outlined ⇨ Specific codes outlined (both old and new) ⇨ Claim number ⇨ Documentation showing how provider is calculating what the correct reimbursement should be (e.g., claim paid $xx.00 less than it should have based on DRG 76)	⇨ Letter stating "claim paid incorrectly, fix claim" ⇨ Letter stating "claim did not pay according to contract" ⇨ Provider computer generated system notes
Overpayments	⇨ Letter/Adjustment Form detailing the situation ⇨ Documentation showing how provider is calculating what the correct reimbursement should be (e.g., claim paid $332 more. Reimbursed was expected at 30% of RBRVS) ⇨ EOB from another carrier (if applicable)	⇨ DO NOT SEND A CHECK PAYABLE TO COLORADO ACCESS ⇨ Letter/Adjustment Form with "take back $xx.00" ⇨ Letter/Adjustment Form with "claim paid incorrectly" ⇨ Provider computer generated system notes
Denied for no authorization or late notification	⇨ Letter/Adjustment Form detailing the situation ⇨ Attach proof of timely notification/request for authorization ⇨ Attach authorization approval form	⇨ Medical necessity is not an argument for timely filing or late notification ⇨ Provider computer generated system notes
Duplicate payment	⇨ Letter/Adjustment Form detailing the situation ⇨ Submit information regarding <u>BOTH</u> claim payments	⇨ Letter/Adjustment Form stating "duplicate payment, do take back". ⇨ Provider computer generated system notes

XX. Member Billing or Balance Billing

CHP+ General Rules

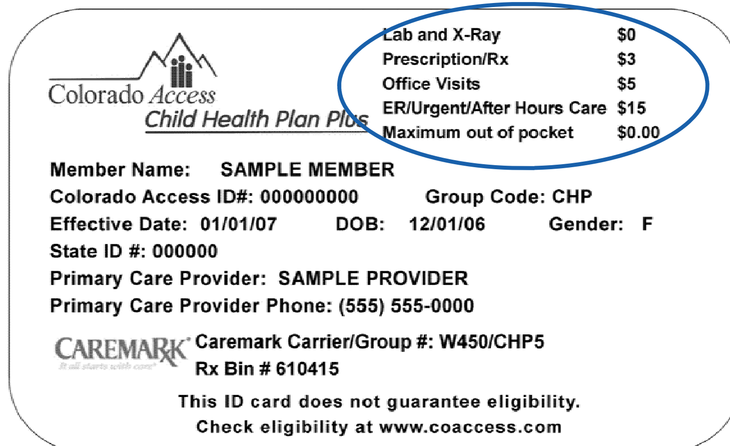
With the exception of the co-payment and/or exhausted benefit, the member may not be billed for any services covered by CHP+ Offered by Colorado Access. The provider may not bill a member for the difference between the provider's charges and payment by Colorado Access. This applies regardless of whether or not Colorado Access has paid the claim.

There are circumstances in which a CHP+ member can be billed for services. They are:

- ⇨ A member signs a written waiver indicating financial responsibility for any service not covered by CHP+.
- ⇨ A member insists on seeing a non-participating provider, without prior authorization or referral (applies to in-state and out-of-state providers).
- ⇨ A member receives any service not covered by CHP+.

CHP+ Co-payment Information

CHP+ Offered by Colorado Access members may have co-payments for services. This information is listed on the member's identification card.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___

2. ___ . ___

3. ___ . ___

4. ___ . ___

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								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **_PLEASE PRINT OR TYPE_** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

