Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Family Planning Services and Family Planning Only Program

For Family Planning Clinics

Billing Instructions

July 2003

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About this publication

This publication supersedes all previous MAA Family Planning Services Billing Instructions.

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Table of Contents

Important Contacts iii
Other Important Numbers v
Definitions 1

Section A: Family Planning Services
What are the three components to Family Planning Services? A.1
What is the purpose of Family Planning Services? A.1
Reimbursement A.1
Provider Requirements A.1

Section B: Client Eligibility
Who is eligible? B.1
Can clients enrolled in a Healthy Options managed care plan receive family planning services? B.2

Section C: Coverage
What is covered? C.1
What is not covered? C.2
What drugs and supplies may be obtained through the pharmacy program? C.3

Section D: Family Planning Only Program
What is the purpose of the Family Planning Only program? D.1
Who is eligible? D.1
Provider Requirements D.1
What is covered? D.2
Reimbursement D.2

Section E: Fee Schedule E.1

Section F: Billing
What if a provider has more than one provider number? F.1
What is the time limit for billing? F.1
What fee should I bill MAA? F.3
When can I bill the client? F.3
Third-Party Liability F.3
What records must be kept? F.4

Table of Contents (cont.)

Section G: Sterilization Policy and Consent Forms

What is sterilization? G.1
What are MAA's reimbursement requirements for sterilizations? G.1
Additional Requirements for Sterilization of Mentally Incompetent or Institutional Clients G.2
When does MAA waive the 30-day waiting period? G.2
When does MAA not accept a signed Sterilization Consent Form? G.3
Why do I need a DSHS-approved Sterilization Consent Form? G.3
Who completes the Sterilization Consent Form? G.3
How to Complete the Sterilization Consent Form G.4
How to Complete the Client Statement Form G.7
How to complete the Sterilization Consent Form for a Client Age 18-20 ..... G.8
Blank Sterilization Consent Form G.9
Sample Sterilization Consent Form G.10
Blank Client Statement Form G.11
Sample Sterilization Consent Form Needing a Client Statement Form G.12
Sample Client Statement Form G.13
Sample Sterilization Consent Form for Client Age 18-20 ..... G.14

Section H: How to Complete the HCFA-1500 Claim Form

General Guidelines H.1
Sample HCFA-1500 Claim Form H.6

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020(2)].

Who do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

How do I obtain information regarding the Family Planning Program?

Check out the Family Planning page on MAA's web site at:
http://maa.dshs.wa.gov/familyplan/

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Who do I contact for Electronic billing?

Write/call:
Electronic Media Claims Help Desk
(360) 725-1267

Who do I contact for Internet billing?
http://maa.dshs.wa.gov/ecs.htm

Who do I contact if I have questions regarding…

Policy or program questions about family planning services?

Division of Program Support/
Family Planning
(360) 725-1652 or
(360) 725-1664

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
Email: providerinquiry@dshs.wa.gov
or call: (800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

How do I obtain pharmacy information?

MAA's Pharmacy Web Site:
http://maa.dshs.wa.gov/pharmacy/

Prescriptions By Mail Web Site:
Providers Call: 1-888-327-9791
Clients Call: 1-800-903-8639
Or go to MAA's website:
http://maa.dshs.wa.gov/RxByMail/

How do I obtain copies of billing instructions or numbered memoranda?

Check out MAA's web site at: http://maa.dshs.wa.gov (click on Provider Publications/Fee Schedules link)

Other Important Numbers

Client Assistance/
Brokered Transportation Hotline (Clients Only) 1-800-562-3022

Fraud Hotline 1-800-562-6906

Healthy Options Enrollment 1-800-562-3022

Pharmacy Authorization **(Providers Only)**..... 1-800-848-2842

Provider Inquiry Hotline **(Providers Only)** 1-800-562-6188

Provider Enrollment..... 1-866-545-0544

Telecommunications Device For The Deaf (TDD) 1-800-848-5429

Third-Party Resource Hotline 1-800-562-6136

Provider Field Representatives

(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Acquisition cost - The cost of an item excluding shipping, handling, and any applicable taxes.

Ancillary services - Services such as laboratory exams, tests, and procedures performed in conjunction with a family planning diagnosis or procedure.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Offices (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level.

Complication - A condition occurring subsequent to and directly arising from the family planning services received under the rules of this chapter.

Contraception - Preventing pregnancy by preventing conception.

Contraceptive - A device, drug, or product that prevents conception.

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department - The state Department of Social and Health Services.
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Family Planning Only Program - A program for women only. The program provides an additional ten months of family planning services to eligible women who have just ended a pregnancy or completed a delivery.

Family Planning Services - Medical care, contraceptive supplies, and educational services that enable individuals to plan and space the number of children by using contraception to avoid unintended pregnancy.

Healthy Options - See Managed Care.

