KIDMED
PROVIDER TRAINING

Medicaid Issues for 2004
(Fall Issue)

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

UNISYS

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Fall 2004 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

NOTICE TO ALL PROVIDERS

Pursuant to Chisholm v. Cerise DHH is required to inform both recipients and providers of certain services covered by Medicaid. The following two pages contain notices that are sent by DHH to some Medicaid recipients notifying them of the availability of services for EPSDT recipients (recipients under age 21). These notices are being included in this training packet so that providers will be informed and can help outreach and educate the Medicaid population. Please keep this information readily available so that you may provide it to recipients when necessary.

DHH reminds providers of the following services available for all recipients under age 21:

- Children under age 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. **This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.**

- Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

- Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment. **TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).**

- **Recipients may also CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544) for referral assistance with all services, not just transportation.**

*****DISCLAIMER: This information is currently being updated and some content may be incorrect or incomplete. If you are unable to get assistance using the telephone numbers listed under the specific programs, you may contact Medicaid Program Operations at 225-342-5774.**

FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD WAIVER WAITING LIST

The MR/DD Waiver Program provides services in the home, instead of institutional care, to persons who are mentally retarded or have other developmental disabilities. Each person admitted to the Waiver Program occupies a "slot." Slots are filled on a first-come, first-served basis. Services provided under the MR/DD Waiver are different from those provided to Medicaid recipients who do not have a Waiver slot. Some of the services that are only available through the Waiver are: *Respite Services; Substitute Family Care Services; Supervised Independent Living and Habilitation/Supported Employment*. There is currently a Waiting List for waiver slots.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

II. BENEFITS FOR CHILDREN AND YOUTH ON THE MR/DD WAIVER WAITING LIST

CASE MANAGEMENT

If you are a Medicaid recipient under the age of 21 and have been on the MR/DD Waiver Waiting list at any time since October 20, 1997, you may be eligible to receive case management *NOW*.

YOU NO LONGER NEED TO WAIT FOR THIS SERVICE. A case manager works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services), then assists you in obtaining them.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

Notice P-17
Revised November 1, 2000
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III. BENEFITS AVAILABLE TO ALL CHILDREN AND YOUTH UNDER THE AGE OF 21

THE FOLLOWING SERVICES ARE AVAILABLE NOW. YOU DO NOT NEED TO WAIT FOR A WAIVER SLOT TO OBTAIN THEM.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history, physical exam, immunizations, vision and hearing checks, and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed.

TO OBTAIN AN EPSDT SCREEN OR DENTAL SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EPSDT screens may help to find problems which need other health treatment or additional services. **Children under 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.** Some of these additional services are very similar to services provided under the MR/DD Waiver Program. There is no waiting list for these Medicaid services.

PERSONAL CARE SERVICES

Personal care services are provided by attendants to persons who are unable to care for themselves. These services assist in bathing, dressing, feeding, and other non-medical activities of daily living. PCS services *do not* include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. Once ordered by a physician, the PCS service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A PCS SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EXTENDED HOME HEALTH SERVICES

Children and youth may be eligible to receive *Skilled Nursing Services* and *Aide Visits* in the home. These can exceed the normal hours of service and types of service available for adults. These services are provided by a Home Health Agency and must be provided in the home. This service must also be ordered by a physician. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A HOME HEALTH SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

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PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AND AUDIOLOGY SERVICES

If a child or youth wants *Rehabilitation Services* such as *Physical, Occupational, or Speech Therapy, or Audiology Services* outside of or in addition to those being provided in the school, these services can be provided by Medicaid at hospitals on an outpatient basis, or, in the home from Rehabilitation Centers or under the *Home Health* program. These services must also be ordered by a physician. Once ordered by a physician, the service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THESES SERVICES AND LOCATING A SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

Children and youth can also obtain *Physical, Occupational, and Speech Therapy, Audiology Services, and Psychological Evaluations and Treatment* through early intervention centers (for ages 0-2) or through their schools (For ages 3-21). Medicaid covers these services if the services are a part of the IFSP or IEP. These services may also be provided in the home.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR EARLY INTERVENTION CENTER OR SCHOOL OR CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. *Medical Equipment and Supplies* must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

FOR ASSISTANCE IN APPLYING FOR MEDICAL EQUIPMENT AND SUPPLIES AND LOCATING MEDICAL EQUIPMENT PROVIDERS CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MENTAL HEALTH REHABILITATION SERVICES

Children or youth with mental illness may receive *Mental Health Rehabilitation Services*. These services include: clinical and medical management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. *MENTAL HEALTH REHABILITATION SERVICES MUST BE APPROVED BY THE LOCAL OFFICE OF MENTAL HEALTH*.

FOR ASSISTANCE IN APPLYING FOR MENTAL HEALTH REHABILITATION SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment.

TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at
1-877-455-9955 (or TTY 1-877-544-9544).

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OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

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Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Case Management
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD waiver, you may be eligible for case management services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

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Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

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KIDMED SCREENINGS

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a Medicaid program that was established by the Federal government in 1967. The purpose of the program is to provide low-income children with comprehensive health care. Louisiana began EPSDT services in 1972. The screening component of EPSDT is called KIDMED and includes medical, vision, and hearing screening services.

KIDMED providers have the responsibility for coordinating medical, vision, and hearing screenings. Medical, vision, and hearing screenings should be performed on the same day to prevent the child from having to return at a later date. The following pages discuss the elements of KIDMED screenings. Additional information, including a description of each component and who may conduct each component, is found in the KIDMED provider manual.

KIDMED Linkage

☞ **Providers cannot obtain KIDMED linkage through traditional forms of eligibility verification, such as REVS, MEVS, or e-MEVS. In order to obtain KIDMED linkage, providers must call Unisys or ACS. When requesting KIDMED linkage, providers must be specific as to whether they are requesting KIDMED or CommunityCARE linkage. In addition, when rendering a screening, the recipient must either be linked to the screening provider, or the screening provider must have a contractual agreement with the provider to whom the recipient is linked.**

MEDICAL SCREENING

Billing may not be submitted for a medical screening unless **all** of the following components are administered:

COMPONENTS OF THE MEDICAL SCREENING
1. Comprehensive health and developmental history (including assessment of both physical and mental health and development)
2. Comprehensive unclothed physical exam or assessment
3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents or guardians refuse at the time)
4. Laboratory tests (including appropriate neonatal, iron deficiency anemia, urine, and blood lead screenings)
5. Health education (including anticipatory guidance)

NOTE: All components, including specimen collection, must be provided on-site during the same medical screening visit.

The following procedure codes are used to bill for the medical screening:

99381*	Initial comprehensive preventive medicine; Infant (age under 1 year)
99382*	Initial comprehensive preventive medicine; Early Childhood (ages 1-4)
99383*	Initial comprehensive preventive medicine; Late Childhood (ages 5-11)
99384*	Initial comprehensive preventive medicine; Adolescent (ages 12-17)
99385*	Initial comprehensive preventive medicine; Adult (ages 18-20)
99391*	Periodic comprehensive preventive medicine; Infant (age under 1 year)
99392*	Periodic comprehensive preventive medicine; Early Childhood (ages 1-4)
99393*	Periodic comprehensive preventive medicine; Late Childhood (ages 5-11)
99394*	Periodic comprehensive preventive medicine; Adolescent (ages 12-17)
99395*	Periodic comprehensive preventive medicine; Adult (ages 18-20)

***Providers should use the TD Modifier in conjunction with the appropriate CPT code to report a screening that was performed by a nurse.**

Note: Providers must use the age appropriate code in order to avoid claim denial**.**

VISION SCREENING

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- any eye disorders of the child or his family
- any systemic diseases of the child or his family which involve the eyes or affect vision
- behavior on the part of the child that may indicate the presence or risk of eye problems
- medical treatment for any eye condition

Objective Vision Screening

KIDMED objective vision screenings (99173 -EP) may be performed by trained office staff under the supervision of a LICENSED Medicaid physician, physician assistant, registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective vision screenings begin at age 4. The objective vision screening must include tests of:

- visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);
- color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and
- muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

The following procedure code is used to bill for vision screening:

99173 with **EP** modifier	Vision Screening

HEARING SCREENING

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- the child's response to voices and other auditory stimuli
- delayed speech development
- chronic or current otitis media
- other health problems that place the child at risk for hearing loss or impairment

Objective Hearing Screening

KIDMED objective hearing screenings (92551) may be performed by trained office staff under the supervision of a LICENSED Medicaid audiologist or speech pathologist, physician, physician assistant, or registered nurse. The interpretive conference to discuss findings from the screenings must still be performed by a licensed physician, physician assistant, or registered nurse, as is currently the stated policy in the KIDMED manual.

Objective hearing screenings begin at age 4. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

The following procedure code is used to bill for hearing screening:

92551	Hearing Screening

Immunizations

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component, and failure to comply with or properly document the immunization requirement constitutes an incomplete screening and is subject to recoupment of the total medical screening fee. KIDMED follows the current Childhood Immunization Schedule recommended by ACIP, AAP, and AAFP, which is updated yearly. Providers are responsible for obtaining current copies of the schedule.

Laboratory

Age-appropriate laboratory tests are required at selected age intervals. Specimen collection must be performed in-house at the medical screening visit. A child cannot be sent to an outside laboratory to have blood drawn. Documented laboratory procedures provided less than six months prior to the medical screening should not be repeated unless medically necessary. **Iron deficiency anemia screening and urine screening when required are included in the KIDMED medical screening fee and CANNOT be billed separately.**

Providers should not bill Medicaid for lab services not performed in their own office.

SCREENING PERIODICITY POLICY

One important obligation of the KIDMED provider is to provide services according to the periodicity schedule. **KIDMED providers should follow the most current copy of the AAP, ACIP, and AAFP Recommended Childhood Immunization Schedule. This schedule should be replaced by KIDMED providers each year as revisions are published.**

Initial Screening

Initial screenings must be scheduled within the time limits given below upon notification by the Louisiana KIDMED office:

Newborns - immediately
Children one month to three years of age - within 45 days
Children three to six years of age - within 60 days
Children six to 21 years of age - within 120 days

Periodicity Restrictions

Screenings must be performed on time at the ages shown on the Periodicity Chart. For example, the screening due when the child is six months old must be performed after he or she has reached the age of six months, but before the seven-month birthday. The screening scheduled for three years of age must be performed between the child's third and fourth birthdays. In addition, the periodic screenings performed on children under two must be performed at least 30 days apart. Screenings performed after the child's second birthday must be at least six months apart. Claims submitted for KIDMED periodic screenings performed at an inappropriate time will not be paid.

Newborn Eligibility

An electronic process to obtain BHSF Form 152-N (Request for Newborn Medicaid ID Number) is available statewide. Each hospital has a unique ID and password for the purpose of logging in and submitting the forms electronically. The forms are received daily from participating hospitals statewide.

Off-Schedule Screenings

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring him or her up to date at the earliest possible time. **However, all screenings on children under two years of age must be at least 30 days apart, and those on children age two through six must be at least six months apart.**

INTERPERIODIC SCREENINGS

Interperiodic screenings may be performed if medically necessary. Any medical provider or qualified health, developmental, or educational professional that comes into contact with the child outside the formal health care system may request the interperiodic screening.

An interperiodic screening can only be billed if the recipient has been given an age-appropriate medical screening. If their medical screening has not been performed, the provider should bill an age-appropriate medical screening. It is not acceptable to bill for an interperiodic screening if the age-appropriate medical screening had not been performed.

An interperiodic screening by a KIDMED provider must contain all of the components required in the periodic screening. This includes a complete unclothed exam or assessment, health and history update, measurements, health education, and other age-appropriate procedures.

Providers should document in the recipient's records who requested the interperiodic screening, why it was requested, and the outcome of the screening. The concern, symptoms or condition that led to the request must be documented, as well as any diagnosis and/or referral resulting from the screening.

There is no limit on the number or frequency of medically necessary interperiodic screenings, or on their proximity to other screenings. Therefore, documenting who requested the interperiodic screening, why it was requested, and the outcome of the screening is essential.

Medically necessary laboratory, radiology, or other procedures may also be performed and should be billed separately. **A well diagnosis is not required.**

These codes are billed on the CMS-1500 form and are listed below. Completed examples are on pages 35 and 36.

Registered Nurse interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TD **plus** TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TD **plus** TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TD **plus** TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TD **plus** TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TD **plus** TS	Interperiodic Re-evaluation and Management (ages 18-21)

TD = Nurse
TS = Interperiodic screening

Physician interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TS	Interperiodic Re-evaluation and Management (ages 18-21)

TS = Interperiodic screening

DIAGNOSIS and TREATMENT

One of the purposes of KIDMED screening services is to assure that health problems are found, diagnosed, and treated early before they become more serious and treatment more costly. KIDMED providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions. **Any referrals made for these conditions must also be reported and documented.**

Diagnosis

When a medical, vision, or hearing screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening.

An infant or toddler who meets or may meet the medical or biological eligibility criteria for EarlySteps (infant and toddler early intervention services) must be referred to the local System Point of Entry (SPOE) **within two working days of the screening.** If the infant or toddler was not screened by a physician, the child must be referred promptly to a physician for a comprehensive examination as part of the EarlySteps assessment. The examination must be performed within 45 days of the referral to EarlySteps.

☞ EarlySteps (formerly known as Childnet) is the responsibility of DHH/Office of Public Health. For further information on EarlySteps refer to the Appendix.

Initial Treatment

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated **within 60 days of the screening.**

Providing or Referring Recipients for Services

KIDMED providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the patient for care without delay. Necessary referrals should be made at the time of screening if possible.

KIDMED providers performing diagnostic and/or initial treatment services should do so at the screening appointment when possible. Otherwise, KIDMED providers must ensure that recipients receive the necessary services within 60 days of the screening.

It is the provider's responsibility to discuss referral options with parents or guardians. You must forward necessary medical information to the 'referred-to' provider, and request from that provider a report of the results of the exam or services provided. This information should be maintained in the recipient's record.

You must follow up and verify that the child keeps the appointment and receives the services. This must be documented in the medical record. If the child missed the appointment, <u>you must make at least two good faith efforts to re-schedule and have a process in place to document these efforts</u>.

A sample referral follow up form (providers may develop their own) has been included in the Appendix for provider use.

Providers and recipients may contact ACS to obtain the names of participating Medicaid providers for referrals to any additional medical services:

KIDMED Hotlines:

ACS Hotline for Providers - (800) 259-8000
ACS Hotline for Recipients - (800) 259-4444
TTY Hotline for Hearing Impaired - (877) 544-9544

Referrals should not be limited to those services covered by Medicaid. For services Medicaid does not cover, KIDMED providers should attempt to locate other providers who furnish the services at little or no cost. Parents or guardians should be made aware of costs associated with services that Medicaid does not cover.

In-House Referral

If a suspected condition is identified and referred in-house, no office visit higher than 99212 is billable and payable to the same provider on the same date of service.

If any other level of office visit is billed by the same attending provider on the same day, the claim processed first (either the screening or the office visit) will pay, and the second claim will deny.

If an office visit higher than 99212 is billed in error on the same date of a screening (same recipient, same attending provider) and is paid, it will cause the screening claim to deny. The provider may adjust the office visit claim to procedure code 99211 or 99212 and then rebill the screening claim.

CONSULTATION CODES

Medical, vision, or hearing screening findings may indicate the need for counseling, consultation, or other intervention by ancillary personnel, including registered nurses, physician assistants, licensed social workers, and registered dietitians, beyond the basic health education and anticipatory guidance components of the medical screening. Services provided by these professionals, billed by an enrolled KIDMED provider certified to bill medical screenings, may be reimbursed if provided to prevent a specific health or mental health problem or condition, to treat or alleviate an actual medical or mental health problem or condition.

