

# NATIONAL PROVIDER IDENTIFIER SEMINAR

January 2007



NPI -Get It! Share It! Use It! Getting one  
is free-not having one can be costly!

# Agenda

- NPI Updates
- Claim Form Instructions
- Carolina ACCESS Reference

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is free-not having one can be costly!

# Objectives

- How to find NPI information on the DMA Website
- How to report NPI and taxonomy to Medicaid
- When to start using NPI and taxonomy

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# DMA Website

*The best way to stay current on  
NPI information*

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# New DMA Website


[www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)



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# New DMA Website

My Web Search  Search Address <http://www.ncdhhs.gov/dma/> Go Link

  
NC Department of Health and Human Services home page

## Division of Medical Assistance

*Providing access to high quality, medically necessary health care for eligible North Carolina residents through cost effective purchasing of health care services and products.*

[Provider Links](#) [Consumer Links](#) [County Links](#) [Programs](#) [Publications](#)

### north carolina medicaid


The Division of Medical Assistance (DMA) oversees two programs: Medicaid and [NC Health Choice for Children](#).

North Carolina's Medicaid program serves approximately one out of every eight people residing in our state. Last year, Medicaid served approximately 1.5 million children, aged, blind and/or disabled individuals. This year's budget for the Medicaid is \$10,262,267,093 – of which is supported by \$7.6B in revenue (predominately federal Medicaid funds) and just under \$2.6B in state appropriations. Medicaid's budget is one of the largest in NC government – second only to overall budget for primary and secondary education.

[NC Health Choice for Children \(NCHC\)](#) provides funding to extend health care coverage to roughly 115,000 children each month whose family income exceed Medicaid eligibility criteria. The budget for NCHC is \$196,868,437 – of which \$145M is

### News and Hot Topics

- [National Provider Identifier \(NPI\) Information and Collection Form](#)
  - [Director's Letter from CMS](#)
- [N.C. Medicaid Ends Year \\$350 Million Under Budget](#)
- [2005 Medicaid Annual Report](#)
- [Mental Health Reform](#)
- [We have a new web address! \[www.ncdhhs.gov/dma\]\(http://www.ncdhhs.gov/dma\)](#)



Done Internet

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# NPI Webpage



## Division of Medical Assistance

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[Provider Links](#) [Consumer Links](#) [County Links](#) [Programs](#) [Publications](#) [DMA Home](#)

### National Provider Identifier (NPI) Information

**Get It! Share It! Use It! Now! Getting one is free - Not having one can be costly!**

- **DMA NPI Collection Spreadsheet (multiple)**
  - [Instructions for Completing the NPI Collection Spreadsheet](#)
  - **Group/Individual Spreadsheet**
    - [Excel Format](#)
  
- **DMA NPI Collection Form**
  - [Instructions for Completing the NPI Collection Form \(single\)](#)
    - **Group Form**
      - [Word Format](#)
    - **Individual Form**
      - [Word Format](#)
    - [Additional Taxonomy Page](#)
  
- **Seminar Information and Upcoming Trainings**



Internet

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# Obtaining an NPI

## *Helpful Tips*

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# Step by Step

- Step 1: Apply for and obtain NPI
  - Federal Requirement
- Step 2: Report your NPI to Medicaid
  - State Requirement

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# Applying for your NPI

- Three methods:
  - Online: <https://nppes.cms.hhs.gov>
  - Paper Application – available only by contacting Enumerator by phone
  - Electronic File Interchange
- Be sure to enter Medicaid Provider number on application

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# NPI Notifications

- Three methods
  - Letter from NPPES
  - Email from NPPES
  - Email or letter from Electronic File Interchange Organization (EFIO)
- This is your NPPES Certification

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# Key Dates to Know

- January 1, 2007- NPI Required on All Medicaid Provider Applications & Change Requests
- March 31, 2007- Deadline for reporting NPI to Medicaid
- May 18, 2007 – NPI required on all claims

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# Reporting the NPI to Medicaid

## *Methods and Requirements*

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# NPI Collection

- Required for providers to report NPI to Medicaid
- Each Medicaid provider number must have an NPI on file
  - Otherwise, claims will not process once NPI is implemented

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# Collection Methods

- Fillable DMA NPI Collection Form
  - Group
  - Individual
- Excel Spreadsheet
- Electronic Solution

\*Instructions located on the DMA website

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# NPI Collection Form

<b>Medicaid Provider Number</b>	<b>National Provider Number</b>	<b>Taxonomy Number</b>
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Are you a Carolina ACCESS Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		To report additional taxonomies use <a href="http://www.dhhs.state.nc.us/dma/npi/taxonomy.doc">http://www.dhhs.state.nc.us/dma/npi/taxonomy.doc</a> .
<b>Physical Address</b>		
<b>Organization Name:</b>		
<b>Address 1:</b>		
<b>Address 2:</b>		
<b>City/State:</b>		
<b>Zip Code – Plus 4:</b>		
<input type="text"/> - <input type="text"/>	<b>REQUIRED</b> <input type="text"/>	<input type="text"/> - <input type="text"/>
<b>Accounting Address</b>		
<b>Organization Name:</b>		
<b>Address 1:</b>		
<b>Address 2:</b>		
<b>City/State:</b>		
<b>Zip Code – Plus 4:</b>		
<input type="text"/> - <input type="text"/>		
<b>REQUIRED</b>		
<input type="text"/> - <input type="text"/>		
<b>REQUIRED</b>		
<b>Printed Name /Title/Date</b>		
<b>Signature</b> (Unless sent via email)		
<b>Phone Number</b>		
<b>Fax Number</b>		
<b>Email Address</b> DMA-4101(11/06)		

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# Additional Taxonomy Page

- Collection Form allows one Taxonomy code
  - Provider can submit up to 15
  - Use additional taxonomy page

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# Additional Taxonomy Page

## National Provider Identifier (NPI) Taxonomy Form

Please use this sheet to report additional taxonomies.



Medicaid Provider Number	National Provider Number	Taxonomy Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
		<input type="text"/>
		<input type="text"/>
		<input type="text"/>
		<input type="text"/>
		<input type="text"/>
		<input type="text"/>

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# NPI Collection Spreadsheet

- Submit group and individual provider numbers on same spreadsheet
- Indicate Carolina ACCESS participation
- Complete a separate line for each Medicaid Provider number

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# NPI Collection Spreadsheet

- Complete a separate line for each Taxonomy
- Organization/Individual Name
  - Verify on RA
- Physical and accounting address fields must be completed
  - Even if they are identical
  - Include Zip+4

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# Provider Address

- Note: If address on collection form/spreadsheet is different from address on file, DMA will update your address
- Use Provider Change Form for changes other than address

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# NPI Collection Spreadsheet

1			<b>Preparer/Title/Date</b>			
2						
3						
4			<b>NPI COLLECTION INFO</b>			
5	<b>Group (G)</b>	<b>Carolina Access Provider Y/ N</b>	<b>Medicaid Provider Number</b>	<b>NPI</b>	<b>Taxonomy</b>	<b>Organization Name</b>
6	G	Y	1234567	1234567890	123456789X	ABC Hospital
7						
8	<b>Individual (I)</b>	<b>Carolina Access Provider Y/ N</b>	<b>Medicaid Provider Number</b>	<b>NPI</b>	<b>Taxonomy</b>	<b>Individual Name</b>
9	I	N	3333333	2222222222	123456789X	John Doe, MD
10						
11						
12						
13						
14						
15						
16						
17						

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# NPPES Certification

- Requested information:
  - Medicaid Provider Number
  - NPI
  - Taxonomy
  - Name
  - Address (including Zip+4)
- Certification must be included with collection form or spreadsheet

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# How do I obtain a copy?