Informed consent - An individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the client's diagnosis;
- Offered the client an opportunity to ask questions about the procedure and to request information in writing;
- Given the client a copy of the consent form;
- Communicated effectively using any language interpretation or special communication device necessary per 42 CFR 441.257; and
- Given the client oral information about all of the following:

  ✓ The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
  ✓ Alternatives to the procedure including potential risks, benefits, and consequences; and
  ✓ The procedure itself, including potential risks, benefits, and consequences.

MAA-approved family planning provider - A physician, advanced registered nurse practitioner (ARNP), or clinic that has been approved for and assigned a family planning provider number.

Managed care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program or medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medical chart –A written summary (kept by the provider) of the nursing or medical care rendered to an individual patient.

Medically necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all.
[WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Over-the-counter (OTC)–Available for sale without a prescription.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and that consists of:

- First and middle initials (or a dash (-) if the middle initial is not indicated).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha character (tie breaker).

Primary Care Case Management (PCCM) - A system under which a provider contracts with the state to furnish case management services, which include the provision, coordination, and monitoring of primary care to Medicaid clients.

Primary Care Provider (PCP) - A person licensed or certified under Title 18 RCW including, but not limited to, a physician or advanced registered nurse practitioner (ARNP) who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialists and ancillary care, and maintains the client's or enrollee's continuity of care.

Principal diagnosis of family planning - The reason for the service or intervention is primarily for family planning purposes.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Remittance and Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Sexually transmitted disease-infection (STD-I) - A disease or infection acquired as a result of sexual contact.

TAKE CHARGE—A five-year demonstration project that provides family planning to men and women with income at or below 200% of the Federal Poverty Level. (Billing instructions for **TAKE CHARGE** can be found in MAA's TAKE CHARGE Family Planning Supplement.) [Refer to WAC 388-532-050]

Third-Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee - The fee that the provider typically charges the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Family Planning Services

What are the three eligibility categories of Family Planning Services?

Family Planning Services consists of three eligibility categories, which cover family planning services for eligible clients. These categories are:

1. Family Planning Services as part of medical coverage for Medicaid programs;

2. The Family Planning Only Program for women (see Section D for more information).

3. The TAKE CHARGE Family Planning Program which is a 5-year federal demonstration waiver that began July 2001 (see MAA's TAKE CHARGE Family Planning Supplement).

What is the purpose of Family Planning Services?

The Medical Assistance Administration (MAA) reimburses for covered family planning services and birth control methods provided to eligible clients. The purpose is to assist individuals in:

- Becoming and remaining self-sufficient; and

- Avoiding unintended pregnancy through planning and spacing the birth of their children.

Reimbursement **[Refer to WAC 388-532-140]**

MAA reimburses covered family planning services using the fee schedule contained in this document.

For Healthy Options enrollees who have self-referred to an MAA-approved family planning provider outside their plan, all laboratory services must be billed through the family planning provider.

Provider Requirements [Refer to WAC 388-532-110]

Family planning clinic providers must:

- Be Medicaid providers qualified to provide family planning services;
- Meet the requirements in Chapter 388-502 WAC, Administration of Medical Programs - Provider rules;
- Provide only those services that are within the scope of their licenses;
- Provide medical information and education about all Food & Drug Administration (FDA)-approved prescription birth control methods and over-the-counter birth control supplies to all eligible clients who request such services; and
- Sign a special agreement that allows the provider to bill for family planning laboratory services provided to Healthy Options enrollees through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA). Laboratories bill their usual and customary charges. The family planning provider, in turn must claim reimbursement from MAA for the lab fees. When reimbursed, the family planning provider pays the lab(s) only the amount reimbursed by MAA. (There is no need to pay other than what MAA reimbursed for lab fees.)

Client Eligibility

Who is eligible?

Clients presenting Medical IDentification (ID) cards with the following identifiers are eligible for Family Planning Services:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – CHIP	CNP – Children's Health Insurance Program
Family Planning Only	Family Planning Only
GAU **No Out of State Care**	General Assistance Unemployable
LCP-MNP	Limited Casualty Program-Medically Needy Program

Note: To provide clarification as a result of a significant number of inquiries, clients presenting Medical ID cards with the following identifiers are not eligible for family planning services:

- **Detox Only**
- **MIP-EMER Hospital Only – No out-of-state care** (Medically Indigent Program).

Can clients enrolled in a Healthy Options managed care plan receive family planning services?

Healthy Options enrollees may self-refer outside their plan (HMO) or primary care case manager (PCCM) for family planning services to:

- An MAA-approved family planning provider; or
- A Pharmacy.

Send claims directly to MAA for self-referred services.

Note: When a Healthy Options primary care provider (PCP) or PCCM refers a client to your agency for family planning services (e.g., Depo-Provera injection), your agency **must bill the Healthy Options plan directly** for reimbursement for the family planning services.

Coverage

What is covered?

MAA covers the following family planning services:

- **Services for Women**

  ✓ Gynecological exams, as medically necessary.

  ✓ Food & Drug Administration (FDA) -approved prescription contraception methods as identified in Chapter 388-530 WAC, Pharmacy Services.

  ✓ Over-the-counter (OTC) contraceptives, drugs, and supplies (as described in Chapter 388-530 WAC, Pharmacy Services).