- The child must have received an age-appropriate KIDMED screening in order for these services to be reimbursable.

Consultation codes are short term codes not designed with episodic or continuous therapy in mind. These codes allow payment for a service identified through the KIDMED screener, who continues to see and have access to the patient in an environment which is conducive to rendering the service, such as in a school, early intervention setting or in a physician's office where the physician serves as a continuing care provider.

KIDMED consult codes are to be specific to an individual child's needs. Documentation should be present justifying the need for the consult for that particular child. **Consult codes are not to be used for ongoing treatment.** Outcomes for the consults are to be documented as well as referrals to appropriate resources for those conditions that might require further attention.

- Consults are to be face-to-face contact in one-on-one sessions. Group sessions are not allowed. Multiple units may not be billed for the same contact.

KIDMED clinics which assume the role primarily as a screener should bill these codes infrequently. One screening provider should never refer to another screening provider for the provision of these services.

The following table identifies consultation procedure codes:

Procedure Code	Description
T1001	Nursing Assessment/Evaluation
S9470	Nutritional Counseling, Dietitian Visit
99211-AJ	Office or other Outpatient Visit for Evaluation and Management of an Established Patient, Minimal Problem(s)

AJ = Social Worker

Consultation Policy Reminders

- Procedure codes T1001, S9470, 99211-AJ **may not** be billed for preventive counseling, anticipatory guidance, or health education provided on the date of the medical screening by the same provider since these services are a component of the screening.

- Procedure codes T1001, S9470, 99211-AJ **may not** be billed on the same date that the same provider bills a physician's evaluation and management visit.

- The social worker (LCSW) consult code (99211-AJ) is not for treatment of mental illness or emotional disturbances**.** Ongoing therapy is payable by Louisiana Medicaid under the Mental Health Rehabilitation Program and appropriate referrals should be made.

- The KIDMED consultation codes are billed on the CMS 1500/837P.

KM-3 INFORMATION

KM3 Form

The KM-3 form should be used when filing for Medicaid reimbursement of screening services provided under the Medicaid EPSDT KIDMED Program. **The screening services include the medical, vision, and hearing screening only**. KM-3 claim forms undergo preliminary processing before the adjudication cycle that results in claim denial or approval on the remittance advice. Once the claims have been entered into the KIDMED system, they are processed to check for errors and missing information. Certain claim errors cause a Resubmittal Turnaround Document (RTD) to be generated to the provider so that corrections may be made directly to the RTD and mailed back to Unisys. More information regarding RTDs can be found on pages 56-57.

Form Completion Reminders

- CPT codes 99381 – 99385 or 99391 – 99395 should be used for medical screenings. Please use the appropriate code to reflect the age of the child and whether or not the screening is an initial or periodic screening.
- Modifier **TD** should be used in conjunction with the appropriate CPT code to report that a screening was performed by a nurse.
- Vision screenings should be billed with CPT code 99173, with modifier -EP.
- Hearing screenings should be billed with CPT code 92551.
- The "Date of Screening" and the amount of the "Billed Charge" must be completed.
- **ONLY** Rural Health Clinics/Federally Qualified Health Centers should complete the "Encounter" block on the KM3 form.
- Item 29 (completeness of immunizations) must always be completed. If the answer is "no", then item 30 must also be completed (please see claim example on page 19).
- Item 31 (suspected conditions) must always be completed. If the answer is "yes", then item 32 must also be completed. If item 32 indicates anything other than undercare, then item 33 must be completed. There must be a referral for each suspected condition which is not undercare (see claim examples on pp. 19 and 20).
- If the recipient is linked to a CommunityCARE PCP that is not the KIDMED provider performing the screening, it will be necessary to indicate the CommunityCARE provider that the recipient *is* linked to in item 9. This should only happen if the KIDMED provider performing the screening has a contractual arrangement with the CommunityCARE PCP. An example is shown on p. 20.
- If the KIDMED provider that the recipient is linked to for KIDMED services is unable to perform the screening and requests that another KIDMED provider perform the screening services for them, the KIDMED provider that has the recipient's KIDMED linkage must forward a referral to the screening KIDMED provider.

REMINDER: Information on the claim form may be handwritten or computer generated. All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

KM3 FORM COMPLETION INSTRUCTIONS

Item No. **Description and details**

1. **Type of claim -** There are three choices in this box. Providers may choose only one, entering a checkmark as appropriate.

Check "original" if this is the original screening claim for this recipient for the service date indicated in item 25. If submitting an "original," skip directly to item 4.

Check "adjustment" if this claim adjusts a previously submitted claim for this recipient for the service date indicated in item 25.

Check "void" if this claim voids a claim already submitted for this recipient for the service date indicated in item 25.

If there is no checkmark in this block, it is considered to be an original claim.

2. **Reason** If "adjustment" or "void" is indicated in item 1, providers must complete item 2 by entering the applicable two-digit code:

	Code	Explanation
Adjustments	02	Adjustment due to provider error
	03	Adjustment not due to provider error
Voids	10	Void due to claim paid for wrong recipient
	11	Void due to claim paid to the wrong provider

3. **Adjustment ICN -** Complete this item only if Item 2 was completed. Enter the 13-digit Internal Control Number (ICN) as listed on the remittance advice for the original claim being adjusted or voided.

4. **Billing Provider No. -** Enter the provider's seven-digit KIDMED Medicaid Provider Number.

5. **Billing Provider Name -** Enter up to 17 letters of the billing provider's name, starting with the last name first and leaving a space between the last and first names. For example, William Sutherland, M.D., would be entered as "Sutherland (space) Willia." If the billing provider is a facility or agency, enter the name of the facility or agency.

6. **Site Number -** This item applies only to providers who have more than one screening site. Providers with only one site should skip to item 7. For providers with more than one screening site, enter the valid three-digit site code at which the screening was conducted. If the site code has less than three digits, fill the empty spaces to the left with zeros. For example, if the site code is 1, enter "001".

7. **Attend Provider No. –** Leave blank.

8. **Attend Provider Name –** Leave blank.

9. **Refer Provider No**. – Complete this item only if the recipient is linked to another KIDMED provider. Enter the CommunityCARE PCP's, or the KIDMED provider's, 7-digit Medicaid provider number.

10. **Medicaid No**. - Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS, or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.

11. **Patient Last Name -** Enter the first 17 letters of the recipient's last name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility systems. If the name has less than 17 letters, leave the remaining spaces blank.

12. **Patient First Name -** Enter up to 12 letters of the recipient's first name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility systems. If the name has less than 12 letters, leave the remaining spaces blank.

13. **Date of Birth -** Enter the six-digit date of birth for the recipient, using the MMDDYY format so that all spaces are filled. The recipient must be under age 21 on the date of the screening. Do not leave any of the spaces blank.

14. **Sex -** This item is optional. Enter "M" for male or "F" for female.

15. **Race -** This item is optional. Enter one of the following codes:

Unknown	0	Hispanic or Latino	5
White	1	Native Hawaiian/ Pacific Islander	6
Black or African American	2	Hispanic/Latino and one or more	7
American Indian or Alaskan Native	3	More than one race (Hispanic or	
Asian	4	Latino not indicated)	8

16. **Medical Record No**. - This item is optional. It may be used to cross-reference a patient's medical record number. Enter up to 18 alphabetical and/or numerical characters that have been assigned as the patient's medical record number.

17. **Patient Address -** This item is optional. Enter the recipient's street address or P.O. Box number, starting at the left of the block. Leave any unused spaces blank.

18. **City -** This item is optional. Enter up to nine letters of the city in which the recipient lives, starting at the left of the block. Leave any unused spaces blank.

19. **State -** This item is optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).

20. **Zip Code-** This item is optional. Enter the zip code for the recipient's address.

21. **Patient Home Phone –** Complete this item if the recipient has a home phone number or a contact phone number. Enter the three-digit area code and seven-digit home or contact phone number.

22. **Patient Work Phone –** Complete this item if the recipient has a work phone number. Enter the three-digit area code and seven-digit work phone number.

23. **Parent/Guardian Last Name -** This item must be completed for all recipients living with a parent or guardian. A foster parent or adoptive parent is considered a guardian. Enter up to 17 letters of the parent or guardian's last name, starting at the left of the block. Leave any unused spaces blank. If the recipient is not living with a parent or guardian, leave this item blank and skip to item 25.

24. **Parent/Guardian First Name –** Complete only if item 23 is completed. Enter up to 12 letters of the parent or guardian's first name, starting at the left of the block. Leave any unused spaces blank.

The next part of the claim form documents what type of provider performed the screening. It also documents the screening fee. In addition, it records information about future screenings scheduled.

Providers may bill for four types of screenings:

- **Medical Screening Nurse (99381-99385 and 99391-99395)** This is a medical screening where a registered nurse or physician assistant conducted the **complete unclothed physical exam** and other required age-appropriate medical screening components, including age-appropriate immunizations.

  REMINDER: The above codes **MUST BE** billed with **modifier TD**, indicating that a nurse performed the screening.

- **Medical Screening Physician (99381-99385 and 99391-99395) -** This is a medical screening where a licensed physician conducted the **complete unclothed physical exam** and other required age appropriate medical screening components, including age-appropriate immunizations.

  ☞ Providers must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conducted the screening, **the individual performing the physical exam or assessment should be entered**.

- **Vision (99173-EP) -** This is an objective vision screening conducted by a licensed physician, physician assistant, registered nurse, licensed optometrist, or trained office staff under the supervision of one of the above listed licensed professionals. **No claim will be paid on a child under age four.**

- **Hearing (92551)-** This is an objective hearing screening conducted by a licensed physician, physician assistant, registered nurse, licensed and ASHA-certified audiologist, licensed and ASHA-certified speech pathologist, or trained office staff under the supervision of one of the above listed licensed professionals. **No claim will be paid on a child under age four.**

A vision and/or hearing screening will be approved only if there is an age appropriate medical screening listed.

☞ **Only Rural Health Clinics and Federally Qualified Health Centers should complete the block marked "Encounter". ALL other KIDMED providers should leave blank.**

Providers may bill for appropriately performed medical, objective vision, and/or objective hearing screenings on the same screening claim form in any combination.

25. **Date of Screening -** For **each** applicable line, enter the date of the screening. For proper reimbursement, providers must date **each** screening type for which they are billing.

26. **Billed Charge -** For **each** line completed in item 25, enter the appropriate charge for services rendered, using four digits for dollars and cents. For example, $51.00 would be entered as “5100".

27. **Next Screening Appointment Date -** If a future screening appointment has been scheduled, enter the six-digit appointment date for each applicable line. If no future appointments have been made at the time the claim form is completed, leave blank and skip to item 29.

28. **Time -** If a future screening appointment has been scheduled, enter the appointment time.

29. **Immunization Status -** This item is required and must be completed for **medical screenings only**. Providers must certify whether the recipient's immunizations are complete and current for his or her age. Check "Yes" if immunizations are complete and current for this recipient. Check "No" if they are not. If "Yes" is indicated, skip to item 31.

30. **Reason -** If providers indicate in item 29 that immunizations are not current and complete, they must check the appropriate box explaining why. Check "A" in the case of medical contraindication. Check "B" if the parents or guardians refuse to permit the immunization. Check "C" if immunizations are off schedule. For example, check "C" if the recipient received an immunization at this visit but is still due one for his or her age. Do not check "C" if immunizations are off schedule and immunizations were not given.

31. **Presence or absence of suspected conditions -** This item is required and relates to screening findings. If no suspected conditions are found, check "no" and skip to item 36. If one or more suspected conditions are found, check "yes" and proceed to item 32.

32. **Nature of suspected conditions and referral strategy -** This item documents the general types of suspected conditions identified during the screening and whether or not a referral was made in-house (includes self-referrals) or offsite. Complete it by checking the appropriate boxes. For example, if a suspected medical condition was found for which the recipient is already under care by any provider, check the far left box on the first line. If a suspected nutritional condition is found and has been self-referred, check the far right column on the fifth line (E). If a suspected psychological/social condition is found and an outside referral is made, check the middle column on the eighth line (H). Be sure to enter information about all suspected conditions found. Do not make any entries on lines J through L.

☞ Note that each of these items may require that up to eight different kinds of information are entered in the spaces marked A, B, C, D, E, F, H, and I.

33-35. **Referrals for Suspected Conditions -** Providers must complete at least one of these items if any suspected conditions are listed in item 32 as being referred in-house or offsite. The number of items completed will depend on how many conditions were found in the screening and on the referrals made. If more than four suspected conditions are found, providers must fill out at least items 33 and 34. If more than eight suspected conditions are found, providers must fill out items 33 through 35. Also, one item must be completed for each referral made. If there are more referrals than blocks 33-35 will accommodate, such referrals should be documented in the recipient’s chart and would not be listed on the claim form.

33A. Suspected Condition - Referring back to item 32, enter in item 33A up to four letters (A through I), identifying the type of condition(s) identified. Remember, the referral may cover up to four conditions, but only one referral provider. Start at the left of the block, and leave any unused spaces blank. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., "URI") here—that information should be entered in 33E.**

33B. Referral Assist Needed - Check "no," as this block is no longer used to obtain referral assistance. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact ACS at (877) 455-9955.

33C. Appointment Date - If the recipient is referred either in-house or offsite, enter the date of the appointment. The appointment date should be estimated if it is not known at the time the claim form is completed.

33D. Appointment Time - If the recipient is referred either in-house or offsite, enter the time of the appointment. The appointment time should be estimated if it is not known at the time the claim form is completed.

33E. Reason for Referral - Enter the reason for the referral, using up to 40 letters and/or the ICD-9 diagnostic codes. In addition, if referral assistance is needed because the referred-to provider requires direct contact with the recipient, indicate so here.

33F. Referred To - If an in-house or offsite referral is made, enter up to 20 letters of the name of the specific provider to whom the recipient was referred, starting with the last name first. Be as specific as possible. For example, if the recipient was referred to a large facility, give the name and department onsite. If self-referred, enter "self" for this item. Skip to item 36 if there is no other referral information to report.

33G. (Blank) - Do not enter any data here. This item is reserved for future use by KIDMED.

33H. Phone No. - If an in-house or offsite referral has been made, enter the area code and seven-digit phone number of the referred-to provider. If a self-referral has been made, leave this item blank.

33I. Transportation Assistance Needed - Check "no," as this block is no longer used to obtain transportation assistance. The recipient (or the recipient's parent) should contact the Medical Dispatch Office in his region. These telephone numbers are listed in the Medicaid Services Chart.