- Contact enumerator at 1-800-465-3203
- Log into NPPES
  - <https://nppes.cms.hhs.gov>
  - Print copy of NPI screenshot
- [www.ncdhhs.gov/dma/NPI/InstructionsSpreadsheets.doc](http://www.ncdhhs.gov/dma/NPI/InstructionsSpreadsheets.doc): link for instructions

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# Sending Collection Form/Spreadsheet

- Information Must be Typed
- Email: [npi.dma@ncmail.net](mailto:npi.dma@ncmail.net)
- Fax: 919-715-7140
- Mail: DMA Provider Services  
Attn: NPI Form  
2501 Mail Service Center  
Raleigh, NC 27699-2501

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# Electronic Solution

- Information on electronic form is emailed to DMA and automatically updated into our system
- If information does not match, updates will not be made
- Check RA to verify information
- Email NPPES Certification to DMA

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# NPI Updates

*Announcements you need to know*

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# Submitting NPI on Claims

- Immediately start submitting NPI and Taxonomy with Medicaid provider number
- Data is needed for testing claims to ensure payment will be made



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# Clearinghouse/Vendors

- Contact vendors to verify fields to submit NPI and Taxonomy
- Make sure software is up to date
- Submit NPI now
- Keep capability to submit Medicaid Provider Number
- NCECS Webtool is NPI ready

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# Prescriber Information

- Prescribing providers need to **SHARE** your NPI with Pharmacies
- Prescriber's NPI is needed on pharmacy claim to ensure patients receive their medicine



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# Mailing List

- DMA is establishing a mailing list for NPI updates via email
- Providers can subscribe online at DMA's website



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# National Provider Identifier

**Get It!**

**Share It!**

**Use It!**

**Getting one is free – Not having one  
can be costly!**

# Claim Forms

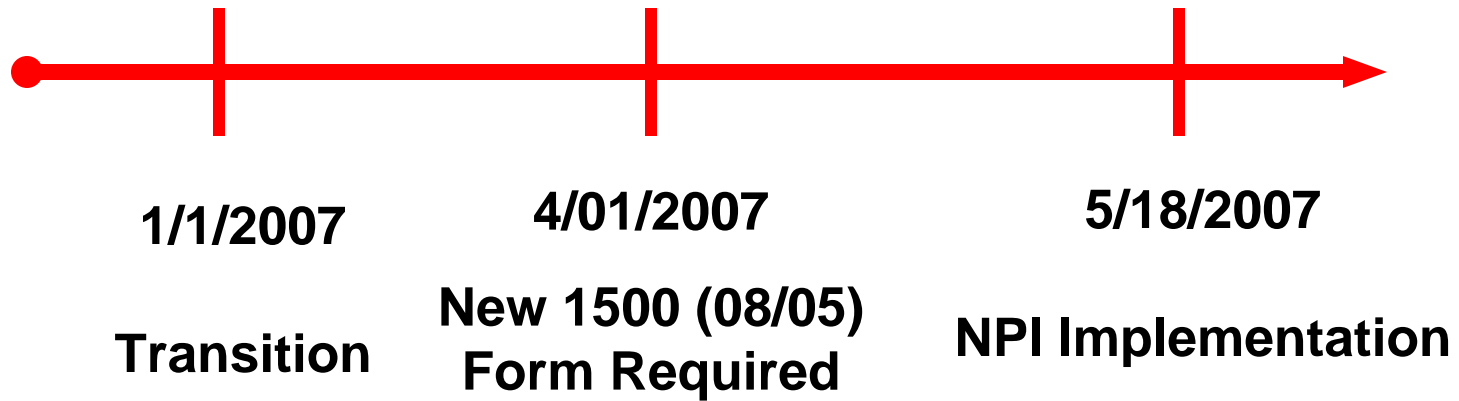
- New CMS 1500
- UB-04
- New ADA



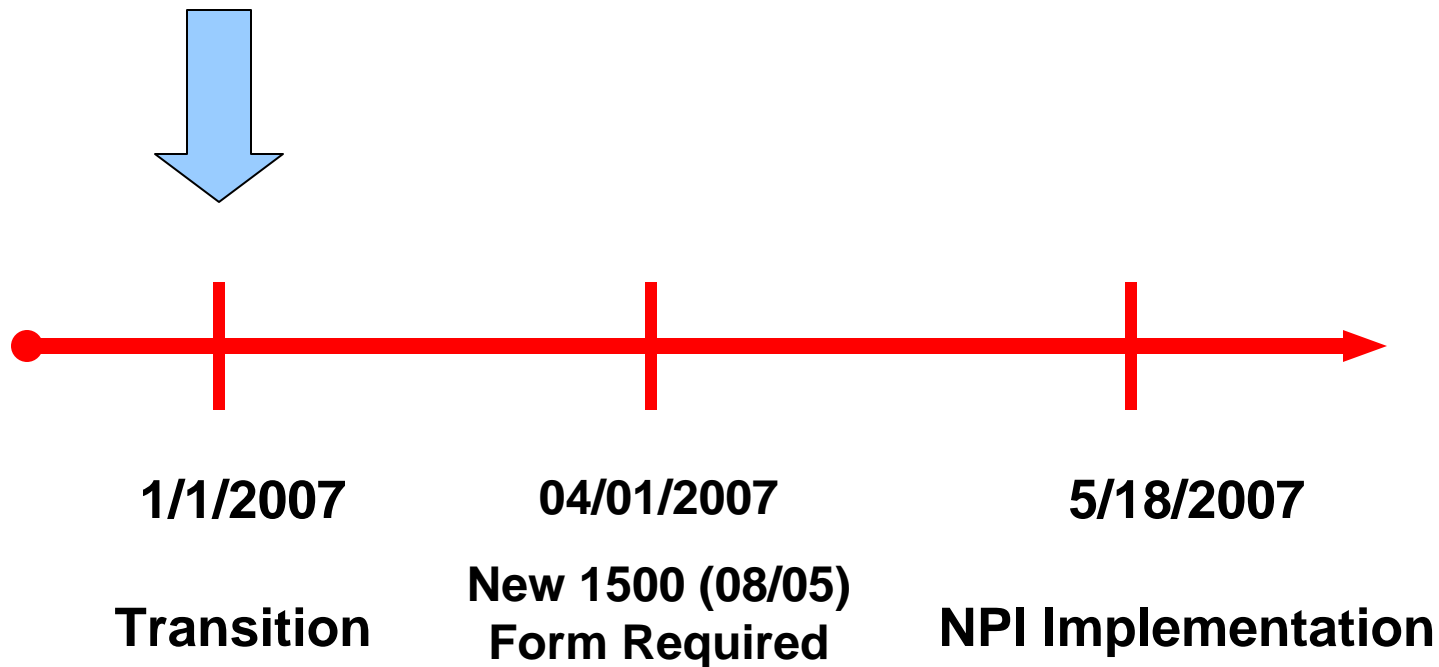
# Overview of Changes

- Transition requirements
- Implementation requirements
- Carolina ACCESS

# CMS-1500 (08/05) Timeline



# CMS-1500 (08/05) Timeline



# CMS-1500 (08/05) Transition Effective 1/1/2007

b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)		b. EMPLOYER'S NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
SIGNED _____				DATE _____				SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT HAD ILLNESS FROM MM DD TO MM DD		18. HOSPITALIZATION DATES FROM MM DD TO MM DD			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		17b. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. RESERVED FOR LOCAL USE		24. 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	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	
23. PRIOR AUTHORIZATION									

# CMS-1500 (08/05) Transition Effective 1/1/2007

b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)	b. EMPLOYER'S NA
c. EMPLOYER'S NAME		ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLA
d. INSURANCE PLAN NA		RESERVED FOR LOCAL USE				d. IS THERE ANOTH <input type="checkbox"/> YES <input type="checkbox"/> NO
12. PATIENT'S OR AUTH to process this claim. I below.  SIGNED _____		THIS FORM. medical or other information necessary to the party who accepts assignment				13. INSURED'S OR / payment of medi services describe  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 FROM MM DD TO MM DD
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		17b. NPI		18. HOSPITALIZATI FROM MM DD TO MM DD
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3)  1. _____  2. _____						MEDICAID RESL CODE  PRIOR AUTHOR  F.  \$ CHARGES
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROC (Exp CPT/HC)		