  ✓ Sterilization procedure that meets the requirements of WAC 388-531-1550 (1), if it is:

    - Requested by the client; and
    - Performed in an appropriate setting for the procedure.

  ✓ Screening and treatment for STD-I when:

    - Performed in conjunction with a principal diagnosis of family planning; and
    - Required as part of the client's selected contraceptive method(s).

  ✓ Education on natural family planning and abstinence.

- **Services for Men**

  ✓ Over-the-counter (OTC) contraceptives, drugs, and supplies (as described in Chapter 388-530 WAC, Pharmacy Services).

  ✓ Surgical sterilization procedure that meets the requirements of WAC 388-531-1550 (1), if it is:

    - Requested by the client; and
    - Performed in an appropriate setting for the procedure.

✓ Screening and treatment for STD-I when:

- ➢ Performed in conjunction with a principal diagnosis of family planning; and
- ➢ Required as part of the client's selected contraceptive method(s).

✓ Education on natural family planning and abstinence.

What is not covered? [Refer to WAC 388-532-130]

MAA does not cover services, equipment, or supplies to which any of the following apply:

- The service or equipment is not included as a covered service in the state plan (e.g., infertility treatment services);
- Federal or state laws or regulations prohibit coverage; or
- The service or equipment is considered experimental or investigational by the FDA or the Centers for Medicare and Medicaid Services (CMS).

The following are not considered family planning services and <u>are not</u> covered under the Family Planning Services program:

- Infertility treatment services;
- Abortions;
- Mammograms;
- Menopausal treatment services;
- Cancer screenings (except pap smears); and
- All other reproductive health care, health care services, or primary care services and prenatal care services (see WAC 388-532-740).

MAA reviews all initial requests for noncovered services based on WAC 388-501-1065.

Note: The Family Planning Only (FPO) program **does not** cover abortions if the client becomes pregnant and requests an abortion. The client must return to the CSO and request a redetermination of her eligibility for full medical coverage.

What drugs and supplies may be prescribed by family Planning Clinics?

Family Planning Clinics may prescribe family planning related drugs and contraceptives within the following therapeutic classifications:

- Contraceptive drugs/devices;
- Emergency contraceptive pills (ECP);
- Analgesics;
- Antibiotics;
- Anti-emetics;
- Antifungals;
- Anti-infectives; and
- Anti-inflammatories.

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, etc.,) may be obtained in a 30-day supply through a pharmacy with a Medical ID card.

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Family Planning Only Program

What is the purpose of the Family Planning Only program?
[Refer to WAC 388-532-500]

The Family Planning Only (FPO) program provides an additional 10 months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. **This program serves women only.**

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a medical ID card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she must notify the CSO to receive the special medical ID card.

Who is eligible?

A woman is eligible for FPO if:

- She received medical benefits during her pregnancy; or
- She is determined eligible for a retroactive period covering the end of the pregnancy.

Provider Requirements **[Refer to WAC 388-532-520]**

Providers must:

- Be Medicaid providers qualified to provide family planning services;
- Meet the requirements in Chapter 388-502 WAC, Administration of Medical Programs - Provider rules;
- Provide only those services that are within the scope of their licenses; and
- Provide medical information and education about all Food & Drug Administration (FDA)-approved prescription birth control methods and over-the-counter birth control supplies to all eligible clients who request such services.

What is covered?

The following family planning services are covered under FPO:

- Gynecological exams as medically necessary;
- Food and Drug Administration (FDA) -approved prescription contraception methods as identified in Chapter 388-530 WAC, Pharmacy Services;
- Nonprescription over-the-counter contraceptives, drugs, and supplies as identified in Chapter 388-530 WAC, Pharmacy Services;
- Education in natural family planning and abstinence;
- Sterilization procedure that meets the requirements of WAC 388-531-1550 (1), if it is:
  - ✓ Requested by the client; and
  - ✓ Performed in an appropriate setting for the procedure; and
- Screening and treatment for STD-I when:
  - ✓ Performed in conjunction with a principal diagnosis of family planning; and
  - ✓ Required as part of the client's selected contraceptive method(s).

What is not covered?

Noncovered services for FPO are the same services not covered under Family Planning Services on page D.2.

Reimbursement

MAA limits reimbursement under FPO to visits and services that have a principal purpose diagnosis of family planning. A qualified, licensed medical practitioner must make the diagnosis.

MAA does not reimburse for inpatient services under FPO. However, inpatient costs may be incurred as a result of complications arising from covered family planning services. Providers of inpatient services must submit a complete report of the circumstances and conditions that caused the need for the inpatient services. MAA will then make a determination of the circumstances and the potential payment sources (e.g., the family planning provider, the ancillary service provider(s), and/or MAA).