36. Providers must read and sign the certification statement at the bottom of the screening claim form in order to be paid. Providers may use a signature stamp if it is initialed by the individual completing the form. If a claim form is received without a signature on it the claim form will not be processed and will be returned to the billing provider. A signature certifies that all components of the screening have been provided**.**

KM-3 claim forms should be mailed to:

Unisys
P.O. Box 14849
Baton Rouge, LA 70821

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	09 01 1999		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	10 15 04	5100		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	10 15 04	400		
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				5500		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [X] YES [ ] NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
- A. [ ] MEDICALLY CONTRAINDICTED
- B. [ ] PARENTAL REFUSAL
- C. [ ] OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? [ ] YES [X] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? [ ] Yes [ ] No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO		G.	
H. PHONE NO. ( ) –		I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO	

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? [ ] Yes [ ] No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO		G.	
H. PHONE NO. ( ) –		I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO	

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? [ ] Yes [ ] No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
E. REASON FOR REFERRAL			
F. REFERRED TO		G.	
H. PHONE NO. ( ) –		I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO	

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:
- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Ima Biller — 36. SIGNATURE OF PROVIDER

10/16/04 — 37. DATE

02/03

KM-3

FISCAL AGENT COPY

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	09 01 1999		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99383	TD	10 15 04	51 00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	10 15 04	3 60		
HEARING	92551		10 15 04	4 00		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				58 60		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [X] YES [ ] NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
- A. [ ] MEDICALLY CONTRAINDICTED
- B. [ ] PARENTAL REFUSAL
- C. [ ] OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? [ ] YES [X] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? [ ] Yes [ ] No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? [ ] Yes [ ] No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? [ ] Yes [ ] No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) – | I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:
- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Ima Biller — 36. SIGNATURE OF PROVIDER

10/16/04 — 37. DATE

02/03

KM-3

FISCAL AGENT COPY

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

ENCOUNTER

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Susie	09 01 1999		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 - 1212	( ) -	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99382	TD	10 15 04	51 00		
MEDICAL SCREENING PHYSICIAN						
VISION	99173	EP	10 15 04	4 00		
HEARING	92551		10 15 04	3 60		
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				58 60		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [ ] YES [X] NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. [X] MEDICALLY CONTRAINDICTED
B. [ ] PARENTAL REFUSAL
C. [ ] OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? [X] YES [ ] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE		
		X	A. MEDICAL	
			B. VISION	
			C. HEARING	
			D. DENTAL	
			E. NUTRITIONAL	
			F. DEVELOPMENTAL	
			G. ABUSE/NEGLECT	
			H. PSYCHOLOGICAL/SOCIAL	
			I. SPEECH/LANGUAGE	
			J.	
			K.	
			L.	

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
A	[ ] Yes [X] No	10 20 04	9 00

E. REASON FOR REFERRAL: GERD

F. REFERRED TO: Dr Tim Smith

G.

H. PHONE NO.: (225) 555 - 2111

I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [X] NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO

G.

H. PHONE NO.: ( ) -

I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO

G.

H. PHONE NO.: ( ) -

I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:

- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Ima Biller — 36. SIGNATURE OF PROVIDER

10/16/04 — 37. DATE

02/03

KM-3

FISCAL AGENT COPY

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

1. [X] ORIGINAL [ ] ADJUSTMENT [ ] VOID
2. REASON 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				1111111

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Tara	09 01 2003		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN	99392		10 15 04	51 00		
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				51 00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [X] YES [ ] NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. [ ] MEDICALLY CONTRAINDICTED
B. [ ] PARENTAL REFUSAL
C. [ ] OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? [X] YES [ ] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
	X		F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
F	[ ] Yes [X] No	10 21 04	10 00

E. REASON FOR REFERRAL: Speech delay

F. REFERRED TO: ABC Therapy — G.

H. PHONE NO.: (225) 555 8255 — I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [X] NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO — G.

H. PHONE NO. — I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	[ ] Yes [ ] No		

E. REASON FOR REFERRAL

F. REFERRED TO — G.

H. PHONE NO. — I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [ ] NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:

- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

Ima Biller — 36. SIGNATURE OF PROVIDER

10/16/04 — 37. DATE

02/03

KM-3

FISCAL AGENT COPY

ADJUSTMENTS AND VOIDS ON THE KM-3 FORM

The KM-3 form can be used to adjust or void incorrect payments made on medical, vision or hearing screenings. Electronic submitters may electronically submit adjustment/void claims. An example of a correctly completed adjustment is shown on the following page.

ADJUSTING/VOIDING CLAIMS

The appropriate block for **"adjustment"** or **"void"** must be checked at the top of the KM-3. One of the following reason codes must be listed in Block 2 of the KM-3:

	Code	Explanation
Adjustments	02	Adjustment due to provider error
	03	Adjustment not due to provider error
Voids	10	Void due to claim paid to wrong recipient
	11	Void due to claim paid to wrong provider

The most recently approved control number must be listed in Block 3 of the KM-3 form.

Only **one** (1) control number can be adjusted or voided on each KM-3 form.

Only an **approved claim** can be adjusted or voided.

Block 3 must contain the claim's most recently approved control number. For example:

1. A claim is approved on the remittance advice dated 10/01/2004, ICN 4266156789000.
2. The claim is adjusted on the remittance advice dated 02/15/2005, ICN 5040126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number, 5040126742100, must be used.

Adjustments: To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, **changing the item that was in error to show the way the claim should have been billed.** The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the remittance advice. The original payment will be taken back on the same remittance advice. in the "previously paid" column.

Voids: To file a void, the provider must enter all the information from the original claim **exactly as it appeared on the original claim**. When the void claim is approved, it will be listed under the "void" column of the remittance advice and a corrected claim may be submitted (if applicable).

KM-3 adjustment/voids should be mailed to the following address for processing:

Unisys
P.O. Box 14849
Baton Rouge, LA 70898

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING
SCREENING SERVICES

1. ☐ ORIGINAL ☒ ADJUSTMENT ☐ VOID
2. REASON: 02
3. ADJUSTMENT ICN: 4000198765432

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.
1234567	Kids R Us				1111111

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE
1234567891234	Smith	Tara	09 01 2003		

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
(225) 555 – 1212	( ) –	Smith	Mary

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE	99392	TD	10 15 04	51 00		
MEDICAL SCREENING PHYSICIAN						
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT				51 00		

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☒ YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
- A. ☐ MEDICALLY CONTRAINDICTED
- B. ☐ PARENTAL REFUSAL
- C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☒ YES ☐ NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
		X	F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
F	☐ Yes ☒ No	10 21 04	10 00

E. REASON FOR REFERRAL: Speech delay

F. REFERRED TO	G.
ABC Therapy	

H. PHONE NO.	I. TRANSPORTATION ASSISTANCE NEEDED?
(225) 555 - 8255	☐ YES ☒ NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ Yes ☐ No		

E. REASON FOR REFERRAL

F. REFERRED TO	G.

H. PHONE NO.	I. TRANSPORTATION ASSISTANCE NEEDED?
( ) –	☐ YES ☐ NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED?	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)
	☐ Yes ☐ No		

E. REASON FOR REFERRAL

F. REFERRED TO	G.

H. PHONE NO.	I. TRANSPORTATION ASSISTANCE NEEDED?
( ) –	☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

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- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

02/03

Ima Biller — 36. SIGNATURE OF PROVIDER

10/29/04 — 37. DATE

KM-3

FISCAL AGENT COPY

KM-3 FORM TIMELY FILING GUIDELINES

Unisys must receive initial KM-3 claim forms for screening services within 60 days from the date of service. Resubmissions must be received within 1 year and 60 days from the date of service and must be accompanied by proof of timely filing.

Proof Of Timely Filing

Acceptable forms of proof of timely filing are limited to the following:

- A remittance advice indicating that the claim was processed within 60 days from the date of service.

The following reports can suffice as proof of timely filing only if **detailed** information is indicated on the report. Refer to page 47 for additional information.

- KIDMED report CP-0-115 (Recycled Claims Listing)
- KIDMED report CP-0-50 (Denied Claims List)
- KIDMED report CP-0-50 (Resubmittal Turnaround Document)
- KIDMED report CP-0-51 (Electronic Media Claim Proof List)
- Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

☞ The medical referral form from the MAP Units (Form 6-MAP) **will not** be accepted as proof of timely filing.

Dates Of Service Over 1 Year And 60 Days Old

Claims with dates of service over 1 year and 60 days old are not to be submitted to Unisys or the BHSF for overriding the timely filing edit unless one or more of the guidelines below is met:

- The recipient was certified for retroactive Medicaid benefits;
- The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits; or
- The failure of the claim to pay was the state's fault, rather than the provider's fault, **each** time the claim was adjudicated.

The provider filing the claim is responsible for supplying supporting documentation and showing that one or more of the above conditions are met.

Electronic Data Interchange (EDI) for KIDMED/Preventive Medicine Claims

HIPAA COMPLIANT TRANSACTIONS

HIPAA mandates that providers billing electronically transition from the currently accepted Louisiana Medicaid proprietary software and Key Master software to the HIPAA standardized EDI specifications. The electronic HIPAA transaction accepted for billing KIDMED/preventive medicine claims is the 837P Professional format, including the K3 KIDMED segment. If you currently submit KIDMED/preventive medicine claims electronically to Louisiana Medicaid and are not using the 837P specifications, your current method **WILL NOT be HIPAA compliant** without modification by your Software Vendor, Billing Agent or Clearinghouse (VBC).

Louisiana is currently accepting HIPAA compliant 837P claim transactions for the KIDMED Program, and discussions are underway to determine the final date on which proprietary KIDMED claims will be accepted by Louisiana Medicaid.

EMERGENCY RULE REQUIREMENTS

The Department of Health and Hospitals promulgated an emergency rule requiring all Medicaid providers performing KIDMED/preventive medicine services to submit information to the Medicaid Program regarding recipient immunizations, referrals, and health status. Thus, KIDMED providers MUST submit claim data concerning not only the actual screening and immunization services provided, but also the immunization status; suspected conditions; and referral information related to suspected conditions.

Please communicate these requirements to your VBC, and let them know that the "file extension" on the electronic file MUST be KID, not PHY.

Effective December 1, 2004, KIDMED/preventive medicine providers will see an **educational edit** appear with any payments for KIDMED services if ALL applicable KIDMED claim detail information (including immunization status, suspected conditions, and referral information) is NOT provided on the claim. **This applies to electronic and hard copy claim submissions.**

The new KIDMED edit 517 (KIDMED Format Required – Claim must be submitted in KIDMED format) will initially serve as a provider notification that the claim does not contain all necessary detail information required. Ultimately, an edit will be set to **deny** KIDMED claims that are submitted without the required detail information.

Providers who are submitting KIDMED/preventive medicine claims using the 837P professional transaction WITHOUT the K3 segment completed should **immediately begin** submitting the 837P KIDMED transaction **and include the K3 segment with the transmission.** A new edit 518 (KIDMED information missing – immunization and suspected condition information required) will initially appear as an educational edit **and will ultimately deny claims that are submitted on the 837P or the CMS-1500 claim form without KIDMED detail.**

Providers who will continue to bill paper claims and currently submit the CMS 1500 claim form with only the screening procedure codes should immediately begin submitting the KM-3 claim form with all detail information.

KIDMED DETAIL INFORMATION WITHIN THE 837P TRANSACTION

The following information may be helpful in communicating these new requirements to your VBC.

Within the 837P transaction is the K3 claim segment which contains detailed information specifically related to the KIDMED screening services provided. Louisiana Medicaid uses the K3 segment to collect the information related to immunization status, suspected conditions and referral information. This segment mirrors what is currently collected on the KM-3 paper claim. As with previous electronic and paper submissions, providers must certify with each claim whether or not the recipient's immunizations are complete and current for his/her age.

The following information is required for each KIDMED claim and appears in the K3 segment once the claim is submitted to Louisiana Medicaid:

Immunization Status (Required Information)
Values in this segment are answered with Y (Yes) or N (No). If the status is N (No) then the following information is also required:
A - if the immunizations are not complete due to medical contraindication;
B - if the parent(s) or guardian(s) refuse to permit the immunization;
C - if the patient is off schedule, having received an immunization at this visit but is still due one.

Screening Finding (Required Information) - Screening results must be reported as follows:

Field qualifier SC (Suspected Conditions)
Initially, this segment is answered with Y (Yes) or N (No). If the value is Y (Yes), additional information or type of suspected condition is required as follows:

A=Medical	D= Dental	G=Abuse/Neglect
B=Vision	E=Nutritional	H=Psychological/Social
C=Hearing	F=Developmental	I=Speech/Language

After each suspected condition is identified, the referral type is also required:

U (if already under care)
O (if referred offsite)
I (if being treated in-house.)

At least one referral type must be entered. Up to three types of referrals may be entered for each condition if applicable.

NOTE 1: No more than four (4) suspected conditions may be entered. If more than four apply, enter the most significant based on medical judgment.

NOTE 2: Any of the nine (9) types of suspected conditions may be entered.

Referral Information (Suspected Conditions)

If a referral is indicated, referral information must be provided using appropriate values and data including:

Referral Number (R1)
Appointment Date
Referral Reason
Provider name
Referral Phone Number

If additional referrals have been given, give the required information for each additional referral, identifying the second referral with a qualifier R2 and the third referral with R3 if needed.

If the referral was made as a result of the EPSDT screening service, a Y (Yes) indicator is also required in the loop. If no suspected health conditions were identified and no referral resulted from the EPSDT screening service, enter N (No).

The referral outcome should be indicated as follows:

AV Patient refused the referral.
S2 Patient is currently under care for the referred condition
ST Patient was referred to another provider as a result of at least one suspected condition identified during the screening. (If several conditions apply as a result of a screening service, this value should take precedence.)

CURRENTLY APPROVED SOFTWARE VENDORS

Listed below are the Software Vendors are currently approved to submit 837P KIDMED transactions to Louisiana Medicaid:

Acadiana Computer System	337-981-2494
Computer Technology and Software of Stonewall	318-925-1048
DataTel Solutions	210-558-3733
MD Technologies	225-343-7169
Med Data Services	985-892-3225
Medtron Software Intelligence	985-893-2550
Michel & Pratt Consulting	337-310-4202
Professional Management & Billing Service	337-625-4616
Public Consulting Group	617-426-2026

NOTE: This list of approved vendors is updated monthly. To download a current VBC list, log onto www.lamedicaid.com. Click on the "HIPAA Information Center" link. The VBC List can be downloaded from the page.

If your Vendor's software is not approved, you should contact your vendor to determine if they have begun the testing process. If the vendor has not begun testing, encourage them to begin the process. (Providers who develop their own electronic means of submitting claims to Louisiana Medicaid are considered vendors.)

Enrollment forms may be downloaded from the web site, www.lamedicaid/hipaa.com or by emailing a request for enrollment to the HIPAA EDI group at *hipaaedi@unisys.com or by calling 225-237-3318.

VACCINES FOR CHILDREN & LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE

Vaccines For Children (VFC)

VFC is covered under Section 1928 of the Social Security Act. Implemented on October 1, 1994, it was an "unprecedented approach to improving vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers."

The goal of VFC is to ensure that no VFC-eligible child contracts a vaccine preventable disease because of his/her parent's inability to pay for the vaccine or its administration.

Persons eligible for VFC vaccines are between the ages of birth through 18 who meet the following criteria:

- Eligible for Medicaid
- No insurance
- Have health insurance, but it does not offer immunization coverage and they receive their immunizations through a Federally Qualified Health Center
- Native American or Alaska native

Providers can obtain an enrollment packet by contacting the Office of Public Health's (OPH) Immunization Section at (504) 483-1900.

Louisiana Immunization Network For Kids Statewide (LINKS)

LINKS is a computer-based system designed to keep track of immunization records for providers and their patients.

The purpose of LINKS is to consolidate immunization information among health care providers to assure adequate immunization levels and to avoid unnecessary immunizations.

LINKS can be accessed through the OPH website: WWW.OPH.DHH.STATE.LA.US.

LINKS will assist providers within their medical practice by offering:

- Immediate records for new patients
- Decrease staff time spent retrieving immunization records
- Avoid missed opportunities to administer needed vaccines
- Fewer missed appointments (if the "reminder cards and letter" option is used)

LINKS will assist patients by offering:

- Easy access to records needed for school and child care
- Automatic reminders to help in keeping children's immunizations on schedule
- Reduced cost (and discomfort to child) of unnecessary immunizations

Providers can obtain an enrollment packet, or learn more about LINKS by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 483-1900.