**17a. Enter Qualifier: "1D" and Medicaid CA PCP, referring provider, or CA Override Number (if applicable)**

**17b. NPI for CA PCP or referring provider**

# CMS-1500 (08/05) Transition Effective 1/1/2007

b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLACE (State) _____	b. EMPLOYER'S NAME _____
c. EMPLOYER'S NAME OR SCHOOL NAME _____			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME _____
d. INSURANCE PLAN NAME OR PROGRAM NAME _____			10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO
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.					13. INSURED'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 _____					SIGNED _____
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT WAS IN HOSPITAL FROM MM DD TO MM DD		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE _____	17a. _____	17b. NPI _____	18. HOSPITALIZATION OUTSIDE LAB? FROM MM DD TO MM DD <input type="checkbox"/> YES <input type="checkbox"/> NO		
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)					22. MEDICAID RESUBMISSION CODE _____
<div style="border: 1px solid black; background-color: #ADD8E6; padding: 10px; width: fit-content; margin: 0 auto;"> <b>19. No longer used for Carolina ACCESS</b> </div>					23. PRIOR AUTHORIZATION NUMBER _____
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS _____ MODIFIER _____		E. DIAGNOSIS POINTER _____		F. \$ CHARGES _____	

# CMS-1500 (08/05) Transition Effective 1/1/2007

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		17. MILITARY ILLNESS	
FROM	TO	YY	YY
MM	MM	DD	DD
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
FROM	TO	YY	YY
MM	MM	DD	DD
20. OUTSIDE LAB?		\$ CHARGES	
<input type="checkbox"/> YES	<input type="checkbox"/> NO		
22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER			
E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNIT	J. RENDERING PROVIDER ID. #
			H. EPSDT Family Plan
			I. ID. QUAL.
			NPI
			NPI
			NPI
			NPI
			NPI
			NPI
			NPI
			NPI
ASSIGNMENT? (no, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
<input type="checkbox"/> NO	\$	\$	\$
33. BILLING PROVIDER INFO & PH # ( )			
a. NPI		b.	

↑  
PHYSICIAN OR SUPPLIER INFORMATION  
↓

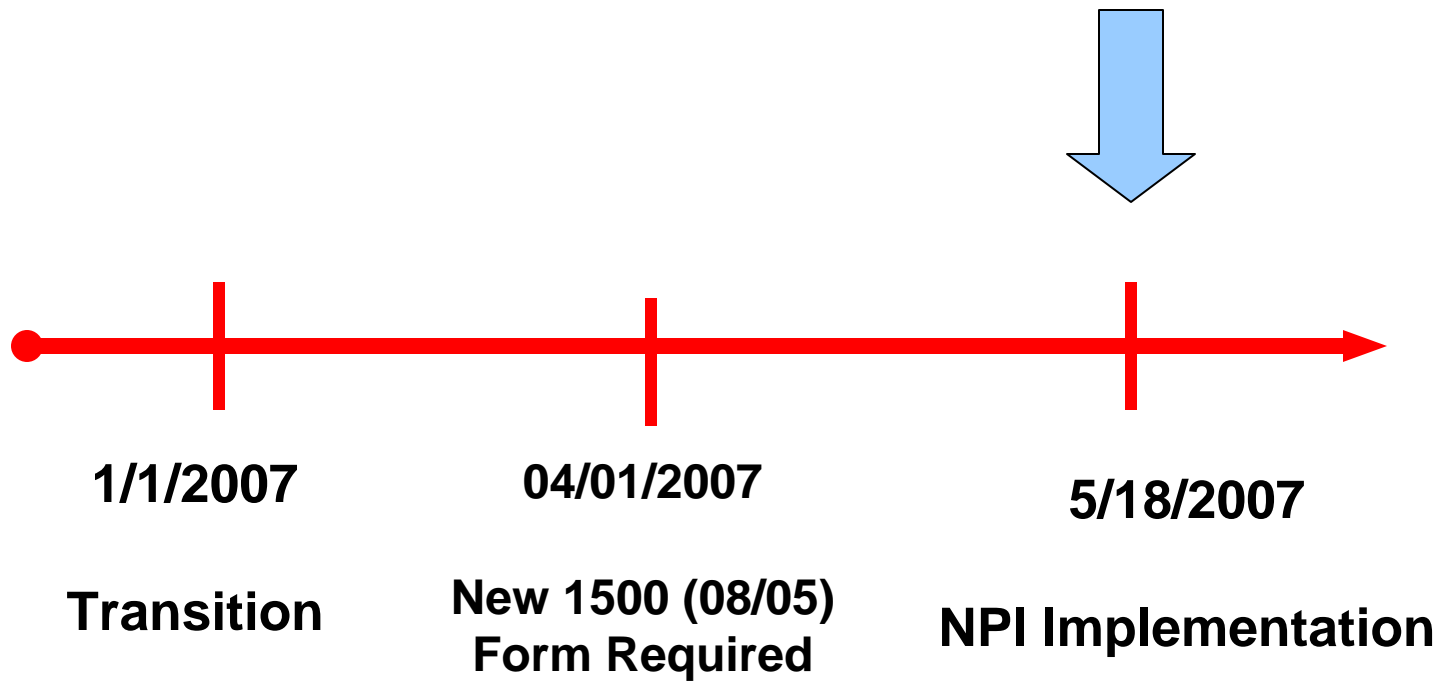








# CMS-1500 (08/05) Timeline



# CMS-1500 (08/05) Implementation Effective 5/18/2007

b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)		b. EMPLOYER'S NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								13. INSURED'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 _____				SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT WAS IN HOSPITAL FROM MM DD TO MM DD		18. HOSPITALIZATION FROM MM DD TO MM DD			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		17b. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. RESERVED FOR LOCAL USE				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE	
1. _____		3. _____		2. _____		4. _____		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES	

# CMS-1500 (08/05) Implementation Effective 5/18/2007

b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)		b. EMPLOYER'S NA		
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLA				
d. INSURANCE PLAN NAME OR PROGRAM N										
12. PATIENT'S OR AUTHORIZED PERSON'S to process this claim. I also request payment 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 FROM MM DD	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____		17b. NPI		18. HOSPITALIZATI FROM MM DD	
19. RESERVED FOR LOCAL USE										
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Item										
1. _____										
2. _____										
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. F. CPT/HCP/PCS	E. MODIFIER	F. POINTER	G. \$ CHARGES		

**17a. Enter Qualifier: "1D" and CA Override Number (if applicable) OR Qualifier: "ZZ" & referring provider's taxonomy number**

**17b. NPI for CA PCP or referring provider**

# CMS-1500 (08/05) Implementation Effective 5/18/2007

b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State) _____		b. EMPLOYER'S NAME _____	
c. EMPLOYER'S NAME OR SCHOOL NAME _____				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME _____			
d. INSURANCE PLAN NAME OR PROGRAM NAME _____				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
SIGNED _____				DATE _____				SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM   DD   YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY		16. DATES PATIENT WAS IN HOSPITAL FROM MM   DD   YY		18. HOSPITALIZATION DATES FROM MM   DD   YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE _____				17a. _____		18. HOSPITALIZATION DATES FROM MM   DD   YY			
				17b. NPI _____		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. RESERVED FOR LOCAL USE				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE			
<div style="background-color: #ADD8E6; padding: 10px; text-align: center;"> <b>19. No longer used for Carolina ACCESS</b> </div>				3. _____		23. PRIOR AUTHORIZATION NUMBER _____			
				4. _____		23. PRIOR AUTHORIZATION NUMBER _____			
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES			
T/HPCS _____ MODIFIER _____									

# CMS-1500 (08/05) Implementation Effective 5/18/2007

MILITARY ILLNESS. YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
		FROM	MM	DD	YY	TO	MM	DD	YY
		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
		FROM	MM	DD	YY	TO	MM	DD	YY
		20. OUTSIDE LAB?		\$ CHARGES					
		<input type="checkbox"/> YES <input type="checkbox"/> NO							
		22. MEDICAID RESUBMISSION CODE			ORIGINAL REF. NO.				
		23. PRIOR AUTHORIZATION NUMBER							
E. DIAGNOSIS POINTER		F. \$ CHARGES	G. DAYS OR UNIT	H. ESRDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
					NPI				
					NPI				
					NPI				
					NPI				
					NPI				
					NPI				
					NPI				
ASSIGNMENT? (no, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
<input type="checkbox"/> NO		\$		\$		\$			
		33. BILLING PROVIDER INFO & PH # ( )							
		a. NPI			b.				