Fee Schedule

OFFICE VISITS

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
99201	Office/outpatient visit, new	$23.75	$15.50
99202	Office/outpatient visit, new	42.25	30.75
99203	Office/outpatient visit, new	62.50	47.00
99204	Office/outpatient visit, new	89.00	69.50
99205	Office/outpatient visit, new	113.50	92.50
99211	Office/outpatient visit, est	14.00	6.00
99212	Office/outpatient visit, est	24.75	15.50
99213	Office/outpatient visit, est	34.50	23.25
99214	Office/outpatient visit, est	54.00	38.00
99215	Office/outpatient visit, est	79.00	61.25

PRESCRIPTION BIRTH CONTROL METHODS

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
Oral Contraceptives			
S4993	Contraceptive pills for birth control	$17.00	$17.00
J3490*	Unclassified Drugs (Use for Emergency Contraception Pills including Preven and Plan B)	Acquisition Cost	Acquisition Cost
Cervical Cap/Diaphragm			
A4261	Cervical cap for contraceptive use	47.00	47.00
A4266	Diaphram	45.00	45.00
57170	Fitting of diaphragm/cap	53.92	29.80
Implant			
A4260	Levonorgestrel (Norplant) implant system, including implant and supplies. ***One allowed in a 5-year period.***	451.68	451.68
11975	Insert contraceptive capsule	93.67	93.67
11976	Removal of contraceptive capsule	119.95	119.95
11977	Removal/insert contra capsule	213.62	213.62

***Claims billed with unlisted drug code J3490 must include the name of the drug, dosage, strength, and NDC in the *Comments* section of the claim form.**

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
Injectables			
J1055	Medroxyprogesterone acetate inj (Depo-Provera). ***Allowed one every 67 days.***	$47.69	$47.69
J1056	MA/EC contraceptive injection (Lunelle). ***Allowed one every 23 days.***	23.21	23.21
90782	Injection, subcutaneous/intramuscular ***May be billed when the contraceptive injection is the only service performed.***	2.73	2.73
Intrauterine Devices (IUD)			
J7300	Intrauterine copper device (Paragard)	257.14	257.14
J7302	Levonorgestrel-releasing IUD (Mirena)	382.17	382.17
S4989	Intrauterine device (non-copper) (Progestacert)	109.93	109.93
58300	Insertion of IUD	57.56	33.44
58301	Removal of IUD	66.43	42.32
Miscellaneous Contraceptives			
J3490*	Unclassified Drug (Use for Ortho-Evra contraceptive patch, each)	Acquisition Cost	Acquisition Cost
J3490*	Unclassified Drug (Use for Nuvaring contraceptive ring, each)	Acquisition Cost	Acquisition Cost

***Claims billed with unlisted drug code J3490 must include the name of the drug, dosage, strength, and NDC in the *Comments* section of the claim form.**

NON-PRESCRIPTION OVER-THE-COUNTER (OTC) BIRTH CONTROL METHODS

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee
A4267	Male Condom, each	Acquisition Cost
A4268	Female Condom, each	Acquisition Cost
A4269	Spermicide (e.g. foam, gel), each	Acquisition Cost
OTC products listed may not be available for billing MAA due to federal approval status.		

HIV COUNSELING

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
99401 Must include dx V65.44	Preventive Counseling, indiv; approx 15 min (use for risk reduction intervention for HIV/AIDS clients)	$25.48	$15.24

STERILIZATION PROCEDURES

(A properly completed Sterilization Consent Form must be attached to the claim in order to receive payment)

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
55250	Removal of sperm duct(s)	$254.80	$144.92
55450	Ligation of sperm duct	234.55	152.88
58600	Division of fallopian tube	208.39	208.39
58615*	Occlude fallopian tube(s)	166.53	166.53
58670	Laparoscopy, tubal cautery	219.08	219.08
58671*	Laparoscopy, tubal block	219.54	219.54

MISCELLANEOUS SURGICAL PROCEDURES

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
17110	Destruct lesion, 1-14	$54.60	$25.71
54050	Destruction, penis lesion(s)	93.05	40.72
54056	Cryosurgery, penis lesion(s)	100.78	41.41
54060	Excision of penis lesion(s)	158.11	81.45
56501	Destroy vulva lesions, simple	88.72	66.89
57061	Destroy vaginal lesions, simple	80.08	57.10

* MAA reimburses for external occlusive devices **only** such as band, clip, or Fallop ring. MAA does not reimburse for occlusive devices introduced into the Lumen of the fallopian tubes.

RADIOLOGY SERVICES

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
76830	Us exam, transvaginal	$57.79	$57.79
76830-26	Professional Component	21.61	21.61
76830-TC	Technical Component	36.17	36.17
76856	Us exam, pelvic, complete	57.79	57.79
76856-26	Professional Component	21.61	21.61
76856-TC	Technical Component	36.17	36.17
76857	Us exam, pelvic, limited	57.79	57.79
76857-26	Professional Component	11.83	11.83
76857-TC	Technical Component	45.95	45.96