Immunizations

In order for providers to receive reimbursement for the administration of immunizations, providers must indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s). All vaccine CPT codes will be paid at zero ($0) because the provider obtains the vaccine from the Vaccines for Children Program at no cost. The listing of the vaccine on the claim form is required for federal reporting purposes.

Billing For a Single Administration

Providers should bill CPT code 90471 (Immunization administration…one vaccine) when administering one immunization. The next line on the claim form must contain the specific CPT code for the vaccine, with $0.00 in the "billed charges" column (see p. 37 for an example).

Billing For Multiple Administrations*

When administering more than one immunization, providers should bill as described above for the single administration. Procedure code 90472 (Immunization administration…each additional vaccine) should then be listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed after CPT code 90472 should match the number of units associated with CPT code 90472. An example of this scenario is on page 38.

*Hard Copy Claim Filing for Greater Than Four Administrations

When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations. An example is shown on pages 39 and 40.

☞ **COMBINATION VACCINES ARE ENCOURAGED IN ORDER TO MAXIMIZE THE OPPORTUNITY TO IMMUNIZE AND TO REDUCE THE NUMBER OF INJECTIONS A CHILD RECEIVES IN ONE DAY.**

Flu Vaccine: Special Situations

If the flu vaccine is not available through the VFC program and Medicaid providers choose to use flu vaccine obtained elsewhere for Medicaid recipients, the **ADMINISTRATION** is reimbursable by Medicaid. If the provider intends to charge the recipient for the vaccine, the following must occur: ***PRIOR*** to the injection, providers **MUST INFORM** recipients that when the actual vaccine does not come from the VFC, the recipient can be responsible for the cost of the vaccine.

The following chart lists vaccines for immunization services.

BILLABLE VACCINE CODES	
Vaccine Code	**Description**
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HEPA-HEPB), adult dosage, for intramuscular use
90645*	Hemophilus Influenza B vaccine (HIB), HBOC conjugate, 4-dose schedule, for intramuscular use
90646*	Hemophilus Influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus Influenza B vaccine (HIB) PRP-OMP conjugate, 3-dose schedule, for intramuscular use
90648*	Hemophilus Influenza B vaccine (HIB), PRP-T conjugate, 4-dose schedule, for intramuscular use
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657*	Influenza Virus vaccine, split virus, 6-35 months dosage, for intramuscular use
90658*	Influenza Virus vaccine, split virus, 3 years and above dosage, for intramuscular use
90660^	Influenza Virus vaccine live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680	Rotavirus vaccine, tetravalent, live, for oral use
90690^	Typhoid vaccine, live, oral use
90691^	Typhoid vaccine, VI capsular polysaccharide (VICPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)
90698	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Haemophilus influenza Type B, and Poliovirus vaccine, inactivated, (DT-aP-Hib-IPV) for intramuscular use
90700 *	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine (DTAP) for intramuscular use
90701	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and Tetanus Toxoids (DT) absorbed for use in individuals younger than 7 years, for intramuscular use
90703	Tetanus Toxoids for trauma, for intramuscular use
90704	Mumps Virus vaccine, live, for subcutaneous use
90705	Measles Virus vaccine, live, for subcutaneous use
90706	Rubella Virus vaccine, live, for subcutaneous use
90707*	Measles, Mumps and Rubella Virus vaccine (MMR), live, for subcutaneous
90708	Measles and Rubella Virus vaccine, live, for subcutaneous use
90710	Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use

BILLABLE VACCINE CODES	
Vaccine Code	**Description**
90712	Poliovirus vaccine, any type(s), (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90715	Tetanus, Diphtheria Toxoids and Acellular Pertusis vaccine (TdaP), for use in individuals 7 years or older, for intramuscular use
90716*	Varicella Virus vaccine, live, for subcutaneous use
90717	Yellow Fever vaccine, live, for subcutaneous use
90718*	Tetanus and Diphtheria Toxoids (TD) adsorbed for use in individuals 7 years or older, for intramuscular use
90719	Diphtheria Toxoid, for intramuscular use
90720	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-HIB), for intramuscular use
90721*	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DTAP-HIB), for intramuscular use
90723*	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (DTAP-HEPB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular or jet injection use
90732*	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3-dose schedule, for intramuscular use
90743	Hepatitis B vaccine, adolescent, 2-dose schedule, for intramuscular use
90744*	Hepatitis B vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90746*	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4-dose schedule, for intramuscular use
90748*	Hepatitis B and Hemophilus Influenza B vaccine (HEP-HIB), for intramuscular use

* indicates the vaccine is available from the Vaccines For Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

REMINDERS:

- Procedure code 90703 (Tetanus Toxoid for Trauma) will be payable at the rate of $2.42, and it is not available through the VFC program.

- If the units for 90472 are greater than the actual vaccines reported for procedure code 90472, the units will be cutback to reflect the number of vaccines codes being reported.

- If the units for 90472 are less than the actual vaccines reported for procedure code 90472, the entire claim will be approved and paid appropriately (based on the information given on the claim form).

CMS-1500 FORM

☞ **Immunizations, laboratory tests, interperiodic screenings, consultations, and low level visits in conjunction with a KIDMED screening are billed on the CMS-1500 claim form.**

CMS-1500 claim forms should be mailed to the following address for processing:

Unisys
P.O. Box 91020
Baton Rouge, LA 70898

☞ **Certain items on the CMS-1500 are mandatory, as indicated by an asterisk (*).**

Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. Such claims cannot be processed until corrected and resubmitted by the provider.

Item No.	Description and details
1.	Enter an "X" in the box marked Medicaid (Medicaid #).
***1a.**	**Insured's ID Number -** Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS, or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month. **Note: If the ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.**
***2.**	**Patient's Name -** Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through the REVS, MEVS, or e-MEVS eligibility systems.
3.	**Patient's Birth Date and Sex -** Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, REVS, or e-MEVS using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.
4.	**Insured's Name -** Leave blank.
5.	**Patient's Address -** Leave blank.
6.	**Patient Relationship to Insured -** Leave blank.
7.	**Insured's Address -** Leave blank.
8.	**Patient Status -** Leave blank.
9.	**Other Insured's Name -** Leave blank.

9a. **Other Insured's Policy or Population Number -** Leave Blank; unless the recipient has private insurance. In that case, indicate the 6-digit TPL carrier code assigned by Medicaid to that insurance company. Be sure to attach the EOB from the third party carrier to the claim.

9b. **Other Insured's Date of Birth -** Leave blank.

9c. **Employer's Name or School Name -** Leave blank.

9d. **Insurance Plan Name or Program Name -** Leave blank.

10. **Was Condition Related To -** Leave blank.

11. **Insured Policy Population or FECA Number -** Leave blank.

11a. **Insured's Date of Birth -** Leave blank.

11b. **Employer's Name or School Name -** Leave blank.

11c. **Insurance Plan Name or Program Name -** Leave blank.

12. **Patient's or Authorized Person's Signature -** Leave blank.

13. **Insured's or Authorized Person's Signature -** Leave blank.

14. **Date of Current Illness -** Leave blank.

15. **Date of Same or Similar Illness -** Leave blank.

16. **Dates Patient Unable to Work -** Leave blank.

17. **Name of Referring Physician or Other Source -** If services are performed by a nurse practitioner, the name of the directing physician must be entered in this field. If the recipient is a lock-in recipient and has been referred to the billing provider for services, the lock-in physician's name must be entered here.

17a. **ID Number of Referring Physician -** If the recipient is linked to a PCP, the Primary Care Physician referral authorization number must be entered here. This information should be identical to item 9 on the KM3 form.

18. **Hospitalization Dates Related to Current Services -** Leave blank.

19. **Reserved for Local Use -** Leave blank.

20. **Outside Lab -** Leave blank.

***21.** **Diagnosis or Nature of Illness or Injury -** Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted.

22. **Medical Resubmission Code -** Leave blank.

***23.** **Prior Authorization -** Leave blank.

***24A.** **Date of Service -** Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

***24B.** **Place of Service -** Enter the appropriate place of service code. Only 2 digit POS service codes are acceptable.

24C. **Type of Service -** Leave blank.

***24D.** **Procedure Code -** Enter the procedures performed using the appropriate CPT code.

24E. Diagnosis Code - Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", "3", or "4". More than one diagnosis may be related to a procedure. Do not enter an ICD-9-CM diagnosis code in this item.

***24F. Charges -** Enter usual and customary charges for this service.

***24G. Days or Units -** Enter the number of units billed for the procedure code entered on the same line in 24D.

24H. EPSDT - Leave blank.

24I. EMG - Leave blank.

24J. COB - Leave blank.

24K. Reserved for Local Use – Enter the attending provider number if group number is indicated in block 33.

25. Federal Tax ID Number - Leave blank.

26. Patient's Account Number - (Optional) Enter the recipient's medical record number or other individual provider-assigned number to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters.

27. Accepts Assignment - Leave blank.

***28. Total Charge -** Total all charges listed on the claim.

29. Amount Paid - Leave this space blank unless payment has been made by a third party insurer. If such payment has been made, indicate the amount paid.

30. Balance Due - If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges.

***31. Signature of Physician/Supplier -** The claim form **MUST** be signed. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does has not been initialed in handwriting, the claim will be returned unprocessed.**

Date - Enter the date of the signature.

32. Name and Address Where Services Were Rendered – Complete as appropriate or leave this space blank.

***33. Physician's or Medical Assistance Supplier's Name, Address, Zip Code and Telephone Number and PIN -** Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid provider number must be entered in the space next to "GRP #." **If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.**

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567891234**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Smith, Johnny**

3. PATIENT'S BIRTH DATE: 01 18 98 SEX: M [X] 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 [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: **(TPL info here if applicable)**

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 _____

PHYSICIAN OR SUPPLIER 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **(PCP Auth# if applicable)**

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. 314.0
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 03 04	11 03 04	11		99393	TD TS	1	51 00	1				1234567
2												
3												
4												
5												
6												

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 $ 51 00

29. AMOUNT PAID $

30. BALANCE DUE $ 51 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.)

SIGNED *IMA BILLER* DATE *11/15/04*

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St Sunny, La 70000

PIN# | GRP# **1111111**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567891234

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 18 98 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 ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: TELEPHONE (Include Area Code) ( )

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: TPL info, if applicable

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 _____

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: PCP Authorization #, if applicable

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. 314.0
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 03 04	11 03 04	11		99393	TS	1	51 00	1				1234567
2												
3												
4												
5												
6												

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 $ 51 00

29. AMOUNT PAID $

30. BALANCE DUE $ 51 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.)

SIGNED *IMA BILLER* DATE *11/15/04*

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St Sunny, La 70000

PIN# GRP# 1111111

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **9752432916523**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **HENRY, JOHN**

3. PATIENT'S BIRTH DATE MM DD YY: **08 25 2004** 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; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: **TPL carrier code if applicable**

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 _____

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Auth# if applicable**

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. **V202**
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 07 04	10 07 04	11		90471		1	9 45	1				1122334
2 10 07 04	10 07 04	11		90707		1	0 00	1				1122334
3												
4												
5												
6												

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 $ 9 45

29. AMOUNT PAID $

30. BALANCE DUE $ 9 45

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.)

Ima Biller 11/15/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

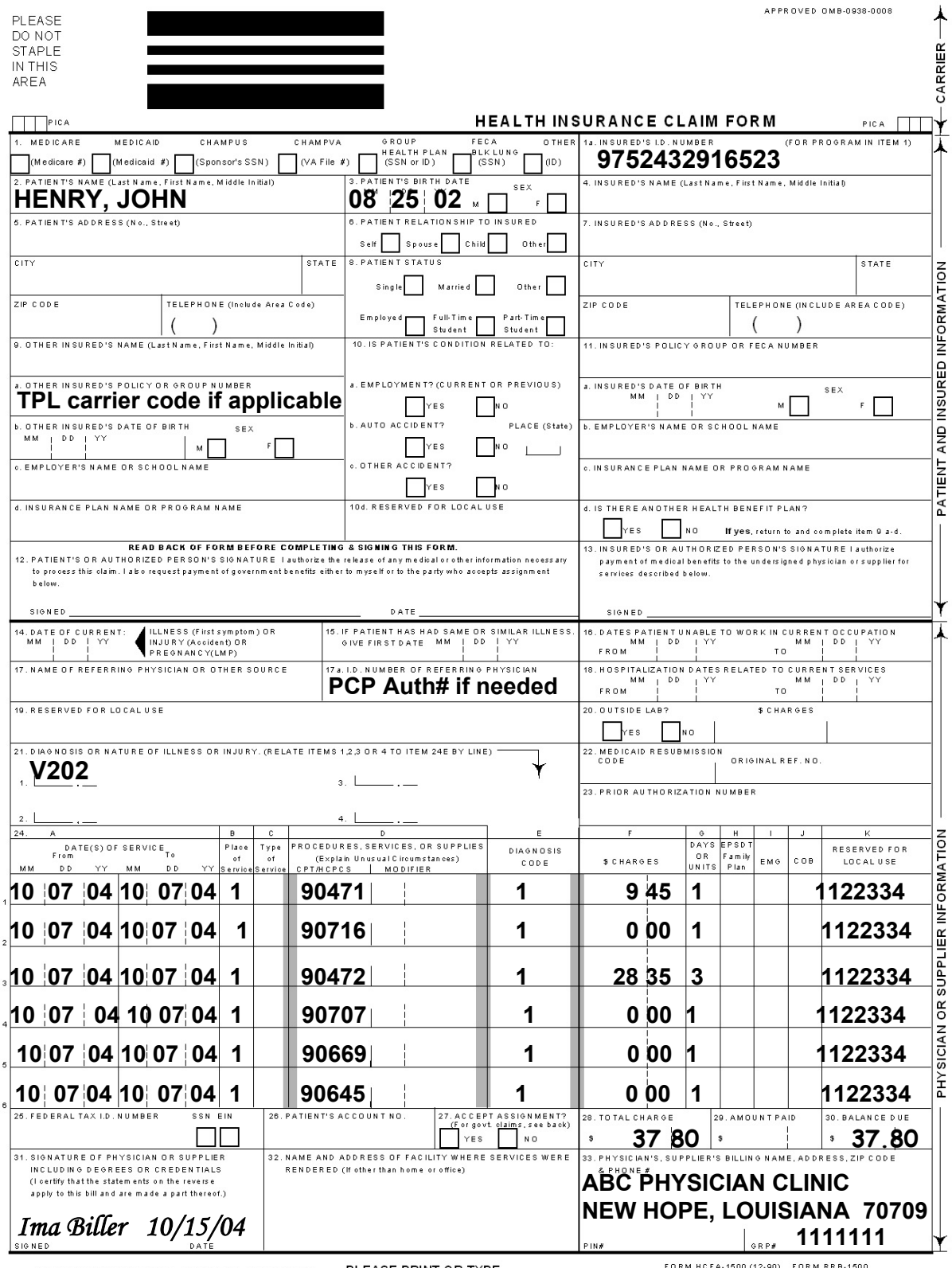
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St, Sunny, LA 70000

PIN# GRP# **1111111**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 9752432916523

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

3. PATIENT'S BIRTH DATE: 08 25 02 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 ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: TPL carrier code if applicable

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 _____

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: PCP Auth# if needed

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. V202 3. ____.__

2. ____.__ 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10 07 04	10 07 04	1		90471		1	9 45	1			1122334
2	10 07 04	10 07 04	1		90716		1	0 00	1			1122334
3	10 07 04	10 07 04	1		90472		1	28 35	3			1122334
4	10 07 04	10 07 04	1		90707		1	0 00	1			1122334
5	10 07 04	10 07 04	1		90669		1	0 00	1			1122334
6	10 07 04	10 07 04	1		90645		1	0 00	1			1122334

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 $ 37 80

29. AMOUNT PAID $

30. BALANCE DUE $ 37.80

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.)