CMS 1500 Box Number	Data Element	Description	Required
1	Type of Insurance	The type of health insurance coverage carried by the patient	Yes
1a	Insured's I.D. Number	Patient's ID Number	Yes
2	Patient's Name	Patient's last name, first name and middle initial exactly as they appear on the MAC	Yes
3	Patient's Birth Date Sex	Patient's DOB using MMDDYY format. Patient's sex (M = Male, F = Female).	Yes
4	Insured's Name		Yes
5	Patient's Address		No
6	Patient's Relationship to Insured	Relationship between the patient and the policy-holder (insured) of the third party insurance.	Required if patient has 3rd party coverage
7	Insured's Address	Address and telephone number of the policyholder (insured) of the insurance. Thirty party claims refer to subscriber not 3rd party.	Required if patient has 3rd Party coverage
8	Patient Status		No
9	Other Insured's Name	Policyholder's last name, first name, and middle initial.	Required if patient has 3rd Party coverage
9a	Other Insured's Policy or Group Number	Policy Number	Required if patient has 3rd Party coverage
9b	Other Insured's Date of Birth Sex	Date of birth, sex of policyholder	Required if patient has 3rd Party coverage
9c	Employer's Name or School Name		No
9d	Insurance Plan Name or Program Name	Name of insurance company or program providing 3rd party coverage.	Required if patient has 3rd Party coverage
10	Is Patient's Condition Related To	Indicate whether patient's condition is related to employment, auto accident or other accident.	No
10d	Reserved For Local Use	Enter the accident date in MMDDYY format	No

CMS 1500 Box Number	Data Element	Description	Required
11	Insured's Policy Group or FECA Number	Enter the Colorado Access group number. Refer to the patient's Colorado Access ID Card for appropriate group numbers.	Optional. Including the Group Name may assist in adjudicating the claim more quickly.
11a	Insured's Date of Birth Sex		No
11b	Employer's Name or School Name		No
11c	Insurance Plan Name or Program Name		No
11d	Is There Another Health Benefit Plan	Indicate whether or not patient has 3rd party coverage. If yes, complete boxes 9 a-d.	Required if patient has 3rd Party coverage
12	Patient's or Authorized Person's Signature	Patient's signature or notation that signature is "on file."	Yes
13	Insured's or Authorized Person's Signature.	Insured's signature or notation that signature is "on file"	Yes
14	Date of Current Illness, Injury or Pregnancy	Date of first symptoms, accident or last menstrual period using MMDDYY format.	Yes
15	If Patient Has Had Same or Similar Illness Give First Date		No
16	Dates Patient Unable to Work in Current Occupation		No
17	Name of Referring Provider or Other Source	Name of Physician	No
17a	I.D. Number of Referring Physician	Provider Tax ID number of the referring physician.	No
17b	NPI	NPI number of the referring physician	No
19	Reserved for Local Use		No

CMS 1500 Box Number	Data Element	Description	Required
20	Outside Lab / $Charges	Indicate whether ALL laboratory work was performed outside of the physician's office by an independent lab. If yes, no payment will be made to the physician for laboratory fees. Do not check yes if ANY laboratory work was performed within the physician's office.	No
21	Diagnosis or Nature of Illness or Injury	Enter up to four ICD-9-CM diagnosis codes. Decimal points should not be entered. A written description is optional. **Note:** Up to four additional diagnoses may be reported by attaching a second claim form.	Yes
22	Medicaid Resubmission Code - Original Ref. No.	Code and the original reference number.	No
23	Prior Authorization Number	Prior Authorization number received from Colorado Access or from the Primary Care Provider (PCP).	No
24 A	Dates of Service	Dates that service began and ended using MMDDYY format	Yes
24 B	Place of Service	Colorado Access requires providers to use the correct CPT™ code that is appropriate for the place of service listed on the claim form. The following is a list of place of service codes used by Colorado Access. In order for claims to be processed, these codes must be used. Single digit or alpha place of service codes will be considered invalid codes. **Code: Description:** 11 Office 12 Patient's home 20 Urgent Care effective 06/01/03 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room-hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing facility 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Air ambulance 51 Inpatient psychiatric 52 Psychiatric facility partial hospital 53 Community mental health center	Yes