LABORATORY SERVICES

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
G0101	CA screen; pelvic/breast exam	$22.07	$14.11
Q0111	Wet mounts/ w preparations	4.83	4.83
Q0112	Potassium hydroxide preps	4.83	4.83
36415	Drawing blood venous	2.45	2.45
36416	Drawing blood capillary	2.45	2.45
81000	Urinalysis, nonauto w/scope	3.59	3.59
81001	Urinalysis, auto w/scope	3.59	3.59
81002	Urinalysis nonauto w/o scope	2.89	2.89
81003	Urinalysis, auto, w/o scope	2.54	2.54
81005	Urinalysis	2.45	2.45
81007	Urine screen for bacteria	2.91	2.91
81015	Microscopic exam of urine	3.43	3.43
81025	Urine pregnancy test	4.25	4.25
82465	Assay, bld/serum cholesterol	4.92	4.92
82947	Assay, glucose, blood quant	4.44	4.44
82948	Reagent strip/blood glucose	3.59	3.59
84702	Chorionic gonadotropin test	17.03	17.03
84703	Chorionic gonadotropin assay	8.50	8.50
85004	Automated diff wbc count	7.32	7.32
85007	Differential WBC count	3.90	3.90
85013	Hematocrit	2.68	2.68
85014	Hematocrit	2.68	2.68
85018	Hemoglobin	2.68	2.68

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
85025	Automated hemogram	$8.80	$8.80
85027	Automated hemogram	7.32	7.32
86255	Fluorescent antibody, screen	13.64	13.64
86255-26	Professional Component	12.51	12.51
86592	Blood serology, qualitative	4.83	4.83
86593	Blood serology, quantitative	4.99	4.99
86631	Chlamydia antibody	13.38	13.38
86632	Chlamydia igm antibody	14.37	14.37
86689	HTLV/HIV confirmatory test	27.05	27.05
86692	Hepatitis, delta agent	19.42	19.42
86701	HIV-1	10.05	10.05
86703	HIV-1/HIV-2, single assay	15.53	15.53
86706	Hep b surface antibody	12.16	12.16
86781	Treponema pallidum, confirm	14.99	14.99
87070	Culture, bacteria, other	9.74	9.74
87076	Culture anaerobe ident, each	9.14	9.14
87081	Culture screen only	7.50	7.50
87084	Culture of specimen by kit	9.74	9.74
87086	Urine culture/colony count	9.14	9.14
87088	Urine bacteria culture	7.27	7.27
87110	Chlamydia culture	22.17	22.17
87140	Cultur type immunofluoresc	6.31	6.31
87147	Culture type, immunologic	5.86	5.86
87164	Dark field examination	12.16	12.16
87164-26	Professional Component	11.38	11.38
87184	Microbe susceptible, disk	7.80	7.80
87186	Microbe susceptible, mic	9.78	9.78
87205	Smear, gram stain	4.83	4.83
87206	Smear, fluorescent/acid stai	6.08	6.08
87207	Smear, special stain	6.78	6.78
87207-26	Professional Component	12.51	12.51
87210	Smear, wet mount, saline/ink	4.83	4.83
87250	Virus inoculate, eggs/animal	21.68	21.68
87252	Virus inoculation, tissue	29.50	29.50
87253	Virus inoculate tissue, addl	22.86	22.86
87274	Herpes simplex 1, ag, if	13.58	13.58
87285	Treponema pallidum, ag, if	13.58	13.58
87340	Hepatitis b surface ag, eia	11.69	11.69
87490	Chylmd trach, dna, dir probe	22.70	22.70
87491	Chylmd trach, dna, amp probe	39.72	39.72
87534	Hiv-1, dna, dir probe	22.70	22.70

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
87535	Hiv-1, dna, amp probe	$39.72	$39.72
87536	Hiv-1, dna, quant	96.30	96.30
87537	Hiv-2, dna, dir probe	22.70	22.70
87538	Hiv-2, dna, amp probe	39.72	39.72
87539	Hiv-2, dna, quant	48.48	48.48
87590	N.gonorrhoeae, dna, dir prob	22.70	22.70
87591	N.gonorrhoeae, dna, amp prob	39.72	39.72
87621	Hpv, dna, amp probe	39.72	39.72
87810	Chylmd trach assay w/optic	13.58	13.58
88141	Cytopath, c/v, interpret	14.11	14.11
88142	Cytopath, c/v, thin layer	28.31	28.31
88143	Cytopath, c/v, thin lyr redo	28.31	28.31
88147	Cytopath, c/v, automated	15.90	15.90
88148	Cytopath, c/v, auto rescreen	21.23	21.23
88150	Cytopath, c/v, manual	14.76	14.76
88152	Cytopath, c/v, auto redo	14.76	14.76
88153	Cytopath, c/v, redo	14.76	14.76
88154	Cytopath, c/v, select	14.76	14.76
88161	Cytopath smear, other source	33.44	33.44
88161-26	Professional Component	16.61	16.61
88161-TC	Technical Component	16.61	16.61
88164	Cytopath tbs, c/v, manual	14.76	14.76
88165	Cytopath tbs, c/v, redo	14.76	14.76
88166	Cytopath tbs, c/v, auto redo	14.76	14.76
88167	Cytopath tbs, c/v, select	14.76	14.76
88174	Cytopath, c/v auto, in fluid	29.53	29.53
88175	Cytopath, c/v auto fluid redo	36.61	37.01
88302	Tissue exam by pathologist, level II	20.25	20.25
88302-26	Professional Component	4.55	4.55
88302-TC	Technical Component	15.70	15.70

INJECTABLE DRUGS AND INJECTION FEE

(These drugs are given in the family planning clinic. These are not take-home drugs or drugs obtained by prescription through a pharmacy.)