Ima Biller 10/15/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ABC PHYSICIAN CLINIC
NEW HOPE, LOUISIANA 70709

PIN# GRP# 1111111

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **9752432916523**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **HENRY, JOHN**

3. PATIENT'S BIRTH DATE MM DD YY: **08 25 02** 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; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: **TPL carrier code if applicable**

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 _____

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Auth# if needed**

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. **V202** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **10 07 04 10 07 04**	**11**		**90471**		**1**	**9 45**	**1**				**1122334**
2 **10 07 04 10 07 04**	**11**		**90713**		**1**	**0 00**	**1**				**1122334**
3											
4											
5											
6											

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 $ **9 45**

29. AMOUNT PAID $

30. BALANCE DUE $ **9 45**

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.)

Ima Biller 10/15/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ABC PHYSICIAN CLINIC
NEW HOPE, LOUISIANA 70709

PIN# GRP# **1111111**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **HENRY, JOHN**

3. PATIENT'S BIRTH DATE MM DD YY: **02 25 03** 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; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: **TPL carrier code if applicable**

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 _____

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Auth# if needed**

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. **V202** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **10 07 04 10 07 04**	**1**		**90472**		**1**	**38 40**	**4**				**1122334**
2 **10 07 04 10 07 04**	**1**		**90657**		**1**	**0 00**	**1**				**1122334**
3 **10 07 04 10 07 04**	**1**		**90744**		**1**	**0 00**	**1**				**1122334**
4 **10 07 04 10 07 04**	**1**		**90700**		**1**	**0 00**	**1**				**1122334**
5 **10 07 04 10 07 04**	**1**		**90716**		**1**	**0 00**	**1**				**1122334**
6											

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 $ **38 40**

29. AMOUNT PAID $

30. BALANCE DUE $ **38 40**

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.)

Ima Biller 10/15/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ABC PHYSICIAN CLINIC
NEW HOPE, LOUISIANA 70709

PIN# GRP# **1111111**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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

213 ADJUSTMENT/VOID FORM

The 213 adjustment/void is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Unisys by calling Provider Relations at (800) 473-2783. An example of a correctly completed void form is shown on the following page.

Form Completion

Only **one** (1) control number can be adjusted or voided on each 213 form.

Only an **approved claim** can be adjusted or voided.

Blocks 26 and 27 of the Unisys 213 form must be completed with the claim's most recently approved control number and RA date. For example:

1. A claim is approved on the RA dated 01/01/2004, ICN 4000061223401.

2. The claim is adjusted on the RA dated 02/15/2004, ICN 4000367890100.

3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (4000367890100) and RA date (02/15/2004) must be used.

Claims paid to the wrong provider or for the wrong recipient cannot be adjusted. They must be voided and the correct claims submitted.

Adjustments: To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, **changing the item that was in error to show the way the claim should have been billed.** The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column.

Voids: To file a void, the provider must enter all the information from the original claim **exactly as it appeared on the original claim**. When the void claim is approved, it will be listed under the "void" column of the R.A. and a corrected claim may be submitted (if applicable).
Only one (1) claim line can be adjusted or voided on each adjustment/void form.

213 Adjustment/void forms should be mailed to the following address for processing:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☒

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Jeffers, Kelly
3 PATIENT'S DATE OF BIRTH: 06/11/89
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE ☐ FEMALE ☐
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
TPL Carrier Code if applicable
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES ☐ NO ☐
B. AN AUTO ACCIDENT YES ☐ NO ☐
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
CommunityCARE Auth# (if needed)
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES ☐ NO ☐ CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 V202
2
3
23 ATTENDING NUMBER
Attending provider number if necessary
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
11	09	04	11	09	04	11	90471	1	9 45	1		TPL amt if any

26 CONTROL NUMBER: 4000456789512
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 11-30-04

28 REASONS FOR ADJUSTMENT
☐ 01 THIRD PARTY LIABILITY RECOVERY
☐ 02 PROVIDER CORRECTIONS
☐ 03 FISCAL AGENT ERROR
☐ 90 STATE OFFICE USE ONLY - RECOVERY
☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

29 REASONS FOR VOID
☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☑ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN
Billed claim in error

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller *12/30/2004*
32 YOUR PATIENT'S ACCOUNT NUMBER
31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Kids R Us 23456 Laurel Dr
Sunny, LA 71333
Provider # 1111111

FISCAL AGENT COPY

UNISYS - 213
5/97

CMS 1500 TIMELY FILING GUIDELINES

Initial Filing Requirements

In order to be reimbursed for services rendered, all providers must comply with the following filing limits set by Medicaid of Louisiana:

- Straight Medicaid claims must be filed within 12 months of the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
- Claims which fail to cross over via tape and have to be filed hard copy must be filed within six months of the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.
- Claims with third-party payment must be filed to Medicaid within 12 months of the date of service.

Dates Of Service Past Initial Filing Limit

Medicaid claims received after the initial timely filing limits cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

- A Remittance Advice indicating that the claim was processed earlier (within the specified time frame)

OR

- Correspondence from either the state or parish Office of Eligibility Determination concerning the claim and/or the eligibility of the recipient.

To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Proof of timely filing documentation must reference the individual recipient and date of service.

Claims filed after the two-year billing limitation cannot be considered for processing. Providers should not resubmit these claims.

KIDMED REPORTS

LINKAGE AND SCREENING REPORTS

EP-0-10 - New Recipient And Missed Screen List

- Lists newly linked recipients and the last day on which an initial screening may be scheduled
- Indicates missed appointment dates (based on lack of paid claim for the appointment date)
- Allows providers to request that KIDMED remind recipients of screening appointments, if desired
- Provided weekly by Unisys Corporation

EP-0-21 - Provider Schedule List

- Lists recipients who have appointments in the coming week and appointment date and time
- Allows providers to report whether screenings were actually performed, the reason why they were not kept, and the new appointment date and time if one has been rescheduled
- Provided weekly by Unisys Corporation (based on information given by the provider)

RS-0-07 - Screening And Provider Beneficiary Report

- Lists all recipients linked to the provider along with the effective date of linkage
- Indicates last screening date for recipients based on paid screening claims on file
- Shows the next screening period, during which next screening should be scheduled, as well as recipients requiring initial screening
- Allows providers to request that KIDMED remind recipients of screening appointments, if desired
- Located on the website www.lamedicaid.com.

If any of these reports are used as a turnaround document for scheduling appointments, they should be returned to the KIDMED office at:

ACS
5700 Florida Blvd., 13th Floor
Baton Rouge, LA 70806

EFW010
RUN: 07/29/01 05:42:32
CYCLE: 07/29/01

LOUISIANA KIDMED SFSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
NEW RECIPIENT AND MISSED SCREEN LIST

REPORT NO: EF-O-10
PAGE NO: 5

PROVIDER ID NO.: 11 1
PROVIDER SITE NO.: 002
PROVIDER: EE CARE
F RD BLVD
S
LA -0000

MEDICAID ID	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	TYP B	NEW BENEFICIARY OR MISSED APPOINTMENT	INITIAL SCREENING DUE/MISSED APPT DATE MM/DD/YY	APPT. DATE AND TIME GIVEN BENEFICIARY DATE / TIME
53- 96	E S M A R	AVENUE CH LA 0000	F	05, 01	504 2 504 47 504 96	H R T	M	NEW BENEF	09, /01	__/__/__ __:__
89- -92	L C A ; M	6[illegible] ST	F	11, 30	504 ; 504 ;4 504)	H R T	M V H	NEW BENEF	11, /01	__/__/__ __:__
57 -89	M: C?	DR.	F	03, 01	504 7 504 53 504 17	H R T	M	NEW BENEF	09, /01	__/__/__ __:__

TOTAL RECIPIENTS FOR ABOVE PROVIDER: 3

CYCLE: 07/2 DEPARTMENT OF HEALTH HOSPITALS PAGE NO:
PROVIDER SCHEDU T

PROVIDER ID NO. 13 1 | PROVIDER SITE NO. 002 | PROVIDER BAT MD AVE/STE303

LA -0000

MEDICAID ID	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	TYPE	APPOINTMENT DATE & TIME MM/DD/YY	SCREENING PERFORMED YES/NO IF NO, REASON	RESCHEDULED APPT. DATE AND TIME GIVEN BENEFICIARY DATE / TIME
80- -36	K KL	721	F	04, /01	985	73 H	M	08, /01	Y__N__R__	___/___/___
					985	71 R		13:30		____:____
	LA	-0000			985	73 T				
41 76	CAM HO	N ST.	F	08/ '99	504	8 H	M	08/ /01	Y__N__R__	___/___/___
	A APT				504	12 R		14:00		
					504	13 H				____:____
	LA	0000			504	13 X				
03 66	MI .NE	2E ST	F	05 /95	504	0 H	M	08/ /01	Y__N__R__	___/___/___
	L				504	60 R	V H	14:30		____:____
	LA	0000			504	0 T				
53- 31	MI ANY	TE ST	F	07/ '96	504	20 H	M	08/ /01	Y__N__R__	___/___/___
	D				504	70 R	V H	14:45		____:____
	LA	0000			504	10 T				
70 -82	DE K	DR	M	05/ /00	318	H	M	08/ /01	Y__N__R__	___/___/___
	E							16:00		
	LA	-0000								____:____

TOTAL NUMBER OF SCHEDULED APPOINTMENTS 11

REASON CODES: F=FORGOT APPT, R=REFUSED SERVICE, S=SICK, T=NO TRANSPORTATION, U=UNABLE TO FIND, X=FAILED TO SHOW, K=KEPT, O=MISSED OTHER

RSM018
RUN: 07/26/01 22:57:40
MONTH: AUGUST, 2001

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
SCREENING PROVIDER BENEFICIARY REPORT
BASED ON SCREENING CLAIMS PAID

REPORT NO: RS-0-07
PAGE NO: 2

PROVIDER ID NO.: 19 3
PROVIDER SITE NO.: 001

PROVIDER
KID MED NORTH-DELMONT VIL
5151 PLANK ROAD STE. 38
BATON ROUGE
LA 70805-0000

MEDICAID ID/ LINKAGE BEGIN DATE MM/DD/YY	BENEFICIARY NAME	MAILING ADDRESS	SEX	D.O.B. MM/DD/YY	TELEPHONE NUMBER(S)	LOCN	TYPE	LAST DATE SCREENED MM/DD/YY	NEXT SCREENING PERIOD MM/DD/YY MM/DD/YY	APPOINTMENT DATE AND TIME GIVEN BENEFICIARY DATE / TIME
17 -04 03/07/01	MA VIC C	DR B E LA -0000	F	03/ /98	225 5	H	M V H	04/06/01	(03/04/02-03/03/03) (03/04/02-03/03/03) (03/04/02-03/03/03)	___/___/___ _____:_____
46 -02 05/01/01	AD MY D	AVE BA LA -0000	M	04/ /96	504 3	H	M V - INITIAL SCREEN REQUIRED - H - INITIAL SCREEN REQUIRED -	10/21/97	(04/04/98-04/03/99)	___/___/___ _____:_____
46 -01 05/01/01	SON MIC D	855 LA -0000	AVE M	01/ /94	504 43	H	M V - INITIAL SCREEN REQUIRED - H - INITIAL SCREEN REQUIRED -	10/21/97	(04/21/98-01/21/99)	___/___/___ _____:_____
17 -01 03/01/00	AD CK K	D BA E LA -0000	M	06/ /95	504 327 504 308	H R	M V H	01/08/01 01/08/01 01/08/01	(07/08/01-06/08/03) (07/08/01-06/08/03) (07/08/01-06/08/03)	___/___/___ _____:_____
17 -01 06/01/98	AG RE	125 DR. B LA -0000	M	12/ /85	50 63	H	M V H	05/22/00 05/22/00 05/22/00	(12/06/01-12/05/03) (12/06/01-12/05/03) (12/06/01-12/05/03)	___/___/___ _____:_____
17 -02 06/01/98	EW CHE	EEN DR. B E LA -0000	F	04/ /93	504 197 504 116	H R	M V H	08/18/99 08/18/99 08/18/99	(04/14/01-04/13/03) (04/14/01-04/13/03) (04/14/01-04/13/03)	___/___/___ _____:_____
17 -04 08/10/99	AI ANNA B	11 DRIVE APT BA E LA -0000	F	08/ /96	504 177 504 586	R R	M V - INITIAL SCREEN REQUIRED - H	10/10/00 10/10/00	(08/05/01-08/04/02) (08/05/01-08/04/02)	___/___/___ _____:_____
17 -03 08/10/99	AI NC T	DRIVE AP BA E LA -0000	F 1	/94	504 177 504 36	R R	M V H	10/10/00 10/10/00 10/10/00	(04/10/01-11/10/02) (04/10/01-11/10/02) (04/10/01-11/10/02)	___/___/___ _____:_____

* SIGNIFIES THAT THIS RECIPIENT IS ON THE REPORT FOR THE FIRST TIME THIS MONTH.
** SIGNIFIES THAT THIS RECIPIENT IS ON THE REPORT FOR THE LAST TIME THIS MONTH.

CLAIM-RELATED REPORTS

CNTL-D010 - Direct Biller Process Summary

- Informs electronic biller whether or not input was accepted (in which case the range of CCNs assigned to individual claims will be displayed) or rejected (which requires the biller to resubmit input).
- **Cannot serve as proof of timely filing, as no specific claim data is displayed.**

CP-0-51 - Electronic Media Claim Proof List

- Displays in summary the CCN range assigned to individual claims which were accepted through electronic transmission.
- Displays in detail the CCN and specific claim data transmitted within each claim line of the transmission.
- **Can serve as proof of timely filing.**

CP-0-115 - Recycled Claims Listing

- Informs provider that certain claims have “pended” for errors encountered within the processing cycle and are being recycled in case recipient eligibility files are updated.
- **Can serve as proof of timely filing.**

CP-0-50 - Resubmittal Turnaround Document (RTD)

- Informs provider of errors encountered in processing KM-3 claim form.
- Allows provider to correct errors and return RTD by specified date.
- **Can serve as proof of timely filing if provider number, recipient name or number, procedure, and date of service are present and correct.**
- Instructions on proper completion of RTD are found on pages 56-57.

CP-0-50 - Denied Claims List

- Informs provider of KM-3 claim denial and errors encountered in processing.
- If errors are correctable, serves as prompt to resubmit corrected KM-3.
- **Can be used as proof of timely filing.**

Examples of the above reports are shown on the following pages.