CMS 1500 Box Number	Data Element	Description	Required
24 B *(Continued)*		54 Interim care facility (ICF) 55 Residential substance abuse facility 61 Comp IP rehabilitation facility 62 Comp OP rehabilitation facility 65 End stage renal treatment facility 71 ST/Local disease treatment facility 72 Rural health clinic 81 Independent laboratory	Yes
24 C	EMG	Enter an "X" if the service provided is emergency related. An emergency is defined as care for any condition which is life threatening or which requires immediate medical intervention.	Required if Applicable
24 D	Procedures, Services or Supplies	CPT-4 or HCPCS code (including any valid modifier codes for the service code).	Yes
24 E	Diagnosis Pointer	Number 1, 2, 3, or 4 from field 21 to indicate which diagnosis is related to the procedure on each billing line. Do not enter the ICD-9-CM code.	Yes
24 F	$ Charges	Usual and customary charge for each service.	Yes
24 G	Days or Units	Number of service units for each procedure. Days or units must be whole numbers.	Yes
24 H	EPSDT Family Plan		No
24 I	ID. Qual		No
24 J	Rendering Provider ID #		No
24 J	NPI	Enter the NPI number of the provider that rendered the service.	Yes
25	Federal Tax ID Number (SSN/EIN)	Enter the nine-digit Provider Tax ID number of the provider or agency that will receive payment for these services (Check the box that applies - SSN or EIN).	Yes
26	Patient's Account No	The account number assigned by the provider's office. If entered, the account number will appear on the Colorado Access voucher for the claim.	Yes
27	Accepts Assignment	All Colorado Access claims are reimbursed to the provider.	No
28	Total Charge	Sum of all charges listed in field 24 F	Yes
29	Amount Paid	All amounts paid by a third party. If not applicable, input $0.	Required if Applicable
30	Balance Due	The net amounts of line 28 and line 29.	Yes
31	Signature of Physician	Authorized signature or printed name and date of the physician. **Note:** including a legible (printed) name assists Colorado Access in more quickly adjudicating the claim.	Yes

CMS 1500 Box Number	Data Element	Description	Required
32	Service Facility Location Information	Name and address of the facility where services were rendered - if other than home or office.	Yes
32 A	NPI	The NPI number of the facility where services were rendered.	Yes
33	Billing Provider Info & PH #	The provider's billing name, payment address, and telephone number.	Yes
33 A	NPI	The NPI number of the billing provider.	Yes

1

2

3a PAT. CNTL #

b. MED. REC. #

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a

b

9 PATIENT ADDRESS a

b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 35 CODE OCCURRENCE SPAN FROM THROUGH | 36 CODE OCCURRENCE SPAN FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a
b
c
d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***						23

SAMPLE

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX | 67 | A | B | C | D | E | F | G | H | 68

I | J | K | L | M | N | O | P | Q

69 ADMIT DX | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL
LAST FIRST

77 OPERATING NPI QUAL
LAST FIRST

80 REMARKS

81CC a
b
c
d

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC™ National Uniform Billing Committee

LIC9213257

UB04/CMS 1450 Box Number	Data Element	Description	Required
1	Provider Data	Provider name, address and telephone number.	Yes
2	N/A		N/A
3a	Pat CNTL #	Patient Control Number - Account or bill control number assigned by the provider.	Yes
3b	Med Rec #	Medical Record Number - Medical record number assigned by the provider.	No
4	Type of bill	Type of facility (1st digit), bill classification (2nd digit), and frequency (3rd digit). Refer to the AHA UB04 Uniform Billing Manual for a list of codes.	Yes
5	Fed Tax No.	The Federal Tax ID Number.	Yes
6	Statement Covers Period	Beginning and ending service dates of the period included on the bill	Yes
7			N/A
8a	Patient Identifier	The patient's ID number.	Yes
8b	Patient Name	The patient's Last, First and Middle Initial.	Yes
9a	Patient Address	The patient's street address.	Optional
9b	Patient's City - *not labeled*	The city in which the patient resides.	Yes
10	Birthdate	The patient's date of birth.	Yes
11	Sex	The patient's gender, enter M or F.	No
12	Admission Date	The date care began (the date of admission or the date care was initiated).	Yes
13	Admission HR	The hour in which the patient was admitted for care. The hour should be entered in military time (00-24).	Optional
14	Admission Type	**The single digit code that describes the reason for admission:** 1. ***Emergency*** – Patient requires medical intervention for severe, life-threatening or potentially disabling conditions. Documentation must be attached. 2. ***Urgent*** – Patient requires immediate attention. 3. ***Elective*** – Patient's condition permits time to schedule services. 4. ***Newborn*** – Patient is a newborn. The newborn source of admission code must be entered in field 15 (see below).	Optional