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
90788	Injection of antibiotic	$2.96	$2.96
J0456	Azithromycin inj, 500 mg	22.34	22.34
J0580	Penicillin g benzathine inj	35.81	35.81
J0690	Cefazolin sodium inj, 500 mg	1.58	1.58
J0694	Cefoxitin sodium inj, 1 g	9.68	9.68
J0696	Ceftriaxone sodium inj, 250 mg	13.51	13.51
J0697	Sterile cefuroxime inj, 750 mg	5.81	5.81
J0698	Cefotaxime sodium inj, per gram	9.46	9.46
J0710	Cephapirin sodium inj, up to 1 g	1.41	1.41
J1200	Diphenhydramine hcl inj, up to 50 mg	1.46	1.46
J1890	Cephalothin sodium inj, up to 1 g	9.29	9.29
J2460	Oxytetracycline inj, up to 50 mg	0.92	0.92
J2510	Penicillin g procaine inj, to 600,000 u	8.19	8.19
J2540	Penicillin g potassium inj, to 600,000 u	0.26	0.26
J3320	Spectinomycn di-hcl inj, up to 2 g	24.26	24.26
Q0144	Azithromycin dihydrate, oral, 1 g	Acquisition Cost	Acquisition Cost

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Billing

What if a provider has more than one provider number?

When your agency has more than one provider number, the following table outlines which number to use for billing Family Planning Services for self-referred Healthy Options enrollees and fee-for-service (FFS) clients.

Type of Service	Self-Referred Healthy Options enrollees	Family Planning Only Program Clients	All Other Eligible Clients
Family Planning	Family Planning number	Family Planning number	Family Planning number
Sexually Transmitted Disease (STD-I)	Family Planning number	Family Planning number or Medical number	Family Planning number or Medical number
Abortion	Medical number	Not covered	Medical number
Other: menopause, preventive care, abnormal pap, precancerous conditions	Refer client to Primary Care Provider	Not covered	Medical number

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  - ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

    - The date the provider furnishes the service to the eligible client;
    - The date a final fair hearing decision is entered that affects or has an impact on the particular claim;
    - The date a court orders MAA to cover the services; or
    - The date DSHS certifies a client eligible under delayed[1] certification criteria.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Note: If MAA has recouped a managed care plan's premium, causing the provider to bill MAA, the billing time limit is 365 days from the date the plan recouped the payment from the provider.

✓ MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

- DSHS certification of a client for a retroactive[2] period; or
- The provider proves to MAA's satisfaction that there are other extenuating circumstances.

✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above. When rebilling, send a copy of the original Remittance and Status Report along with the claim. Be sure to cross out any lines that have already been paid.

- The time periods listed above do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- The provider, or any agent of the provider, **must not bill a client or a client's estate** when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA?

Bill MAA your *usual and customary fee* (the fee you bill the general public). MAA's payment will be either your usual and customary fee or MAA's maximum allowable rate, whichever is less.

When can I bill the client?

Please refer to MAA's General Information Booklet for information on billing the client or to WAC 388-502-0160.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claims is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's Web site at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  ✓ Patient's name and date of birth;
  ✓ Dates of service(s);
  ✓ Name and title of person performing the service, if other than the billing practitioner;
  ✓ Chief complaint or reason for each visit;
  ✓ Pertinent medical history;
  ✓ Pertinent findings on examination;
  ✓ Medications, equipment, and/or supplies prescribed or provided;
  ✓ Description of treatment (when applicable);
  ✓ Recommendations for additional treatments, procedures, or consultations;
  ✓ X-rays, tests, and results;
  ✓ Plan of treatment and/or care, and outcome; and
  ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

Note: MAA does not reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to MAA's Physician-Related Services Billing Instructions for information on hysterectomies.

What are MAA's reimbursement requirements for sterilizations? [Refer to WAC 388-531-1550(2)]

MAA covers sterilization when all of the following apply:

- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual;
- The client has **voluntarily** given informed consent in accordance with all of the requirements explained under this section as required by CFR 441.258; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

Note: MAA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system.

MAA reimburses providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for the sterilization procedure only when a completed, federally approved Sterilization Consent Form is attached to the claim. MAA reimburses after the procedure is completed.

MAA reimburses providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. MAA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and

- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before MAA will reimburse the provider for the sterilization of a mentally incompetent or institutionalized client. MAA requires both of the following to be attached to the claim form:

- A court order; and
- A Sterilization Consent Form signed by the legal guardian.

When does MAA waive the 30-day waiting period?