CPD010
RUN: 07/18/01 15:43:59
YCLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DIRECT BILLER PROCESS SUMMARY

REPORT NO: CNTL-D010
PAGE NO: 1

SUBMITTER NAME:

DATE OF DATA: 07/18/2001 TAPE 0004 119

116 DR.

, LA 70

ILLER ID: 45000 FROM CCN: 11 1001 001 THRU CCN: 11 100 2201 BILLED CHARGES: $332.(

ROVIDER ID: 1 9231 SITE#: FROM CCN: 11 100 001 THRU CCN: 11 100 1001 BILLED CHARGES: $60.(

ROVIDER ID: 1 4835 SITE#: FROM CCN: 11 1001 101 THRU CCN: 11 100 2201 BILLED CHARGES: $272.(

RECORDS READ: 54
RECORDS WRITTEN: 13
DOCUMENTS WRITTEN: 13

ATTN
116

AUX

705

***** END - OF - REPORT *****

CPD010
RUN: 07/18/01 15:43:59
CLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
ELECTRONIC MEDIA CLAIM PROOF LIST

REPORT NO: CP-0-51
PAGE NO: 1

SUBMITTER NAME:

ATTN: RANDY BOUDREAUX
116 FOREMAN DR.
LA 70

DATE OF DATA: 07/18/2001 TAPE 000004 1199

CCN	PROVIDER NUMBER	SITE NO	RECIPIENT MEDICAID ID	RECIP NAME	MEDICAL RECORD NUMBER	SCREENING TYPE	SCREEN DATE	BILLED CHARGE	NEXT APPT DATE	NEXT APPT TIME	IMMUN COMP CURR	SUS CON
99 0121	1 17 14		05 2119 919	B 01	R 25 61,00	MED - NURSE	05/07/2001	60.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		05 7268 276	C BE	P 26 7,01	MED - NURSE	07/17/2001	60.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		05 7268 276	C BE	P 26 7,01	HEARING	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		05 7268 276	C BE	P 26 7,01	VISION	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		16 0039 902	H ST	S 22 3,01	MED - NURSE	07/17/2001	60.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		16 0039 902	H ST	S 22 3,01	HEARING	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		16 0039 902	H ST	S 22 3,01	VISION	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		24 5720 740	H	D 25 8,01	MED - NURSE	07/17/2001	60.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		24 5720 740	H	D 25 8,01	HEARING	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0121	1 19 57		24 5720 740	H	D 25 8,01	VISION	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0122	1 19 57		61 2877 090	AS O	A 12 11,01	MED - NURSE	07/17/2001	60.00	00/00/0000	00:00	Y	N
99 0122	1 19 57		61 2877 090	AS O	A 12 11,01	HEARING	07/17/2001	4.00	00/00/0000	00:00	Y	N
99 0122	1 19 57		61 2877 090	AS O	A 12 11,01	VISION	07/17/2001	4.00	00/00/0000	00:00	Y	N

***** END - OF - DETAILS *****

CPD010
RUN: 07/18/01 15:43:59
CLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
ELECTRONIC MEDIA CLAIM PROOF LIST

REPORT NO: CP-O-51
PAGE NO: 2

SUBMITTER NAME:
ATTN: RANDY BOUDREAUX
116 FOREMAN DR.
, LA 705

DATE OF DATA: 07/18/2001 TAPE 000004 1199

LLER ID: 4 0013		FROM CCN: 11 1001210	THRU CCN: 1 91001222	BILLED CHARGES:	$332.00
OVIDER ID: 1 231	SITE#:	FROM CCN: 11 1001210	THRU CCN: 1 91001210	BILLED CHARGES:	$60.00
OVIDER ID: 1 335	SITE#:	FROM CCN: 11 1001211	THRU CCN: 1 91001222	BILLED CHARGES:	$272.00

RECORDS READ: 54
RECORDS WRITTEN: 13
DOCUMENTS WRITTEN: 13

***** END - OF - REPORT *****

RUN: 07/18/01
CYCLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RECYCLED CLAIMS LISTING

014 = MEDICAID NUMBER NOT ON FILE
015 = RECIPIENT NOT ELIGIBLE ON DATE OF SEVICE
017 = PATIENT LAST NAME/MEDICAID NUMBER MISMATCH
019 = PATIENT FIRST NAME/MEDICAID NUMBER MISMATCH

NESOM J A M
P.O. BOX
OAKDALE LA 71463-0000

BILLING PROV NO	SITE NO	CCN	MEDICAID NO	PATIENT NAME		DATE OF SCREENING	ERROR 1	ERROR 2	ERROR 3	ERROR 4	ERROR 5	FIRST PEND DATE	TOTAL
0 970	001	11 00010 03	350 278 705	AM	D	07/11/2001	017	019				07/16/2001	
		11 00010 02	350 278 705	AM	D	07/11/2001	017	019				07/16/2001	
		11 00010 01	350 278 705	AM	D	07/11/2001	017	019				07/16/2001	
970	001												
970													

1 3970 1
N OM
P . BO 140
O DALE LA 63-0000

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RESUBMITTAL TURNAROUND DOCUMENT

PROVIDER: 9 20

CCN: 1043000

1. CLAIM TYPE: ORIGINAL	2. REASON:	3. ADJUSTMENT ICN: 0000000000000

4. BILLING PROVIDER NO: 94 20	6. SITE NO: 001	7. ATTENDING PROVIDER NO: 0000000	9. REFERRING PROVIDER NO: 0000000

10. MEDICAID NO: 2 40 149 5	11. PAT LAST NME: WASHI	12. PAT FIRST NME: D	13. DOB: 02 /2000

16. MED REC NO:	RECIPIENT NAME ON FILE: WAS NG SHA S

21. PAT HOME #: (504) 86	22. PAT WORK #: (000) 000-0000	23. PARENT/GUARDIAN LAST NAME: HIN	24. FIRST NAME: TO IKA

SCRN TYPE	25. DATE OF SCREEN:	26. BILLED CHG:	27. NEXT APPT DATE:	28. TIME:
MED/PHYS	02/07/2001	51.00	00/00/0000	00:00

29. ARE IMMUNIZATION COMPLETE AND CURRENT FOR THIS AGE PATIENT: N
30A. MEDICALLY CONTRAINDICATED Y
30B. PARENTAL REFUSAL:
30C. OFF SCHEDULE:

RETURN REASON *** ERROR CODE: 030 MESSAGE: SUSPECTED CONDITIONS ARE MISSING AND REQUIRED

********** ATTENTION: THIS IS TO REMIND YOU THAT THIS RESUBMITTAL TURNAROUND DOCUMENT IS STILL OUTSTANDING **********

CONTINUED NEXT PAGE

CPW400
RUN: 07/18/01 15:51:38
CYCLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
RESUBMITTAL TURNAROUND DOCUMENT

REPORT NO: CP-0-50
RPT PAGE NO: 10
PAGE NO: 4

CCN: 104300 PROVIDER: 119462

31. ARE THERE SUSP COND: Y	33A. SUSP COND:	33B. REF ASST NEED:	33C. APPT DATE: 00/00/0000	33D. TIME: 00:00
32. SUSPECTED CONDITIONS:	33E. REASON FOR REFERRAL:			
U O I DESCRIPTION	33F. REFERRED TO:		33G.	
_ _ _ A. MEDICAL	33H. PHONE NO: (000) 000-0000		33I. TRANSPORTATION ASSISTANCE NEEDED:	
_ _ _ B. VISION	34A. SUSP COND:	34B. REF ASST NEED:	34C. APPT DATE: 00/00/0000	34D. TIME: 00:00
_ _ _ C. HEARING	34E. REASON FOR REFERRAL:			
_ _ _ D. DENTAL	34F. REFERRED TO:		34G.	
_ _ _ E. NUTRITIONAL	34H. PHONE NO: (000) 000-0000		34I. TRANSPORTATION ASSISTANCE NEEDED:	
_ _ _ F. DEVELOPMENTAL	35A. SUSP COND:	35B. REF ASST NEED:	35C. APPT DATE: 00/00/0000	35D. TIME: 00:00
_ _ _ G. ABUSE/NEGLECT	35E. REASON FOR REFERRAL:			
_ _ _ H. PSYCHOLOGICAL	35F. REFERRED TO:		35G.	
_ _ _ I. SPEECH/LANGUAGE	35H. PHONE NO: (000) 000-0000		35I. TRANSPORTATION ASSISTANCE NEEDED:	
_ _ _ J.				
_ _ _ K.				
_ _ _ L.				

CORRECT AND RESUBMIT THIS COPY

THIS CORRECTED COPY MUST BE RECEIVED BEFORE 09/16/2001 OR THIS CLAIM WILL BE DENIED.

I HEREBY AMEND/CORRECT, AS INDICATED ABOVE, THE MEDICAID CLAIM IDENTIFIED ON THIS SHEET AND REQUEST THE REPROCESSING OF THE SAID CLAIM BE MADE WITH THE INFORMATION PROVIDED ON THIS DOCUMENT. ALL INFORMATION ON THE CLAIM IDENTIFIED ABOVE AND NOT AMENDED SHALL REMAIN AS IS. I HEREBY CERTIFY THAT THE CLAIM FOR SERVICES AND INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS

PROVIDER SIGNATURE: _____ DATE OF SIGNATURE

PLEASE RETURN TO: UNISYS-KIDMED
P.O. BOX 14849

BATON ROUGE, LA 70898-4849

CPW400
RUN: 07/18/01 15:51:38
CYCLE: 07/18/01

LOUISIANA KIDMED EPSDT INFORMATION SYSTEM
DEPARTMENT OF HEALTH AND HOSPITALS
DENIED CLAIMS LIST

REPORT NO: CP-0-50
RPT PAGE NO: 6
PAGE NO: 2

PROVIDER: 9127
SITE: 001

RECIPIENT MEDICAID ID	RECIPIENT LAST NAME	RECIPIENT FIRST NAME	MEDICAL RECORD NUMBER	SITE NO	CCN	CLAIM TYPE MODIFIER	SCREENING TYPE	SCREEN DATE	STATUS	ERROR CODE
21 1204 701	LIN	E	45	0006 98	001 11 100 0401	ORIGINAL	MED - NURSE	07/11/2001	DENIED	068
33 0023 401	ALI	N	11	0006 54	001 11 100 1801	ORIGINAL	MED - NURSE	07/09/2001	DENIED	043
33 0023 401	ALI	N	11	0006 55	001 11 100 1901	ORIGINAL	VISION	07/09/2001	DENIED	030
33 0023 401	ALI	N	11	0006 56	001 11 100 2001	ORIGINAL	HEARING	07/09/2001	DENIED	030
36 2780 701	ORG	J	72	0006 40	001 11 100 3501	ORIGINAL	MED - NURSE	07/11/2001	DENIED	068
65 0362 301	ART	G	11	0006 30	001 11 100 3901	ORIGINAL	MED - NURSE	07/16/2001	DENIED	068
65 2355 102	ITT	M	14	0006 21	001 11 100 2901	ORIGINAL	MED - NURSE	07/11/2001	DENIED	068

ERROR CODE	ERROR CODE DESCRIPTION	NUMBER OF OCCURRENCES
030	SUSPECTED CONDITIONS ARE MISSING AND REQUIRED	2
043	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL #1	1
068	BILLING PROVIDER IS NOT THE DESIGNATED PROVIDER OF RECORD	4

CP-0-50 RESUBMITTAL TURNAROUND DOCUMENTS

When KM-3 claim forms are processed, errors that are detected may result in the claim denying. However, certain errors do not cause denial but rather cause the claim to pend, enabling the provider to correct it without having to resubmit a new KM-3. Generally in these cases the erroneous claim causes a resubmittal turnaround document (RTD) to be generated and mailed by Unisys to the provider.

The RTD can be used to correct certain errors made in completing the KM-3 form. For providers who submit their claims hardcopy, it is normally much easier to make needed corrections on the RTDs and return them, as opposed to completing entirely new KM-3 claim forms containing the correct information. Providers who submit KIDMED claims electronically may either submit corrected RTDs or they may resubmit the corrected claim electronically. There is an expiration date shown on the RTD by which the RTD must be corrected and returned to Unisys. If the RTD is not returned by the deadline, the claim will be denied and would have to be resubmitted as a corrected claim.

Each RTD lists specific information regarding the error(s) made on the KM-3 submission. The information on the original KM-3 is reflected on the RTD, and the fields on the RTD correspond to those on the KM-3 claim form. Completion requirements for the RTD parallel those of the KM-3 (e.g., a particular response in one item may require that the next item must be completed). The RTD indicates the error or omission so that it can be corrected.

Most of the errors that result in RTDs are easily understood and corrected. If needed information is missing, it can be written in on the RTD. If information shown on the RTD is incorrect, it can be lined through to delete it, or it can be lined through and the correct information written below it to make the correction. Following are instructions for correcting the RTD for the errors that seem to be most common. In addition, this information can be used to determine the cause of denials and the steps to correcting them.

Eligibility Errors – Denial Codes 013 – 019

Items 10 – 12 of the KM-3 and the RTD must be completed and must match the information on the Medicaid recipient eligibility files. Normally the Medicaid recipient eligibility files match the information you receive on the RS-0-07 report. Occasionally providers will receive eligibility denials because they are using an old Medicaid number on their files instead of the recipient ID number on the RS-0-07. In addition, errors can be caused by incomplete Medicaid ID numbers, transposing numbers within the Medicaid ID number, using part of the card control number from the Medicaid ID card rather than the 13-digit Medicaid ID number, and using the ID number for one sibling with the name of another.

Items to look for on the RTD:

10. **Medicaid No**. - Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS, or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.

11. **Patient Last Name** - Enter the first 17 letters of the recipient's last name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility system. The name should also appear on the recipient's current Medicaid eligibility card. If the name has less than 17 letters, leave the remaining spaces blank.

12. **Patient First Name** - Enter up to 12 letters of the recipient's first name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility system. The name should also appear on the recipient's current Medicaid eligibility card. If the name has less than 12 letters, leave the remaining spaces blank.

Screening Date And Billed Charges – Denial Codes 023 – 024

Items 25 and 26 should reflect the date of the screening and the charge for it. If these items are inadvertently omitted or are only partially completed, the claim will deny. These items can easily be completed or corrected on the RTD.

Items to look for on the RTD:

25. **Date of Screening** - For **each** applicable line, enter the date of the screening. For proper reimbursement, the provider must date **each** screening type that is being billed.

26. **Billed Charge** - For **each** line completed in item 25, enter the appropriate charge for services rendered, using four digits for dollars and cents. For example, $51.00 would be entered as “5100."

Immunization Status – Denial Codes 025 – 027

Item 29 must contain a response. If the response is that immunizations are not complete and up-to-date, item 30 must be completed.

Items to look for on the RTD:

29. - **Immunization Status** - Enter “Y” if immunizations are complete (items 30A – 30C should contain neither “Y” nor “N”). Enter “N” if they are not and enter Y in one of 30A – 30C (whichever is appropriate) to indicate why immunizations are not complete.

Suspected Conditions And Referrals – Denial Codes 028 – 066

Item 31 must contain a response. If the response is that there are suspected conditions, item 32 must be completed. If item 32 indicates any condition other than undercare, at least one referral must be entered in items 33-35.

Items to look for on the RTD:

31. - **Suspected Conditions** - Enter N if there are no suspected conditions (make sure there are no suspected conditions indicated in 32). Enter “Y” if there are suspected conditions and specify them in 32. In item 32, suspected conditions are noted with “U” (undercare), “O” (off-site referral), or “I” (in-house referral). Mark an “X” in the corresponding blank to indicate the type of condition suspected.

32. **Referrals** - If there are no suspected conditions, or if the conditions are all undercare, this section should have no information entered. Otherwise, items 33A, 34A, and 35A may be completed only with letters A – I signifying which suspected condition the referral is for. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., “URI”) here, that information should be entered in 33E, 34E, and 35E.** The other items in this section are self-explanatory.

COMMUNITYCARE

Program Description

CommunityCARE is operated in Louisiana under a freedom of choice waiver granted by the Centers for Medicare and Medicaid Services (CMS). It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommunityCARE links Medicaid eligibles with a primary care physician (PCP) that serves as their medical home.

Recipients

Participation in the CommunityCARE program is mandatory for most Medicaid recipients. Currently, seventy-five to eighty percent of all Medicaid recipients are linked to a primary care provider. Recipients not linked to a CommunityCARE PCP may continue to receive services without a referral/authorization just as they did before CommunityCARE. Those recipient types that are **EXEMPT** from participation in CommunityCARE, and will not be linked to a PCP, are listed below. (This list is subject to change.)

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 years or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid 'Lock In' program
- Recipients who have other primary insurance with physician benefits, including HMO's
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive eligibility (for the retroactive eligibility period only as CommunityCARE linkages may not be retroactive)
- BHSF case-by-case approved "Medically High Risk" exemptions
- Recipients enrolled in Hospice
- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle, and Avoyelles Parishes)

CommunityCARE recipients are identified under the CommunityCARE segment of REVS, MEVS and the online verification system through the Unisys website – www.lamedicaid.com. This segment gives the name and telephone number of the linked PCP.

Primary Care Physician

As part of the case management responsibility, the PCP is obligated to ensure that referrals/authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP cannot unreasonably withhold them **OR** require that the requesting provider complete them. **Any referral/authorization requests must be responded to, either approved or denied, within 10 business days.** The need for a PCP referral/authorization does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referral/authorization from the PCP.

The Medicaid covered services, which do not require a referral/authorization from the CommunityCARE PCP, are "**exempt**." The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referral (ages 0-21)
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dentures for adults
- Dental services for Pregnant Women (ages 21-59), billed on the ADA claim form
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services. (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but do require POST authorization). Refer to "Emergency Services" in the CommunityCARE Handbook.
- Inpatient Care that has been precerted (this also applies to public hospitals even though they aren't required to obtain precertification for inpatient stays) and related hospital, physician and ancillary services
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program

  Note: A REFERRAL/AUTHORIZATION from the PCP IS REQUIRED for "Children's Special Health Services" clinics (Handicapped Children's Services) operated by The Office of Public Health.
- Family planning services
- Prenatal/Obstetrical Services
- Services provided through the Home and Community Based Waiver programs.
- Targeted case management
- Mental Health Clinic services (State facilities)
- Mental Health Rehabilitation services
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists Services
- Transportation services
- Hemodialysis
- Hospice services
- Specific lab and radiology codes

Non-PCP Providers and Exempt Services

Any provider, other than the recipient's PCP, must obtain a referral/authorization from the recipient's PCP in order to receive payment for services rendered. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid.

When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

General Assistance – all numbers are available Mon-Fri, 8am-5pm

Providers:

Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE

ACS - (800) 609-3888 - PCP assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 - referral assistance

Recipients:
ACS - (800) 259-4444

HARD COPY REQUIREMENTS

DHH has made the decision to continue requiring hardcopy claim submissions for all existing hardcopy attachments, as indicated in the table below.

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient - 110MNP Spend Down Form	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing

PLEASE NOTE: When a provider submits a claim, which has more than one page of procedures and charges, each claim page must be totaled and attachments must be submitted with each page of the claim.

LOUISIANA MEDICAID WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

www.lamedicaid.com

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login And Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. Unisys may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

WEB APPLICATIONS

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries;
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

ADDITIONAL DHH AVAILABLE WEBSITES

www.lamedicaid.com/HIPAA: Louisiana Medicaid HIPAA Information Center

www.la-communitycare.com: DHH website – CommunityCARE (program information, provider listings, Frequently Asked Questions (FAQ)

www.la-kidmed.com: DHH website - KIDMED – (program information, provider listings, FAQ)

www.dhh.la.gov/BCSS DHH website - Bureau of Community Supports and Services

www.oph.dhh.state.la.us DHH website - EarlySteps Program

www.oph.dhh.state.la.us DHH website - LINKS

www.dhh.state.la.us/RAR DHH Rate and Audit Review (nursing home updates and cost report information, contacts, FAQ)

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, the Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, and program training packets are available online at www.lamedicaid.com.

UNISYS PROVIDER RELATIONS TELEPHONE INQUIRY UNIT

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 237-3334**

* Please listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387. Providers may also check eligibility by accessing the web-based application, e-MEVS, now available on the Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

NOTE: UNISYS cannot assist recipients. If recipients have problems, please direct them to the Parish Office or the number on their card:

RECIPIENT HELPLINE (800) 834-3333

** Provider Relations will accept faxed information regarding provider inquiries on an **approved** case by case basis. However, faxed claims **are not** acceptable for processing.

UNISYS PROVIDER RELATIONS CORRESPONDENCE GROUP

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

All requests to the Correspondence Unit should be submitted to the following address:

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.**

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses".

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

UNISYS PROVIDER RELATIONS FIELD ANALYSTS

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. **However, since Field Analysts routinely work in the field, they <u>are not</u> available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040**.

FIELD ANALYST	PARISHES SERVED	
Martha Craft (225) 237-3306	Jefferson Orleans	St. Charles Plaquemines St. Bernard
Open	Bienville Bossier Caddo Claiborne East Carroll Lincoln Madison Morehouse	Ouachita Richland Union Webster West Carroll Marshall, TX Vicksburg, MS
Mona Doucet (225) 237-3249	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion
Open	Allen Beauregard Calcasieu Cameron Vernon	Jeff Davis Lafourche Terrebonne Beaumont, TX Jasper, TX
Sharon Harless (225) 237-3267	Avoyelles Iberville West Baton Rouge Pointe Coupee	East Feliciana West Feliciana Woodville/Centerville (MS)
Erin McAlister (225) 237-3201	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)
Courtney Patterson (225) 237-3269	East Baton Rouge	
Kathy Robertson (225) 237-3260	Caldwell Catahoula Concordia DeSoto Franklin Grant Jackson LaSalle	Natchitoches Rapides Red River Sabine Tensas Winn Natchez (MS)

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 237-3334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Data Interchange (EDI) - Unisys		(225) 237-3200 option 2	(225) 237-3331
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - Unisys **EPSDT PCS P.A.** - Unisys	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. - LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification - Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline-Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 925-7948	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues.
Eligibility Operations –BHSF	(888) 342-6207	Recipients may address questions concerning eligibility issues.
LaCHIP Program	(877) 252-2447	Providers and recipients may obtain information regarding the LaCHIP program, which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
EarlySteps	(866) 327-5978	Providers and recipients may obtain information on the EarlySteps program and services offered.
LINKS	(504) 483-1900	Providers may obtain immunization information on recipients.
Referral Assistance - ACS	(877) 455-9955	Providers or recipients may use this phone number for referral assistance.
KIDMED Provider Hotline – ACS	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of agencies that provide PCS services.
KIDMED Recipient Hotline – ACS	(800) 259-4444	Recipients request enrollment in KIDMED program and obtain information on KIDMED linkage.
CommunityCARE Provider Hotline – ACS	(800) 609-3888	Providers inquire about PCP assignment for CommunityCARE recipients and about CommunityCARE monitoring/certification.
CommunityCARE Recipient Hotline – ACS	(800) 359-2122	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Bureau Of Community Supports Services – BCSS	(800) 660-0488 (225) 219-0200	Providers and recipients may request assistance regarding waiver services provided to waiver recipients **(does not include claim or billing problems or questions)**

DHH PROGRAM MANAGER REQUESTS

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Program Manager - (i.e. KIDMED)
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821

EDI CLAIMS SUBMISSION

Electronic date interchange is the preferred method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data interchange must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Each reel of tape, diskette or telecommunicated file submitted for processing must be accompanied by a submission certification form signed by the authorized Medicaid provider or billing agent for each provider whose claims are billed using electronic data. The certification must be included in each tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a “Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Copies of required Certification forms are included in the 2004 Basic training packet and may also be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are available in both the General EDI Companion Guide and the EDI Enrollment Packet.

For telecommunication files, the required Certification Form must be mailed to the Unisys EDI Unit within 48 hours. The form must be completed in its entirety including the following fields:

- Provider Name
- Provider Number
- Submitter Number
- Claim Count
- Total Charges of submission
- Submission Date
- Original Signature
- For **THIRD PARTY BILLERS / CLEARINGHOUSES** - a list of Provider Names and Numbers contained in the submission must be attached.

Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EDI Department at Unisys, call (225) 237-3200 and select option 2. Providers may write to Unisys EDI Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) may be submitted by magnetic tape, 5 1/4" diskette, 3 1/2" diskette, or telecommunication (modem).

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

SUBMISSION DEADLINES

Regular Business Weeks

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
KIDMED Submissions (All Media)	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/23/04
KIDMED Submissions	4:30 P.M. Tuesday, 11/23/04
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/24/04

Important Reminders For EDI Submission

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.
- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- **All claims submitted must meet timely filing guidelines.**

ELECTRONIC DATA INTERCHANGE (EDI) GENERAL INFORMATION

- Please review the entire **General EDI Companion Guide** before completing any forms or calling the EDI Department.

- The following claim types may be submitted as approved HIPAA compliant 837 transactions:

    - Pharmacy
    - Hospital Outpatient/Inpatient
    - Physician/Professional
    - Home Health
    - Emergency Transportation
    - Adult Dental
    - Dental Screening
    - Rehabilitation
    - Crossover A/B

- The following claim types may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions):

    - Case Management services
    - Non-Ambulance Transportation

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller -** complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS** (EDI Contract).

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse** – complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE SUBMISSION OF CLAIMS** (EDI Contract) **and** a Limited Power of Attorney.

- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a completed EDI Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EDI billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EDI billers to download their remittance advices weekly.

- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EDI Department at (225) 237-3200 ext. 2.

EDI General Information

- Any number of claims can be included in production file submissions. There is no minimum number.

- EDI Testing is required for all submitters (including KIDMED) before they are approved to submit claims for production unless the testing requirement has been completed by the Vendor. LTC providers must test prior to submission to production.

- Case Management Services and Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

UNISYS CLAIMS FILING ADDRESSES

To expedite payment, providers should send "clean" claims directly to the appropriate Post Office Box as listed below. All Post Office Boxes are for Unisys Corporation, Baton Rouge, LA.

Type of Claim or Department	Post Office Box
The zip code for the following P.O. Boxes is <u>70821</u>:	
Pharmacy (original claims and adjustment/voids).....	91019
CMS-1500, including services such as Professional, Independent Lab, Substance Abuse and Mental Health Clinic, Hemodialysis, Professional Services, Chiropractic, Durable Medical Equipment, Mental Health Rehabilitation, EPSDT Health Services, Case Management, FQHC, and Rural Health Clinic (original claims and adjustment/voids)	91020
Inpatient and Outpatient Hospitals, Long Term Care, Hospice, Hemodialysis Facility, Freestanding Psychiatric Hospitals (original claims and adjustment/voids).....	91021
Dental, Transportation (Ambulance and Non-ambulance), Rehabilitation, Home Health (original claims and adjustment/voids).....	91022
All Medicare Crossovers and All Medicare Adjustments and Voids.....	91023
Provider Relations.....	91024
EDI, Unisys Business, and Miscellaneous Correspondence.....	91025
The zip code for the following P.O. Boxes is <u>70898</u>:	
Provider Enrollment……	80159
Prior Authorization.....	14919
KIDMED.....	14849

CLAIMS PROCESSING REMINDERS

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

If claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in you printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**

- Paper claims must be legible and in good condition for scanning into our document imaging system.

- **Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges-black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Do not submit two-sided documents.

- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

The recipient's 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic card is NOT acceptable.

REJECTED CLAIMS

Unisys currently returns illegible claims. These claims have not been processed and are returned along with a cover letter stating what is incorrect.

The criteria for legible claims are:

(1) all claim forms are clear and in good condition,
(2) all information is readable to the normal eye,
(3) all information is centered in the appropriate block, and
(4) all essential information is complete.

ATTACHMENTS

All claim attachments should be standard 8 1/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

CHANGES TO CLAIM FORMS

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf.

DATA ENTRY

Data entry clerks do not interpret information on claim forms-data is keyed as it appears on the claim form. If the data is incorrect, or **IS NOT IN THE CORRECT LOCATION**, the claim will not process correctly.

APPENDIX

EARLYSTEPS

In order to qualify for EarlySteps, the recipient must be between the ages of birth to 3 and have been diagnosed with a medical condition associated with a developmental disability or developmental delay. If a medical diagnosis has not been determined, the recipient may still qualify if they have a developmental delay in at least one of the following areas of development:

Cognitive
Social/emotional
Communication
Adaptive
Physical (including hearing or vision)

All EarlySteps services are provided through a Plan of Care called the "Individualized Family Service Plan (IFSP)". Early intervention is provided through EarlySteps in conformance with part C of the Individual with Disabilities Act.

EarlySteps provides the following Medicaid-covered services:

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Psychology
- Audiology
- Family Service Coordination

EarlySteps also provides the following non-Medicaid covered services:

- Nursing services
- Health services
- Medical services for evaluation purposes only
- Special instruction
- Vision services
- Assistive technology devices and services
- Social work
- Counseling services
- Transportation
- Nutrition

If providers should come into contact with recipients that meet the aforementioned criteria, they may refer them to the local System Point of Entry detailed on the following pages, or have them call EarlySteps at (866) 327-5978.

System Points of Entry (SPOE's)

DHH Region	SPOE	Parishes	Contractor Information
1	National Rehab Partners	Orleans St. Bernard	**Joan Semmes, Director** 2714 Canal Street, Suite 304 New Orleans, LA 70119 Phone (504) 821-6661 Fax (504) 822-0943 E-mail: joan.semmes@rehabnrp.com
1	Families Helping Families of Greater New Orleans	Jefferson Plaquemine's	**Mary Kulas, Program Supervisor** 4323 Division St., Suite 208 Metairie, LA 70002-3179 Phone (504) 324-1442 Toll-Free (800) 766-7736 Fax (504) 457-0337 E-mail: mkulas@fhfofgno.org
2	Families Helping Families of Greater Baton Rouge	East Baton Rouge East Feliciana West Feliciana	**Renee Barber, Program Supervisor** 3060 Teddy Drive, Suite A Baton Rouge, LA 70809 Phone (225) 925-2426 Toll Free (866) 925-2426 Fax (225) 925-1370 E-mail: spoegbr1@bellsouth.net
2	Families Helping Families of Greater Baton Rouge	Pointe Coupee West Baton Rouge Iberville Ascension	
3	Bayou Land Families Helping Families	Assumption St. John St. Charles St James	**Lisa Deroche, Program Supervisor** 2840 West Airline Hwy, Suite D LaPlace, LA 70068 **Phone (985) 479-2430** **Toll Free (866) 234-0593** **Fax (985) 479-2432** **E-mail:** lderoche@sw.rr.com
3	Bayou Land Families Helping Families	Terrebonne Lafourche St. Mary	**Samantha Lassere,Program Supervisor** 760 West Tunnel Blvd., Suite B Houma, LA 70360 **Phone (985) 872-1830** **Fax (985) 872-1841** **E-mail:** slassere@bellsouth.net
4	First Steps Referral and Consulting LLC	Lafayette Iberia St. Martin Vermillion	**Mary F. Hockless, CEO** P.O. Box 12213 New Iberia, LA 70562 Phone (337) 359-8748 Toll-Free (866) 494-8900 Fax (337) 359-8747 E-mail: teamfsrc@bellsouth.net
4	First Steps Referral and Consulting LLC	St. Landry Evangeline Acadia	
5	First Steps Referral and Consulting LLC	Cameron Calcasieu	

DHH Region	SPOE	Parishes	Contractor Information
5	Families Helping Families of Southwest Louisiana, Inc	Beauregard Jefferson Davis Allen	**Crystal Broussard, Intake Supervisor** 109 N. Pine Street **DeRidder, LA 70634** Phone (337) 460-8440 Toll-Free (866) 460-8440 Fax (337) 460-8446 **E-mail:** **bajdspoe@bellsouth.net**
6	Families Helping Families at the Crossroads of Louisiana	Vernon Rapides	**Teresa Harmon, Program Supervisor** 2840 Military Highway Suite B Pineville, LA71360 Phone (318) 640-7078 Toll-Free (866)-445-7672 Fax (318) 640-5799 **E-mail:** **tjharmon891@hotmail.com**
6	Families Helping Families at the Crossroads of Louisiana	Winn, Grant, La Salle, Catahoula, Concordia, Avoyelles	
7	Families Helping Families of Northwest Louisiana, Inc.	Caddo	Jennifer Boyll, Program Supervisor 2620 Centenary Blvd., Bldg. 2, Suite 236 Shreveport, LA 71104 Phone (318) 226-8038 Toll-Free (866) 676-1695 Fax (318) 425-8295 E-mail: jennifer@spoe.ntcmail.net
7	Families Helping Families of Northwest Louisiana, Inc	Bossier Webster Claiborne Bienville	
7	Natchitoches Parish School Board	Natchitoches Sabine DeSoto Red River Parishes	**Cynthia C. Winston, Director** 415 Martin Luther King Jr. Drive Natchitoches, LA 71457 Phone (318) 238-2578 Toll-Free (800) 710-0133 Fax (318) 238-2580 E-mail: Cynthia@walt.nat.k12.la.us & jones@nat.k12.la.us
8	Easter Seals of Louisiana	Ouachita Union Jackson Lincoln Caldwell	**Shellie Hubbard, Director** 1300 Hudson Lane, Suite 5 Monroe, LA 71201 Phone (318) 322-4788 Toll-Free (877) 322-4788 Fax (318) 322-1549 E-mail: shubbard@bayou.com
8	Easter Seals of Louisiana	Morehouse West Carroll East Carroll Richland Franklin Tensas Madison	
9	Northshore Families Helping Families	St. Tammany	**Donna Reno, Program Supervisor** 111 N. Madison St. Covington, LA 70433 Phone (985) 875-0612 Toll-Free (800) 383-8700 Fax (985) 809-5092 E-mail: donnareno@charterinternet.com
9	Southeast Area Health Education Center	Livingston Tangipohoa Washington St. Helena	**Brian Jakes, CEO** 1302 J.W. Davis Drive Hammond, LA 70403 Phone (985) 345-1119 Toll-Free- (888) 295-4270 Fax (985) 419-9486 E-mail: ahecbpj@juno.com

Revised 7/13/2004

REFERRAL FOLLOW UP FORM

Patient name	*Date of Birth*	*Date Referred*	*Reason for referral*	*Referred to*	*Appointment date*	*Follow up effort 1*	*Follow up effort 2*	*Follow up complete*

MAIL TO:
UNISYS KIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING SCREENING SERVICES

1. ☐ ORIGINAL ☐ ADJUSTMENT ☐ VOID
2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO.

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST.	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
( ) —	( ) —		

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN						
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT						

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? ☐ YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
- A. ☐ MEDICALLY CONTRAINDICTED
- B. ☐ PARENTAL REFUSAL
- C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES ☐ NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:

- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

02/03

36. SIGNATURE OF PROVIDER

37. DATE

KM-3

FISCAL AGENT COPY

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

3 PATIENT'S DATE OF BIRTH

4 MEDICAID ID NUMBER

5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

6 PATIENT'S SEX
MALE ☐ ☐ FEMALE

7 INSURED'S NAME

8 PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

9 INSURED'S GROUP NO. (OR GROUP NAME)

10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.

11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. AN AUTO ACCIDENT
YES ☐ ☐ NO

12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

14 DATE FIRST CONSULTED YOU FOR THIS CONDITION

15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

16 DATE PATIENT ABLE TO RETURN TO WORK

17 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18A REFERRING ID NUMBER

19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE?
YES ☐ ☐ NO CHARGES

22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3

23 ATTENDING NUMBER

24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $

26 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY - RECOVERY
- ☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

29 REASONS FOR VOID

- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE

32 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

UNISYS - 213
5/97

UNIVERSAL SCREENING DOCUMENTATION TOOLS - OPTIONAL

A universal screening documentation tool is one that can be used at the screening provider's **option.** The tool is attached. This tool should be completed thoroughly and accurately to ensure all components of a screening are documented. Providers should be familiar with the program requirements of a screening as explained in the KIDMED provider manual. Any additional information necessary to support the screening should also be found in the patient's chart. This tool was designed to incorporate necessary items for a screening in a clear, concise manner. **We <u>are not</u> requiring this tool to be used; it is for your convenience, only**. However, any tool used must document that all five components of a medical screening as stated in the KIDMED manual, were completed. Program compliance reviews will look for such documentation. Furthermore, be aware that the same documentation applies to a "well-child" visit which must also conform to the requirements mandatory for a KIDMED screening. If you do not wish to use this documentation, you may develop your own.

INITIAL SCREENING
BIRTH THROUGH 5 YEARS

DATE:

ıtient Name: Age:

Family History

[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____
_____
_____

(Please note family member's relation to patient)

Birth History

[ ] Term [ ] Premature [ ] Post-mature
[ ] Prenatal care [ ] Complications

[ ] NVD [ ] C-Section

[ ] Neonatal Complications _____

Neonatal Screen: WNL Repeated
Results requested: Yes No

Comments: _____

Past Medical History

Illness _____
_____

Hospitalization _____
_____
_____
_____
_____

Allergies _____
_____
_____

HT. WT. T P R Head Circ. (0-2yrs): Blood Pressure
(3yrs and up):

Hct or Hgb: WNL UTD UTO Urine Dipstick: WNL UTD UTO Lead: Drawn UTD UTO
Value: Comments: [ ] Not required at this time

Vision Screening

Subjective: any eye disorder	Yes	No
F.H.O. eye disorder	Yes	No
Wear glasses	Yes	No

Objective: Visual acuity R20/ L20/
Muscle Balance pass fail
(Objective screening begins at age 4.)

Hearing Screen

Subjective: response to voices	Yes	No
Delayed speech development	Yes	No
Recurrent O.M	Yes	No

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear	_____	_____	_____
Left Ear	_____	_____	_____

Lead Poisoning Risk Assessment

Peeling paint in house, daycare etc.	Yes	No
Relative with lead poison	Yes	No
House built before 19	Yes	No
Renovation	Yes	No
Adult work in pottery or ceramics	Yes	No
Live near battery recycling plant or lead release industry	Yes	No
Live near highway or heavy traffic	Yes	No

Developmental Assessment

Subjective Assessment WNL Suspect Objective
Assessment WNL Delayed
(Copy of screen must be in chart.)

Physical Exam **Normal (✓)** **Abnormal** (Describe)

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ]Breast fed [ ] Formula

Eating Problems _____

Vitamins Supplements	Yes	No
Growth Grid Normal	Yes	No

(Growth Grid must be in chart..)

Dental Assessment

Any Dental Disease	Yes	No
Dental Caries	Yes	No
Brush Teeth Regularly	Yes	No
Do You Have a Dentist?	Yes	No

Name of Dentist _____

Environmental Assessment

Water supply: City Well None
Sewer system: City Septic None
[ ] Smokers in the home: _____
[ ] Pets in home: _____

Comments:

Immunization Status

[ ] Immunizations current
[ ] Off Schedule* [ ] Parental Refusal*
[ ] Medically Contraindicated*

Explain * _____
(Vaccine record must be in chart.)

Anticipatory Guidance
(mark those discussed)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Toilet Training _____

Impressions:

ıan or Referral: [ ]Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

INITIAL SCREENING
AGES 6 TO 21 YEARS

DATE:

ıtient Name: Age:

Family History

[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____
_____
_____

(Please note family member's relation to patient)

Birth History

[ ] Term [ ] Premature [ ] Post-mature

[ ] Prenatal care [ ] Complications

Note: _____

[ ] NVD [ ] C-Section

[ ] Neonatal Complications _____

_____

Past Medical History

[ ] Major Illness _____

_____

[ ] Hospitalizations _____

_____

_____

[ ] Allergies _____

HT. WGT. B.P. T. P. R.

Labs Hct or Hgb: WNL UTD UTO Value: _____ Urine Dipstick: WNL UTD UTO Comments:

Vision Screen

Subjective: any eye disorder	Yes	No
F.H.O. eye disorder	Yes	No
Wear glasses	Yes	No

Objective: Visual acuity	R 20/	L 20/
Muscle Balance	pass	fail
Color Perception	pass	fail

(6 years and up)

Hearing Screen

Subjective: response to voices	Yes	No
Delayed speech development	Yes	No
Recurrent O.M.	Yes	No

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear	_____	_____	_____
Left Ear	_____	_____	_____

Developmental Assessment

Appropriate verbal communication	Yes	No
Drugs/Alcohol/Tobacco	Yes	No
Hobbies & Sports	Yes	No

Family/Peer Relationship	WNL	Poor
School/Job Performance	WNL	Poor

Reproductive

Sexually active Yes Denies
Contraceptive used _____
Menarche age _____ LMP _____
Gravida _____ Para _____

Physical Exam **Normal (✓)** **Abnormal (Describe)**

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ] Special Diet _____
[ ] Vitamins/ Supplements _____
[ ] Growth Chart WNL See Grid
Comments: _____

Dental Assessment

Any Dental Disease	Yes	No
Dental Caries	Yes	No
Brush Teeth Regularly	Yes	No
Do You Have a Dentist?	Yes	No

Name of Dentist _____

Anticipatory Guidance
(Mark ones taught)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Health/Reproduction _____
High Risk activities _____

Environmental Assessment

Water supply: City Well None

Sewer system: City Septic None

Smokers in the home? _____

Pets in home? List:

Immunization Status

[ ] Immunizations current [ ] Off Schedule*

[ ] Medically Contraindicated* [ ] Parental Refusal*

Explain * _____

Impressions:

Plan or Referral: [ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

PERIODIC SCREENING
BIRTH THROUGH 5 YEARS

DATE:

Patient Name:

Age:

Family History

[ ] No changes since last screen
[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Sickle Cell _____
[ ] T.B. _____
[ ] Other: _____

(Please note family member's relation to patient)

Recent Medical History

[ ] No changes since last screen
[ ] Major Illness _____
[ ] Hospitalizations _____
[ ] Allergies _____
[ ] Current Medications _____

Neonatal Screen: WNL Repeated
Results requested: Yes No

Comments: _____

Environmental Assessment

[ ] No changes since last screen

Water supply: City Well None
Sewer: City Septic None

Smokers in home: _____

Pets in home: _____

Developmental Assessment

Subjective Assessment WNL Suspect

Objective Assessment WNL Delayed

(Objective Assessment Must Be In Chart)

HT. WT. T P R
Head Circ. (0-2yrs): Blood Pressure (3yrs and up):

Hct or Hgb: WNL UTD UTO Urine Dipstick: WNL UTD UTO Lead: Drawn UTD UTO
Value: Comments: [ ] Not required at this time

Vision Screening

Subjective: any eye disorder	Yes	No
F.H.O. eye disorder	Yes	No
Wear glasses	Yes	No

Objective: Visual acuity R20/ L20/
Muscle Balance pass fail
(Objective screening begins at age 4)

Hearing Screen

Subjective: response to voices	Yes	No
Delayed speech development	Yes	No
Recurrent O.M.	Yes	No

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear	_____	_____	_____
Left Ear	_____	_____	_____

Lead Poisoning Risk Assessment

Peeling paint in house, daycare etc.	Yes	No
Relative with lead poison	Yes	No
House built before 1960	Yes	No
Renovation	Yes	No
Adult work in pottery or ceramics	Yes	No
Live near battery recycling plant or lead	Yes	No
Release industry	Yes	No
Live near highway or heavy traffic	Yes	No

Physical Exam **Normal (✓)** **Abnormal** (Describe)

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Nutritional Assessment

[ ] Breast fed [ ] Formula

Eating Problems _____

Vitamins Supplements	Yes	No
Growth Grid Normal	Yes	No

(Growth Grid must be in chart)

Dental Assessment

Any Dental Disease	Yes	No
Oral Car e Appropriate	Yes	No

Comments:

Name of Dentist _____
(Dental Visits are recommended by age 3)

Immunization Status

[ ] Immunizations current [ ]Off Schedule* [ ]Medically Contraindicated* [ ]Parental Refusal*

Explain * _____

(Vaccine record must be in chart.)

Anticipatory Guidance
(mark those discussed)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____

Impressions:

Plan or Referral:

[ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

PERIODIC SCREENING
AGES 6 TO 21 YEARS

DATE:

Patient Name: 6 8 10 12 14 16 18 20 Age:

Family History

[ ] No changes since last screen
[ ] Allergy or Asthma _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Heart Disease _____
[ ] Stroke _____
[ ] T.B. _____
[ ] Other: _____

Recent Medical History

[ ] No changes since last screen
[ ] Major Illness _____
[ ] Hospitalizations _____
[ ] Current Medications _____

Environmental Assessment

[ ] No changes since last screen

Water supply: City Well None
Sewer: City Septic None
Smokers in home: _____
Pets in home: _____

Developmental Assessment

[ ] No changes since last screen

Verbal communication: WNL poor
Relationships WNL poor
School/Job Performance: WNL poor
Hobbies & Sports WNL No

Comments: _____

HT. WT. B.P. T. P. R.

Labs Hct or Hgb: WNL UTD UTO Value: _____ Urine Dipstick: WNL UTD UTO Comments:

Vision Screen

Subjective Assessment WNL: Yes No
Wears Glasses: Yes No

Objective: [ ] Unable to Perform

Visual acuity	R 20/	L20/
Muscle Balance	pass	fail
Color Perception	pass	fail

Hearing Screen

Subjective: [ ] No change since last screen
Note change: _____

Hearing 20 db HL

	1000Hz	2000 Hz	4000Hz
Right Ear			
Left Ear			

Reproductive

Sexually active Yes Denies
Contraceptive used _____
Menarche age _____ LMP _____
Gravida _____ Para _____

Immunization Status

[ ] Immunizations current [ ] Off Schedule* [ ] Medically Contraindicated* [ ] Parental Refusal*

Explain * _____

(Vaccine record must be in chart.)

Nutritional Assessment

[ ] Nutritional Status WNL
[ ] Vitamins/ Supplements _____
[ ] Growth Chart WNL
(Growth Grid Must Be In Chart)

Physical Exam

Normal (✓) Abnormal (Describe)

1. Cranium /Face _____
2. Hair / Scalp _____
3. EENT _____
4. Mouth / Teeth _____
5. Skin / Lymph Nodes _____
6. Heart _____
7. Lungs _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal System _____
11. Extremities _____
12. Nervous System _____

Dental Assessment

[ ] No changes since last screen
[ ] Appropriate oral hygiene
Name of Dentist _____

Anticipatory Guidance
(Mark ones taught)

Nutrition/Diet _____
Skin Care/Hygiene _____
Oral/Dental _____
Behavioral/Developmental _____
Safety _____
Parenting/Discipline _____
Immunization Management _____
School Status _____
Health/Reproduction _____
High Risk activities _____

Impressions:

Plan or Referral:

[ ] Interpretive Conference Conducted

Key: UTD-Up To Date; UTO-Unable to Obtain; WNL-Within Normal Limits

Signature: _____

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us**.

Seminar Date:_____ Location of Seminar (City):_____

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**				**Excellent**
The seminar location was satisfactory	1	2	3	4	5
Facility provided a comfortable learning environment	1	2	3	4	5
SEMINAR CONTENT	**Poor**				**Excellent**
Materials presented are educational and useful	1	2	3	4	5
Overall quality of printed material	1	2	3	4	5
UNISYS REPRESENTATIVES	**Poor**				**Excellent**
The speakers were thorough and knowledgeable	1	2	3	4	5
Topics were well organized and presented	1	2	3	4	5
Reps provided effective response to questions	1	2	3	4	5
Overall meeting was helpful and informative	1	2	3	4	5
SESSION: KIDMED					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at **(800) 473-2783 or (225) 924-5040.**