UB04/CMS 1450 Box Number	Data Element	Description	Required
15	Admission SRC	**The code that best describes the source of the admission:** 1. Physician Referral 2. Clinical Referral 3. HMO Plan Referral 4. Transfer from Hospital 5. Transfer from Skilled Nursing Home 6. Transfer from other Health Care Facility 7. Emergency Room 8. Court/Law Enforcement 9. Information not available Newborns (Refer to Field 19) 1. Normal Birth 2. Premature Birth 3. Sick Newborn 4. Extramural Birth	No
16	DHR	The hour in which the patient was discharged. The hour should be entered in military time (00-24).	Optional
17	STAT	**The code that best describes the patient's status for this billing period:** 1. Discharged to home or self care 2. Transferred to another short-term hospital 3. Transferred to a skilled nursing facility 4. Transferred to an intermediate care facility 5. Transferred to another type of institution 6. Discharged to home under care of an Organized Home Health Services Organization 7. Left Against Medical Advice 8. Discharged/Transferred to Home under Care of Home IV Provider 20. Expired 30. Still a Patient 40. Expired at Home 41. Expired in Hospital, SNF, ICF or Hospice 42. Expired, Place Unknown	Yes
18 - 28	Condition Codes	Codes used to identify conditions related to the claim that may affect processing.	No
29	ACDT State	Accident State - if the claim is related to an accident, enter the abbreviation of the state in which the accident occurred.	No
30			N/A
31 - 34	Occurrence Code and Date	The code and associated date defining a significant event relating to the claim that may affect processing.	Optional
35 - 36	Occurrence Span Code, From Through	The beginning and end dates of the event relating to the claim.	Optional

UB04/CMS 1450 Box Number	Data Element	Description	Required
37			N/A
38	Name & Address of Responsible Party		No
39 - 41	Value Code and Amount	Codes used to identify payment variations	No
42	Revenue Codes	Codes that identify a specific accommodation, ancillary service, or billing calculation. Accommodation days should not be billed on outpatient bill types. Revenue codesare to be billed in the following sequence: chronologically for accommodation dates; in descending order for non-accommodation revenue codes.	Yes
43	Description	Description of the related revenue code.	No
44	HCPCS/Rate/HIPPS Code	Accommodation rate for inpatient bills and the HCPCS code for all ancillary services and outpatient bills. HCPCS codes & rates should be submitted on lab claims that fall under the Colorado Access Lab Contract.	Yes
45	Serv. Date	Date of outpatient service in MMDDYY format	Yes
46	Serv. Units	Services units provided. If accommodation days are billed, the number of units billed must be consistent with the Statement Covers Period (Box 6). Service units should be billed in whole numbers. Round any fractions to the nearest whole number.	Yes
47	Total Charges	Total Charges for Field 47 are obtained by multiplying the units of service (Box 46) by the value of the revenue code (Box 42).	Yes
48	Non-Covered Charges		No
49			N/A
50 A, B, C	Payer Name	Name of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement.Colorado Access should be the last entry.	No
51 A, B, C	Health Plan ID	Identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement.	No
52	REL Info	Release of Information - Enter “Y” if the provider has signed written consent from the patient to release medical/billing information. Otherwise, enter “R” for restricted or modified release or “N” for no release.	No

UB04/CMS 1450 Box Number	Data Element	Description	Required
53	ASG. BEN.	Assignment of benefits - A code showing whether the provider has a signed form authorizing the party payer to pay the provider.	N/A
54	Prior Payments	Amount received toward payment from any payer, including the patient. If no payment was received as a result of billing, enter "0." The "0" indicates that a reasonable attempt was made to determine available coverage for the services provided.	No
55	Estimated Amount Due		No
56	NPI	National Provider Identifier - The NPI number of the billing provider.	Yes
57	Other Prv ID	Other Provider ID - Number assigned to the provider by the payer indicated in Box 50 A, B, C.	No
58	Insured's Name	Name of the insured who is covered by the payer listed in Box 50.	No
59	P. Rel	Patient's Relationship to the Insured - Code indicating relationship of the insured to the patient. For Medicaid, code will be 01.	No
60	Insured's Unique ID	The patient's member ID Number.	Yes
61	Group Name	Insured's group name. Refer to Colorado Access ID card.	No
62	Insurance Group No.	The Insurance Group Number - Refer to the Colorado Access ID. Valid Colorado Access Group Numbers: **CHP** **ABCD** **MDAA**	Optional
63	Treatment Authorization Codes	If applicable, enter the Colorado Access authorization number for the services rendered.	Yes - if applicable
64	Document Control Number	N/A	N/A
65	Employer Name		No
66	Dx	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) - Enter "9"	Yes
67	Principal Diagnosis Code	Principal diagnosis, determined after study, using ICD-9-CM codes. The codes should match those on the Colorado Access prior authorization letter if an authorization has been obtained. (Continued on next page)	Yes