[WAC 388-531-1550(3)(4)]

MAA waives the 30-day waiting period, **but does require** at least a 72-hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

MAA waives the 30-day waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a sterilization consent form when one of the following circumstances apply:

- The client became eligible for Medical Assistance during the last month of pregnancy *("NOT ELIGIBLE 30 DAYS BEFORE DELIVERY");* or
- The client did not obtain medical care until the last month of pregnancy *("NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"*); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. *("NO SUBSTANCE ABUSE AT TIME OF DELIVERY.")*

The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver conditions has been met. REQUIRED LANGUAGE IS SHOWN IN PARENTHESIS. Electronic billers must indicate this information in the *Comments* field.

When does MAA not accept a signed Sterilization Consent Form? [Refer to WAC 388-531-1550(5)(6)]

MAA does not accept a signed Sterilization Consent Form obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form to attach to their claim. **MAA does not accept any other form**.

MAA will deny a claim for a sterilization procedure received without a Sterilization Consent Form.

MAA will deny a claim with an incomplete or improperly completed Sterilization Consent Form. The claim and completed Sterilization Consent Form are to be submitted to the:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

Who completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page 18b: "When does MAA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed on or after the surgery date by the physician who performed the surgery.

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent Form must be legible.
- All blanks on the Sterilization Consent Form must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- MAA does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form:

Section I: Consent to Sterilization	
Item	**Instructions**
1. Physician or Clinic:	**Must be name of physician or clinic that gave client required information regarding sterilization.** This may be different than performing physician if another physician takes over.
2. Specify type of operation:	**Indicate type of sterilization procedure.**
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's name and match Items #7, #12, and #18 on Sterilization Consent Form.
5. Physician:	Must be name of physician who will perform sterilization. Physician who performs surgery must be same physician who signs on bottom right (see #22) of Sterilization Consent Form. If a different physician performs the surgery, he/she must complete Item #22 and attach a completed Client Statement Form (see page 20c).
6. Specify type of operation:	Indicate type of sterilization procedure.
7. Signature:	Client signature. Must be client's first and last name. Must match name on Items #4, #12, and #18 on Sterilization Consent Form. Must be original signature in ink.
8. Month/Day/Year:	Date of consent. Must be date that client signed Sterilization Consent Form. Must be more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page 18b: "When does MAA waive the 30 day waiting period?" and/or section IV of Sterilization Consent Form.

Section II: Interpreter's Statement	
Item	**Instructions**
9. Language:	**Must specify language into which sterilization information statement has been translated.**
10. Interpreter:	Must be interpreter's name. **Must be interpreter's original signature in ink.**
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent	
Item	**Instructions**
12. Name of individual:	Must be client's first and last name. Must match client's name on Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure.
14. Signature of person obtaining consent:	Must be original signature in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. **Initials are not accepted.**
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	**Instructions**
18. Name of individual to be sterilized:	Must be client's first and last name. Must match client's name on Items #4, #7, and #12 on Sterilization Consent Form.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page 18b: "When does MAA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
20. Specify type of operation:	Indicate type of sterilization procedure.
21. Expected date of delivery:	When premature delivery box is checked, this date must be *expected* date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's signature. Must be physician who actually performed sterilization procedure. Must be original signature in ink.
23. Date:	Date of physician's signature. Must be completed with either same date as listed in Item #19 or later. **NO EXCEPTIONS!**
24. Physician's printed name	Must be printed name of physician who signed in Item #22.

☞ **Note:** If the physician who performs the surgery is different from the physician identified in Item #5, then a Client Statement Form must be attached to the Sterilization Consent Form. See "How to Complete a Client Statement Form."

How to Complete the Client Statement Form

When do I need a Client Statement Form?

- When the physician who performs the surgery is different from the physician identified in Item # 5; or
- When there is a change in the sterilization method.

General Guidelines

- All information must be legible.
- The Client Statement Form **must** be attached to the Sterilization Consent Form and submitted with each claim.
- The physician who performs the surgery must fill out items 18-24 on the Sterilization Consent Form.
- All blanks must be completed.

The following numbers correspond to those listed on the Client Statement Form:

Client Statement Form	
Item	**Instructions**
1. Individual to be sterilized:	Must be client's first and last name.
2. Physician:	Must be name of physician who actually performed sterilization. Must be same physician who signs Item #22 on Sterilization Consent Form.
3. Specify type of operation:	Indicate type of sterilization procedure.
4. Signature:	Client signature. Must be client's first and last name. Must match name on Items #4, #12, and #18 on Sterilization Consent Form. Must be original signature in ink.
5. Month/Day/Year:	Must be date that client signed Client Statement Form.