PHYSICIAN OR SUPPLIER INFORMATION

# CMS-1500 (08/05) Implementation Effective 5/18/2007

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		↑	
FROM	MM	DD	YY
18. HOSPITALIZATION DATE		↑	
FROM	MM	DD	YY
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
22. MEDICAID RESUBMISSION CODE			
23. PRIOR AUTHORIZATION			
E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
			I. ID. QU.
			J. RENDERING PROVIDER ID. #
			NPI
			NPI
			NPI
PHYSICIAN OR SUPPLIER INFORMATION			
BALANCE DUE			
33. BILLING PROVIDER INFO & PH #			
a.	NPI		b.

**24I and 24J. Enter Qualifier: "ZZ" & attending provider's taxonomy number**

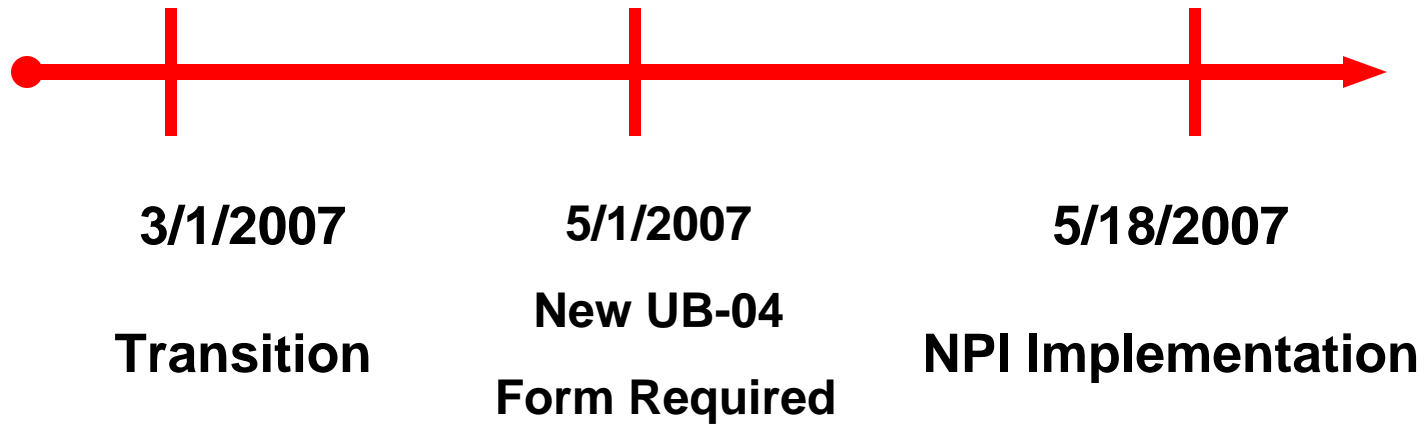
**24J. Attending provider NPI.**



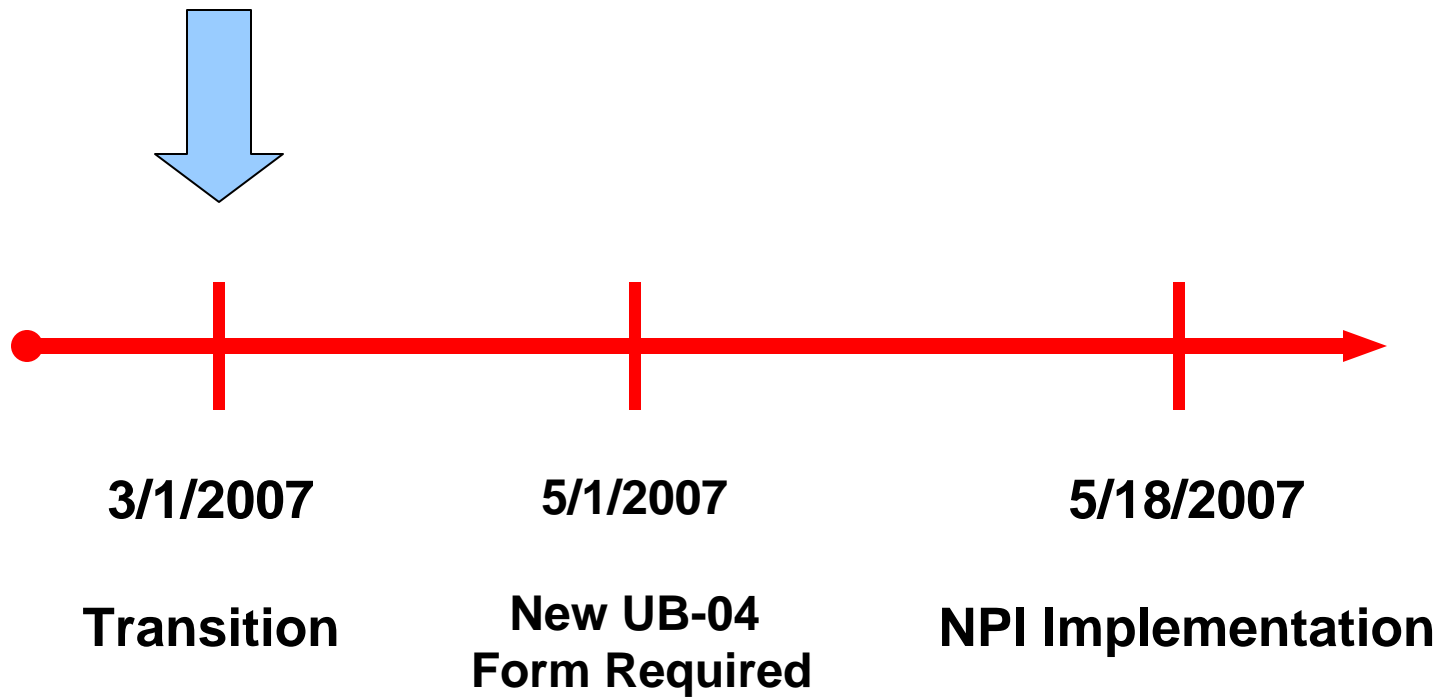




# UB-04 Timeline



# UB-04 Timeline



# UB-04 Transition Effective 3/1/2007

1										2										3a PAT. CNTRL. #		5 MED. REC. #																								
																				5 FED. TAX NO.		6 STA FR																								
8 PATIENT NAME a										9 PATIENT ADDRESS a																																				
b										b																																				
10 BIRTHDATE		11 SEX	12 DATE		ADMISSION 13 HR 14 TYPE		15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES		22	23	24	25	26	27																									
31 OCCURRENCE CODE		DATE		32 OCCURRENCE CODE		DATE		33 OCCURRENCE CODE		DATE		34 OCCURRENCE CODE		DATE		35 OCCURRENCE CODE		FROM		THROUGH		36 OCC CODE		OFF																						
38																							39 VALUE CODES CODE		AMOUNT		40 VALUE CODES CODE		AMOUNT																	
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42 REV. CD.		43 DESCRIPTION						44 HCPCS / RATE / HIPPS CODE						45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHG																												
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# UB-04 Transition Effective 3/1/2007