UB04/CMS 1450 Box Number	Data Element	Description	Required
67 (Continued)		**For Inpatient Admissions:** A CMS requirement mandates that hospitals provide a present on admission (POA) indicator as the 8th digit in field 67. Valid entries are: Y = Yes N = No U = Unknown W = Clinically Undetermined I = Unreported/Not Used	Yes
67 A - Q	Other Diagnosis Codes	Other applicable ICD-9-CM diagnosis codes. These should include codes for other conditions that existed during the episode of care being billed, but were not primarily responsible for admission **For Inpatient Admissions:** Include the POA indicator. See above.	Yes - if applicable
68	N/A		N/A
69	Amit Dx	Admitting Diagnosis - ICD-9-CM diagnosis code that represents the significant admitting diagnosis.	Yes - if inpatient
70 A, B, C	Patient Reason Dx	The diagnosis that represents the the reason for the patient's outpatient visit.	Yes - if outpatient
71	PPS Code	Prospective Payment System Code - The code that identifies the DRG.	Yes - if applicable
72	ECI	External Cause of Injury - the E-Code (ICD-9CM code) that represents the cause of injury, poisonings or adverse affects.	No
73	N/A		N/A
74	Principal Procedure Date	Principal procedure code and date the principal procedure was performed during this hospital stay. ICD-9-CM procedure codes are required. If more than one procedure is performed, the principal procedure should be the one related to the principal diagnosis, which was performed for definitive treatment of that condition and requires the highest skill level.	No
74 A - E	Other Procedure Date	Other procedure codes performed during the hospital stay. Enter the codes in descending order of importance.	No
75	N/A		N/A
76	Attending	Attending provider's National Provider Identifier (NPI) number, and the provider's Last and First name	Yes
77	Operating	Operating physician's National Provider Identifier (NPI) number, and the physician's Last and First name	Yes - if applicable

UB04/CMS 1450 Box Number	Data Element	Description	Required
78 - 79	Other	Other providers' National Provider Identifier (NPI) number, and the provider's Last and First name	Yes - if applicable
80	Remarks	Information when applicable.	No
81 a - d	CC	Codes that do not fit in the other code fields of the form, and externally maintained codes approved by NUBC for the institutional data set.	No

NON-CLINICAL ADJUSTMENT/APPEAL REQUEST

1. Please indicate the type of request you are submitting:

❑ **ADJUSTMENT** (claims may be adjusted in the event of underpayments or overpayments)
❑ **APPEAL** (A claim appeal relates solely to disagreements regarding claims payment or denial)

2. Please indicate the line of business your request is for:

❑ **Access Advantage** ❑ **Access Behavioral Care** ❑ **Access Child Health Plan Plus**

COMPLETE A SEPARATE REQUEST FOR EACH RECIPIENT AND/OR CLAIM AND INCLUDE THE FOLLOWING:

1) A copy of the claim in questions
2) A copy of the voucher showing the recent payment
3) Medicare/Third Party Liability - A copy of the Explanation of Benefits
4) Other documentation necessary
5) If you are making this appeal on the member's behalf, include an **Authorization of Representative Form**

Provider Name

Street Address

City, State, Zip Code

Contact Name	Telephone #

ALL FIELDS BELOW MUST BE COMPLETED

Member Identification Number:	Date of Service
Member Name	Voucher Date
Billing Provider TIN	Claim #

DESCRIBE REQUEST (YOUR DESCRIPTION MUST INCLUDE ANY PROCEDURE CODES/UNITS/AMOUNTS, ETC.)

Date: By (Provider Authorized Signature):

MAIL REQUEST TO: Colorado Access Appeals
PO Box 17189
Denver, CO 80217-0189

TO BE COMPLETED BY COLORADO ACCESS

❑ Reprocess to pay ❑ Reprocess to deny ❑ Void original claim

Comments:

Reviewed By: Date: