DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	Approved Childbirth Education Providers Managed Care Organizations	**Memorandum No: 06-19** **Issued:** April 19, 2006
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information, contact:** 800.562.3022 http://maa.dshs.wa.gov/contact/prucontact.asp
Subject:	**First Steps Childbirth Education Program: HCFA-1500 Claim Form Required for Billing**	

Effective for dates of services on and after May 1, 2006, providers must use the HCFA-1500 claim form to bill for childbirth education services provided to HRSA clients.

What has changed?

Beginning May 1, 2006, providers must use the HCFA 1500 claim form when billing HRSA for services provided to HRSA clients. HRSA will no longer accept the Childbirth Education Billing Form, DSHS 13-724.

How do I use the HCFA-1500 Claim Form?

Refer to HRSA's current *General Information Booklet* for instructions on completing the HCFA-1500 claim form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section). For specific instruction related to Childbirth Education, read the revised pages to HRSA's *Childbirth Education Billing Instructions* (attached to this memorandum).

Billing Instructions Replacement Pages

Attached are replacement pages i-ii, E.1–E.2, and F.1-F.2 for HRSA's current *Childbirth Education Billing Instructions.*

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Health and Recovery Services Administration*.**

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Document Correction***. You will then need to select a year and then select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)

Table of Contents

Important Contacts ii

Definitions 1

Section A: About the Program
What is the purpose of the Childbirth Education Program? A.1
Freedom of Choice/Consent for Services A.1

Section B: Client Eligibility
Who is eligible for childbirth education? B.1
Are clients enrolled in an HRSA managed care plan eligible for childbirth education? B.2

Section C: Provider Requirements
Who can provide childbirth education? C.1
How do I become an "approved" childbirth education provider? C.1

Section D: Covered Services
What is covered? D.1
What is not covered? D.1

Section E: Billing
What is the time limit for billing? E.1
What fee must I bill HRSA? E.1
What records must be kept? E.1
Billing Electronically E.1
Billing Hard Copy E.1
Fee Schedule E.2
Reimbursement for Childbirth Education E.2

Section F: Completing the HCFA-1500- Form
Instructions F.1
Sample Claim Form F.2

Important Contacts

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

Where do I call to ask about a provider application packet?

Call the Department of Health at
360.236.3552

Where do I send my HCFA-1500 claims?

Division of Program Support
P.O. Box 9245
Olympia, WA 98507-9245

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

To **view and download,** visit HRSA on the web: http://maa.dshs.wa.gov. Click on *Billing Instructions/ Numbered Memoranda*

To **have a paper copy sent to you,** visit the Dept. of Printing on the web: http://www.prt.wa.gov. Click on *General Store.*

Who do I contact if I have questions on…

Program/Application

Policy/Program Oversite
Department of Health (DOH)
Maternal and Infant Health
360.236.3552

Billing Questions

HRSA Customer Service Center for Providers
http://maa.dshs.wa.gov/provrel/
800.562.6188 (toll free)

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

Coordination of Benefits Section
800.562.6136 (toll free)

Billing

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

HRSA requires providers to submit claims within 365 days of the delivery of service.

What fee must I bill HRSA?

Bill HRSA your usual and customary fee.

What records must be kept?

Specific to Childbirth Education:

Providers must:

- Maintain documentation of names of First Steps attendees and dates they participated in the classes (a client sign-in sheet is preferred for each class); and
- Make charts and records available to DSHS, its contractors [such as the Department of Health], 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. [Refer to WAC 388-502-0020]

Billing Electronically

HRSA strongly recommends Childbirth Education provider submit billings electronically.
For more information on Electronic Billing, go to:
https://wamedweb.acs-inc.com/wa/general/home.do

Billing Hardcopy

To bill hardcopy, send completed HCFA-1500 claim forms to:

Division of Program Support
PO Box 9245
Olympia, WA 98507-9245

(Blank HCFA-1500 forms may be obtained through most office supply stores.)

Fee Schedule

Note: CBE providers must be approved by the Department of Health in order to bill for this service.

Reimbursement for Childbirth Education

Reimbursement for Childbirth Education classes includes all classes and educational materials provided throughout the session. Reimbursement is limited to one series per client, per pregnancy. Use the most appropriate diagnosis code (such as V22.2) when billing for the following procedure code:

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 10/1/03
S9436	HD	Childbirth Education Classes, per client, per series	$ 60.00

(Entire Page Changed.)

How to Complete a HCFA-1500 Claim Form for Childbirth Education

Refer to HRSA's current *General Information Booklet* for instructions on completing the HCFA-1500 claim form.

You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see *Important Contacts* section).

Instructions Specific to Childbirth Education Providers

Field Number	Instructions
24B	Enter Place of Service. Example code 99 (other), 12 (office)
24D	Enter HCPCS code S9436 with modifier HD (S9436-HD)

(Entire Page is New.)

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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

PHYSICIAN OR SUPPLIER INFORMATION

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

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

SIGNED DATE

32. 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 #

PIN# GRP#

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

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