1		2		3a PAT. CNTRL. #		5 MED. REC. #		5 FED. TAX NO.		6 STA FR																																																																																	
<div style="border: 1px solid black; background-color: #ADD8E6; padding: 5px; text-align: center;"> <b>FL1: Billing Provider information (must include Zip +4)</b> </div>																																																																																											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">20</td> <td colspan="2">21</td> <td colspan="2">22</td> <td colspan="2">23</td> <td colspan="2">24</td> <td colspan="2">25</td> <td colspan="2">26</td> <td colspan="2">27</td> </tr> <tr> <td colspan="16" style="text-align: center;">CONDITION CODES</td> </tr> <tr> <td colspan="2">31 OCCURRENCE CODE</td> <td colspan="2">32 OCCURRENCE DATE</td> <td colspan="2">33 OCCURRENCE CODE</td> <td colspan="2">34 OCCURRENCE DATE</td> <td colspan="4">35 OCCURRENCE SPAN FROM</td> <td colspan="2">36 THROUGH</td> <td colspan="2">38 OCC FR</td> </tr> <tr> <td colspan="12">38</td> <td colspan="2">39 VALUE CODES</td> <td colspan="2">40 VALUE CO AMOU</td> </tr> <tr> <td colspan="2">a</td> <td colspan="2">b</td> <td colspan="2">c</td> <td colspan="2">d</td> <td colspan="2">e</td> <td colspan="2">f</td> <td colspan="2">g</td> <td colspan="2">h</td> </tr> </table>												20		21		22		23		24		25		26		27		CONDITION CODES																31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM				36 THROUGH		38 OCC FR		38												39 VALUE CODES		40 VALUE CO AMOU		a		b		c		d		e		f		g		h	
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**FL39-41: New value codes to report covered/non-covered days, coinsurance & lifetime reserve**

# UB-04 Transition

Effective 3/1/2007

- Form Locators 39 – 41 (Value Codes):
  - Covered days (80)
  - Non-covered days (81)
  - Coinsurance days (82)
  - Lifetime days (83)
- UB-04 Manual contains other value code definitions.







# UB-04 Transition

Effective 3/1/2007

- Form Locator 50 (Payer Name): Two digit payer code
  - MC Medicaid
  - MA Medicare Part A
  - MB Medicare Part B
  - BL Blue Cross/Blue Shield
  - CI Commercial Insurance

# UB-04 Transition Effective 3/1/2007

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
A																													
B																													
C																													
66 DX	67		A		B		C		D		E		F		G		H		68										
69 ADMIT DX	70 PATIENT REASON DX		a		b		c		71 FPS CODE		72 ECI		73		74	75	76 ATTENDING		NPI		QUAL								
74 PRINCIPAL PROCEDURE CODE DATE			a. OTHER PROCEDURE CODE DATE			b. OTHER PROCEDURE CODE DATE									LAST			FIRST											
															77 OPERATING			NPI		QUAL									
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UB-04 CMS-1450

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**NUBC** National Uniform  
Billing Committee  
LIC9213257

# UB-04 Transition Effective 3/1/2007

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																													
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68 ADMIT DX					70 PATIENT REASON DX					71 FPS CODE					72 ECI																																		
74 PRINCIPAL PROCEDURE CODE					a. OTHER PROCEDURE CODE					b. OTHER PROCEDURE CODE					75					76 ATTENDING NPI					QUAL																								
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										d										LAST										FIRST																			

**FL76: Attending Medicaid provider number.  
Enter Qualifier: "1D"**

**FL76: Attending provider's NPI**

UB-04 CMS-1450

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Billing Committee  
LIC9213257

# UB-04 Transition Effective 3/1/2007

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
A																													
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C																													
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69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI			73																			
74 PRINCIPAL PROCEDURE CODE DATE		a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75		76 ATTENDING		NPI		QUAL																	
								LAST				FIRST																	
c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE				77 OPERATING		NPI		QUAL																	
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								79 OTHER		NPI		QUAL																	
								LAST				FIRST																	

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LIC9213257

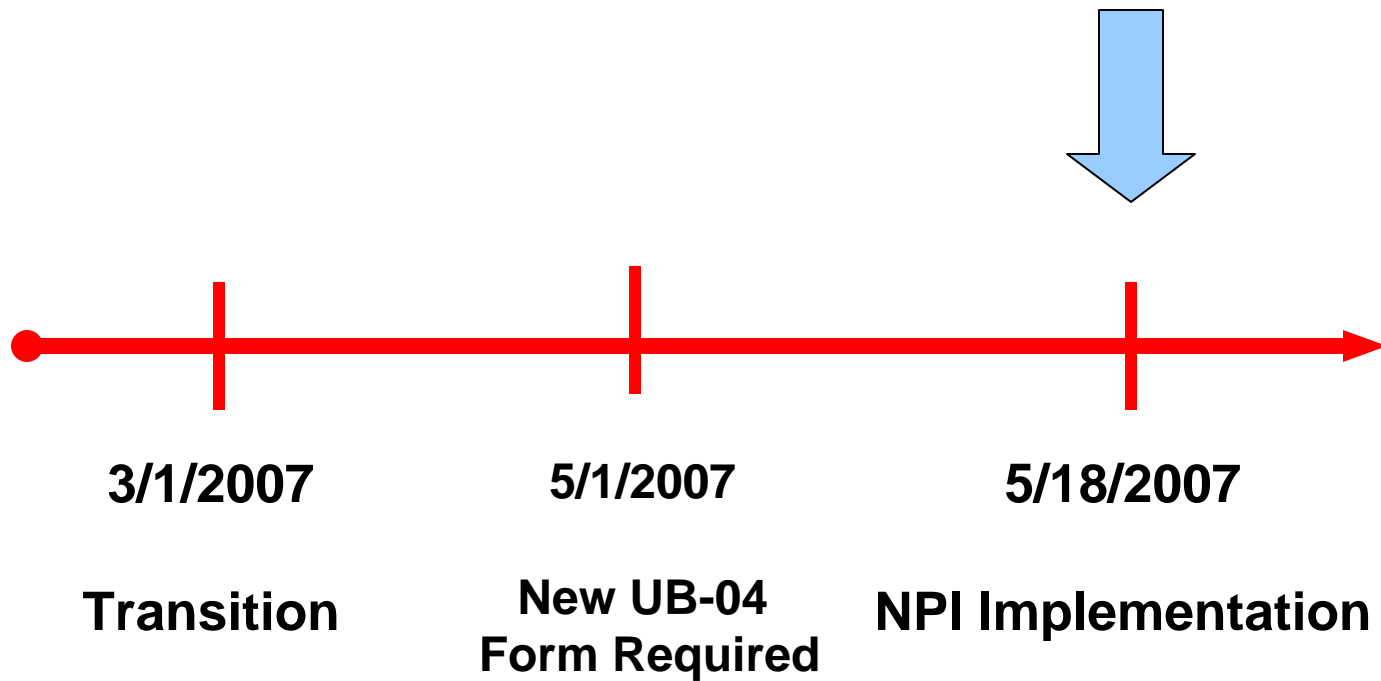
# UB-04 Transition Effective 3/1/2007

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
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80 REMARKS										81CC a										78 OTHER NPI									
										b										QUAL									
										c										FIRST									
										d										79 OTHER									
																				LAST									

**FL78: NPI for CA PCP or referring provider**

**FL78: Medicaid CA number, referring provider number, or CA override number.  
Enter Qualifier: "1D"**

# UB-04 Timeline



# UB-04 Implementation Effective 5/18/2007

1										2										3a PAT. CNTRL. #		5 MED. REC. #		
																				5 FED. TAX NO.		6 STA FR		
8 PATIENT NAME a										9 PATIENT ADDRESS a														
b										b														
10 BIRTHDATE		11 SEX	12 DATE		ADMISSION 13 HR 14 TYPE		15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES		22	23	24	25	26	27			
31 OCCURRENCE CODE		DATE		32 OCCURRENCE CODE		DATE		33 OCCURRENCE CODE		DATE		34 OCCURRENCE CODE		DATE		35 OCCURRENCE CODE		FROM		THROUGH		36 OCC CODE		OFF
38										39 VALUE CODES										40 VALUE CODE		AMOUNT	AMOUNT	
a																								
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d																								
42 REV. CD.		43 DESCRIPTION								44 HCPCS / RATE / HIPPS CODE				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHG						
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# UB-04 Implementation Effective 5/18/2007

1		2		3a PAT. CNTRL. #		5 MED. REC. #		5 FED. TAX NO.		6 STA FR	
<div style="border: 1px solid black; background-color: #ADD8E6; padding: 5px; text-align: center;"> <b>FL1: Billing Provider information (must include Zip +4)</b> </div>											
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE FROM		36 OCCURRENCE THROUGH	
37		38		39 VALUE CODES		40 VALUE CODES		41		42	
a		b		c		d		e		f	
42 REV. CD.		43 DESCRIPTION				44 HCPCS / RATE / HIPPS CODE					
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9											