How to Complete the Sterilization Consent Form For a Client Age 18-20

1. Use DSHS 13-364(x) Sterilization Consent Form.
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":

    a. Section I: Consent to Sterilization: **"I am at least 21…"**
    b. Section III: Statement of Person Obtaining Consent: **"To the best of my knowledge… is at least 21…"**
    c. Section IV: Physician's Statement: **"To the best of my knowledge… is at least 21…"**

STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) _____
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) _____ The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) _____
Month Day Year

I (4) _____ hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) _____
Physician

by a method called (6) _____ My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) _____ signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) _____ the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) _____
Signature of person obtaining consent *Date*

(16) _____
Facility

(17) _____
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) _____ (19) _____
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) _____ The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

☐ Premature delivery
Individual's expected date of delivery (21) _____
☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) _____
Physician's Signature *Date*

(24) _____
Physician's Printed Name

SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) _____ hereby consent of my own free will to be sterilized by (2) _____
Individual to be sterilized *Physician*

by a method called (3) _____ My consent expires 180 days from the date of my signature below. I
Specify type of operation

also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ (5) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to
Language

him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

SAMPLE STERILIZATION CONSENT FORM NEEDING CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2002**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2002**
Physician's Signature *Date*

(24) **Mary Williams**
Physician's Printed Name

SAMPLE CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) **Jane Doe** hereby consent of my own free will to be sterilized by (2) **Dr. Mary Williams**
Individual to be sterilized *Physician*

by a method called (3) **tubal ligation** My consent expires 180 days from the date of my signature below. I
Specify type of operation

also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ (5) **October 1, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☒ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in **Spanish** language and explained its contents to
Language

him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ **October 1, 2001**
Interpreter *Date*

STERILIZATION CONSENT FORM FOR A CLIENT 18 TO 20 YEARS OF AGE

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 18 years of age and was born on (3) **August 1, 1984**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
- ☒ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, faxed, or laser printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field **Description**

1a. **Insured's I.D. No.:** Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly Medical ID card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker; and
d) An alpha or numeric character (tiebreaker).

For example:
1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name** (Last Name, First Name, Middle Initial): When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name:** When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24. Indicate the name of the coverage source in field 10d* (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth:** When applicable, enter the insured's birthdate, if different from *field 3.*

11c. **Insurance Plan Name or Program Name:** When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d.*

17. **Name of Referring Physician or Other Source:** When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number Of Referring Physician:** When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved For Local Use:** When applicable, enter indicator B, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury:** When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission:** When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number:** When applicable. If the service or equipment you are billing for requires authorization, enter the nine digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 12, 2003 = 071203).

24B. **Place of Service:** Required. These are the only appropriate code(s) for Washington State Medicaid:

Code	To Be Used For
1	Inpatient hospital
2	Outpatient hospital
3	Office or ambulatory surgery center
4	Client's residence
5	Emergency room
6	Congregate care facility
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service:** Required. Enter a 3 for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS:** Required. Enter the appropriate procedure code for the services being billed. Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9- CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges:** Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units:** Required. Enter the total number of days or units for each line. These figures must be whole units.

24K. **Reserved for Local Use:** Enter the laboratory's independent Clinical Laboratory Improvements Act (CLIA) number (see the information on your special agreement). Use this only when you are billing for a referred lab (test). Electronic billers must put the CLIA number in the comments field.

25. **Federal Tax I.D. Number:** Leave this field blank.

26. **Your Patient's Account No.:** This is any nine-digit alphanumeric entry *that you may use as your internal reference number*. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due:** Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.:
This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); or
B. An identification number for individuals only when they are part of a group practice (see below).

Group:
This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, family planning, etc.). When a valid group number is entered in this field, payment will be made under this number.

Note: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

Sample:
Jennifer Spear was seen at ABC Family Planning Clinic (MAA Family Planning Provider #7777777) on 6/12/03. She received a Physical Exam (99203) which included a Pap Test (88150). An STD was suspected, so a Wet Mount (87210) was done. Birth control options were discussed, a Pregnancy Test (84703) was done, and the client received a 6-month supply of Oral Contraceptives - Birth Control Pills (S4993). The Pap Test was sent out to an independent lab (CLIA #06E3333333). They billed the clinic their usual and customary charge of $10.00. The Wet Mount and Pregnancy Test were read onsite at the clinic. The following is a sample claim for the services this client received, including billing for the test done at the independent lab.

PLEASE DO NOT STAPLE IN THIS AREA

SAMPLE

SAMPLE

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): JL042760SPEARA

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

3. PATIENT'S BIRTH DATE MM 04 DD 27 YY 60 SEX M ☐ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 42 COTTONWOOD LA

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 98500 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

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. ____ . __ 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	07	12	03	07	12	03	3	3	99203		V25.4	12000	1				
2	07	12	03	07	12	03	3	3	88150		V25.4	1500	1				06E33333
3	07	12	03	07	12	03	3	3	87210		616.9	500	1				
4	07	12	03	07	12	03	3	3	84703		616.9	1000	1				
5	07	12	03	07	12	03	3	3	S4993		V25.4	1700	1				
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 16700

29. $ AMOUNT PAID

30. $ BALANCE DUE 16700

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

SIGNED DATE

32. 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 FAMILY PLANNING
1601 DUKE STREET
ANYTOWN, WA 98500 (360) 555-0909

PIN# GRP# 7777777

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500