**FL39-41: New value codes to report covered/noncovered days, coinsurance and lifetime reserve**

# UB-04 Implementation

Effective 5/18/2007

- Form Locators 39 – 41 (Value Codes)
  - Covered days (80)
  - Non-covered days (81)
  - Coinsurance days (82)
  - Lifetime days (83)
- UB-04 Manual contains other value code definitions



# UB-04 Implementation Effective 5/18/2007

**FL50: New two digit identifying payer**

**FL56: Billing Provider NPI**

PAGE ___ OF ___														CREATION DATE				TOTALS →											
50 PAYER NAME														51 HEALTH PLAN ID				52 REL. INFO	53 AGG. BEN.	54 PRIOR PAYMENTS				55 EST. AMOUNT DUE				56 NPI	
A														B				C	D	E				57 OTHER PRV ID					
58 INSURED'S NAME														59 P. REL.		60 INSURED'S UNIQUE ID				61 GROUP NAME				62 INSURANCE GROUP NO.					
A														B				C	D	E				F					
63 TREATMENT AUTHORIZATION CODES														64 DOCUMENT CONTROL NUMBER															
A														B				C	D	E				F					

**FL57: Qualifier: "ZZ" and billing provider's taxonomy number**

# UB-04 Implementation Effective 5/18/2007

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
A																													
B																													
C																													
66 DX	67		A		B		C		D		E		F		G		H		68										
69 ADMIT DX	70 PATIENT REASON DX		a		b		c		71 FPS CODE		72 ECI		73																
74 PRINCIPAL PROCEDURE CODE DATE			a. OTHER PROCEDURE CODE DATE			b. OTHER PROCEDURE CODE DATE			75	76 ATTENDING		NPI		QUAL															
										LAST				FIRST															
c. OTHER PROCEDURE CODE DATE			d. OTHER PROCEDURE CODE DATE			e. OTHER PROCEDURE CODE DATE				77 OPERATING		NPI		QUAL															
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UB-04 CMS-1450

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**NUBC** National Uniform  
Billing Committee  
LIC9213257



# UB-04 Implementation Effective 5/18/2007

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
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69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 FPS CODE	72 ECI			73																			
74 PRINCIPAL PROCEDURE CODE DATE		a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75		76 ATTENDING		NPI		QUAL																	
								LAST				FIRST																	
c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE				77 OPERATING		NPI		QUAL																	
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80 REMARKS										81CC a								78 OTHER		NPI		QUAL							
										b								LAST		FIRST									
										c								79 OTHER		NPI		QUAL							
										d								LAST		FIRST									

UB-04 CMS-1450

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# UB-04 Implementation

## Effective 5/18/2007

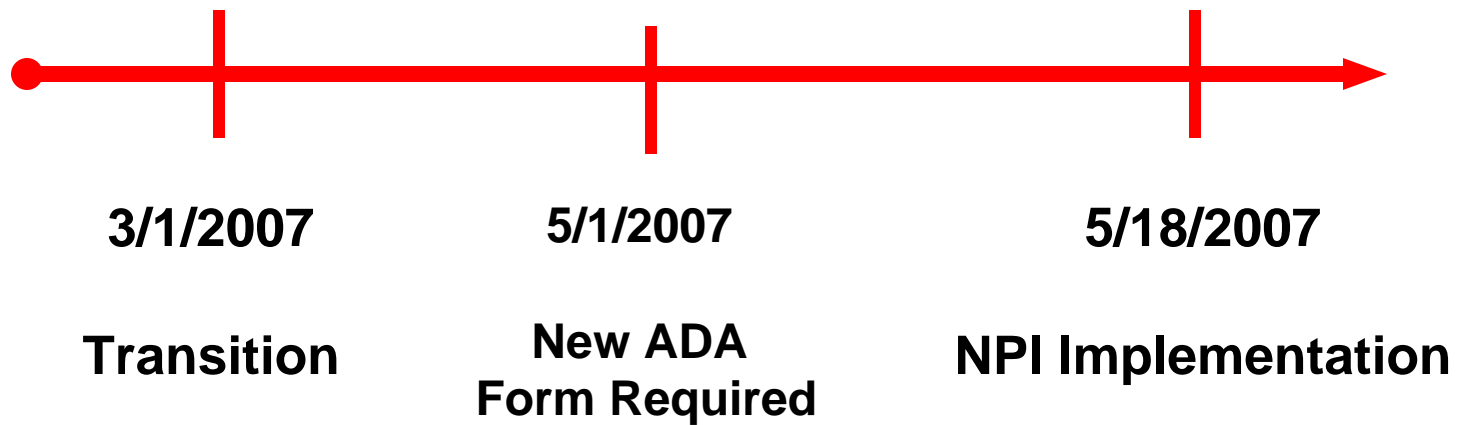
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME									
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C																				C									
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69 ADMIT DX										70 PATIENT REASON DX										73									
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UB-04 CMS-1450 APPROVED CMS NO.

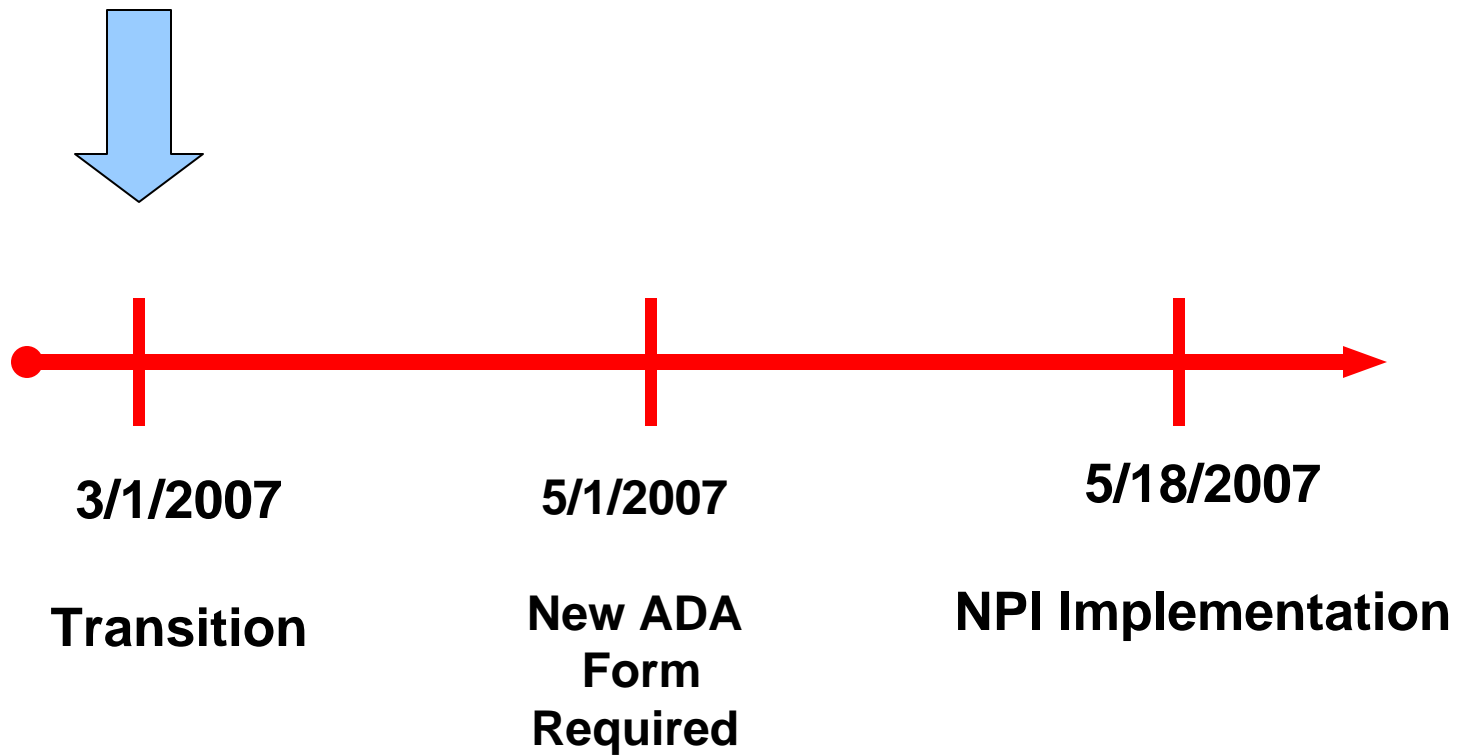
**FL78: NPI for CA PCP or referring provider**

**FL78: Enter Qualifier: "1D" and CA Override number (if applicable) OR Qualifier: "ZZ" and referring provider's taxonomy**

# ADA Timeline



# ADA Timeline



# ADA Transition Effective 3/1/2007

10																																			
<b>MISSING TEETH INFORMATION</b>																<b>Equipment</b>																			
34. (Place an "X" on each missing tooth)																1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D
																32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	C
35. Remarks																																			
<b>AUTHORIZATIONS</b>																<b>ANCILLARY CLAIM/TREATMENT</b>																			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.																39. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital																			
X _____ Patient/Guardian signature Date																40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes ( )																			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.																42. Months of Treatment Remaining						43. Replacements Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes ( )													
X _____ Subscriber signature Date																45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury																			
<b>TREATING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																46. Date of Accident (MM/DD/CCYY)																			
48. Name, Address, City, State, Zip Code																<b>TREATING DENTIST AND TREATMENT</b>																			
																53. I hereby certify that the procedures (visits) or have been completed.																			
																X _____ Signed (Treating Dentist)																			
																54. NPI																			
																56. Address, City, State, Zip Code																			
49. NPI						50. License Number						51. SSN or TIN																							
52. Phone Number ( ) - -						52A. Additional Provider ID						57. Phone Number ( ) - -																							

# ADA Transition Effective 3/1/2007

**35. Billing provider's  
taxonomy number**

Equipment													A	B	C	D			
34. (Place an "X" in each missing tooth)																			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	C
35. Remarks																			
<b>AUTHORIZATIONS</b>													<b>ANCILLARY CLAIM/TREATME</b>						
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.													39. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital						
X _____ Patient/Guardian signature													40. Is Treatment for Orthodontics? No (Skip 41-42) <input type="checkbox"/> Yes <input type="checkbox"/>						
37. I hereby authorize and direct dentist or dental entity.													43. Replacement <input type="checkbox"/> No <input type="checkbox"/>						
X _____ Subscriber signature													Treatment Resulting from Occupational Illness/Injury Date of Accident (MM/DD/CCYY)						
<b>BILLING DENTIST OR D</b> claim on behalf of the patient													<b>TING DENTIST AND TRE</b> I hereby certify that the procedures have been completed.						
48. Name, Address, City, State													X _____ Signed (Treating Dentist)						
													54. NPI						
													56. Address, City, State, Zip Code						
49. NPI			50. License Number			51. SSN or TIN													
52. Phone Number ( ) -						52A. Additional Provider ID						57. Phone Number ( ) -							

**48. Billing provider information  
Provider address & Zip +4**

# ADA Transition Effective 3/1/2007

10																			
<b>MISSING TEETH INFORMATION</b>																			
34. (Place an "X" on each missing tooth)																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	C
35. Remarks																			
<b>AUTHORIZATIONS</b>																			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.																			
X _____ Patient/Guardian signature Date																			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.																			
X _____ Subscriber signature Date																			
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																			
48. Name, Address, City, State, Zip Code																			
49. NPI																			
50. License Number																			
51. BSN or TIN																			
52. Phone																			
52A. Additional Provider ID																			
.J404)																			
<b>ANCILLARY CLAIM/TREATMENT</b>																			
39. Place of Treatment																			
<input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital																			
40. Is Treatment for Orthodontics?																			
<input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes																			
42. Months of Treatment Remaining																			
43. Replace <input type="checkbox"/> No <input type="checkbox"/> Yes																			
45. Treatment Resulting from																			
<input type="checkbox"/> Occupational Illness/Injury																			
46. Date of Accident (MMDD/CCYY)																			
<b>TREATING DENTIST AND TREATMENT</b>																			
53. I hereby certify that the procedures (visits) or have been completed.																			
X _____ Signed (Treating Dentist)																			
54. NPI																			
56. Address, City, State, Zip Code																			

**49. Billing Provider NPI**

**52A. Billing Medicaid provider number**

# ADA Transition Effective 3/1/2007

		<input type="checkbox"/> No (Skip 41-42)	<input type="checkbox"/> Yes (Complete 41-42)
Date	42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
<input type="checkbox"/> Otherwise payable to me, directly to the below named  Date			
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident			
Date		46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State
<input type="checkbox"/> Bank if dentist or dental entity is not submitting			
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>			
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.			
X		_____	
Signed (Treating Dentist)		Date	
54. NPI		55. License Number	
56. Address, City, State, Zip Code		56A. Provider Specialty Code	
51. SSN or TIN			
52A. Additional Provider ID	57. Phone Number ( ) -	58. Additional Provider ID	

408, J404)

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# ADA Transition Effective 3/1/2007

<input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)			
Date	42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
Otherwise payable to me, directly to the below named	45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident		
	46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State	
<b>PATIENT LOCATION INFORMATION</b>			
Detailed by date are in progress (for procedures that require multiple			
X Signed (Attending Dentist)		Date	
54. NPI		55. License Number	
56. Address, City, State, Zip Code		56A. Provider Speciality Code	
51. SSN or TIN			
ID			

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**54. Attending Provider NPI**

**56. Attending provider information  
Provider address & Zip +4**

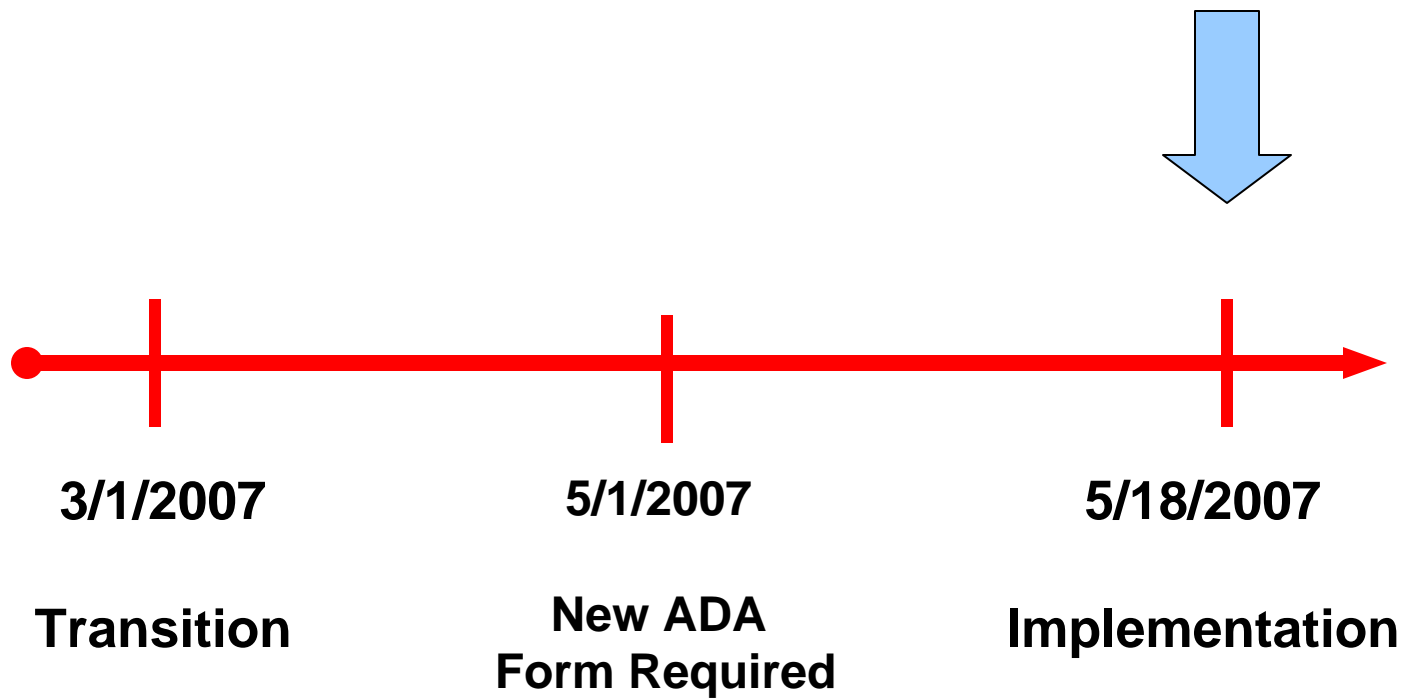
# ADA Transition Effective 3/1/2007

		<input type="checkbox"/> No (Skip 41-42)	<input type="checkbox"/> Yes (Complete 41-42)
Date	42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
is otherwise payable to me, directly to the below named	45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident		
Date	46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State	
: blank if dentist or dental entity is not submitting			
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>			
53. I hereby certify that the procedures as indicated by date are in progress (visits) or have been completed.			
X _____ Signed (Treating Dentist)			
54. NPI		55. License Number	
56. Address, City, State, Zip Code		56A. Provider Speciality Code	
51. SSN or TIN			
52A. Additional Provider ID	57. Phone Number ( ) -	58. Additional Provider ID	

**56A. Attending provider's taxonomy number**

**58. Attending Medicaid provider number**

# ADA Timeline



# ADA Implementation Effective 5/18/2007

10	<b>MISSING TEETH INFORMATION</b>																<b>Equipment</b>				
34. (Place an "X" on each missing tooth)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	C	
35. Remarks																					
<b>AUTHORIZATIONS</b>												<b>ANCILLARY CLAIM/TREATMENT</b>									
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.												39. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital									
X _____ Patient/Guardian signature Date												40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes ( )									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.												42. Months of Treatment Remaining					43. Replacements Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes ( )				
X _____ Subscriber signature Date												45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury									
<b>TREATING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)												<b>TREATING DENTIST AND TREATMENT</b>									
48. Name, Address, City, State, Zip Code												46. Date of Accident (MMDD/CCYY)									
49. NPI												53. I hereby certify that the procedures (visits) or have been completed.									
50. License Number												X _____ Signed (Treating Dentist)									
51. SSN or TIN												54. NPI									
52. Phone Number ( ) - -												56. Address, City, State, Zip Code									
52A. Additional Provider ID												57. Phone Number ( ) - -									

# ADA Implementation Effective 5/18/2007

**35. Billing provider's  
taxonomy number**

Equipment													A	B	C	D													
34. (Place an "X" in each missing tooth)													4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	C										
35. Remarks																													
<b>AUTHORIZATIONS</b>												<b>ANCILLARY CLAIM/TREATMENT</b>																	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.												39. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital																	
X _____ Patient/Guardian signature												40. Is Treatment for Orthodontics? No (Skip 41-42) <input type="checkbox"/> Yes <input type="checkbox"/>																	
37. I hereby authorize and direct dentist or dental entity.												41. Date of Treatment Beginning																	
X _____ Subscriber signature												43. Replacement <input type="checkbox"/> No <input type="checkbox"/>																	
<b>BILLING DENTIST OR DENTIST</b> claim on behalf of the patient												Treatment Resulting from Occupational Illness/Injury																	
48. Name, Address, City, State												Date of Accident (MM/DD/CCYY)																	
49. NPI												<b>BILLING DENTIST AND TREATING DENTIST AND TREATING DENTIST</b> I hereby certify that the procedures have been completed.																	
50. License Number												X _____ Signed (Treating Dentist)																	
51. SSN or TIN												54. NPI																	
52. Phone Number ( ) -												56. Address, City, State, Zip Code																	
52A. Additional Provider ID												57. Phone Number ( ) -																	

**48. Billing provider information  
Provider address & Zip +4**



# ADA Implementation Effective 5/18/2007

		<input type="checkbox"/> No (Skip 41-42)	<input type="checkbox"/> Yes (Complete 41-42)
Date	42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
<input type="checkbox"/> Otherwise payable to me, directly to the below named _____ Date			
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident			
Date		46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State
<input type="checkbox"/> Blank if dentist or dental entity is not submitting _____			
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>			
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.			
X _____ Signed (Treating Dentist)		Date	
54. NPI		55. License Number	
56. Address, City, State, Zip Code		56A. Provider Speciality Code	
51. SSN or TIN			
52A. Additional Provider ID	57. Phone Number ( ) -	58. Additional Provider ID	

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# ADA Implementation Effective 5/18/2007

Date		<input type="checkbox"/> No (Skip 41-42)	<input type="checkbox"/> Yes (Complete 41-42)
Other else payable to me, directly to the below named		42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)
		44. Date Prior Placement (MM/DD/CCYY)	
		45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident	
		46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State
<b>AND TREATMENT LOCATION INFORMATION</b>			
procedures as indicated by date are in p			
51. SSN or TIN		54. NPI	55. License Number
52A. Additional Provider ID		56. Address, City, State, Zip Code	56A. Provider Speciality Code
408, J404		<p style="text-align: center;"><b>54. Attending Provider NPI.</b></p> <p style="text-align: center;"><b>56A. Attending provider's taxonomy number</b></p> <p style="text-align: center;"><b>56. Attending Provider information Provider Address &amp; Zip +4</b></p>	

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# Carolina ACCESS Information

# Carolina ACCESS

- NPI will replace Medicaid Carolina ACCESS referral number
- December 2006 Special Bulletin
  - Quick Reference Guide

NPI -Get It! Share It! Use It! Getting one is free-not having one can be costly!

# CMS-1500 (08/05) Transition

## CA PCP/CA Override Effective 1/1/2007

<b>Block</b>	<b>Block Name</b>	<b>Required Field</b>	<b>Value</b>
<b>17</b>	<b>Referring Provider Name</b>	<b>No</b>	
<b>17a (small box)</b>	<b>Qualifier</b>	<b>Yes</b>	<b>Qualifier: "1D"</b>
<b>17a (large box)</b>	<b>CA PCP or CA Override #</b>	<b>Yes</b>	<b>Medicaid # or CA Override #</b>
<b>17b (large box)</b>	<b>NPI</b>	<b>No</b>	

# CMS-1500 (08/05) Implementation

## CA PCP Effective 5/18/2007

<b>Block</b>	<b>Block Name</b>	<b>Required Field</b>	<b>Value</b>
<b>17</b>	<b>Referring Provider Name</b>	<b>No</b>	
<b>17a (small box)</b>	<b>Qualifier</b>	<b>No</b>	
<b>17a (large box)</b>	<b>Referring Taxonomy</b>	<b>No</b>	
<b>17b (large box)</b>	<b>NPI</b>	<b>Yes</b>	<b>CA PCP NPI</b>

# CMS-1500 (08/05) Implementation

## CA Override Effective 5/18/2007

<b>Block</b>	<b>Block Name</b>	<b>Required Field</b>	<b>Value</b>
<b>17</b>	<b>Referring Provider Name</b>	<b>No</b>	
<b>17a (small box)</b>	<b>Qualifier</b>	<b>Yes</b>	<b>Qualifier: "1D"</b>
<b>17a (large box)</b>	<b>CA Override #</b>	<b>Yes</b>	<b>CA Override #</b>
<b>17b (large box)</b>	<b>NPI</b>	<b>No</b>	

# UB-04 Transition

CA PCP/CA Override Effective 3/1/2007

<b>Form Locator</b>	<b>Description</b>	<b>Required Field</b>	<b>Value</b>
<b>78 (large box)</b>	<b>NPI</b>	<b>No</b>	
<b>78 (small box)</b>	<b>Qualifier</b>	<b>Yes</b>	<b>Qualifier: "1D"</b>
<b>78 (large box)</b>	<b>CA PCP or CA Override #</b>	<b>Yes</b>	<b>Medicaid # or CA Override #</b>
<b>78 Last</b>	<b>Referring Provider Name</b>	<b>No</b>	
<b>78 First</b>	<b>Referring Provider Name</b>	<b>No</b>	

# UB-04 Implementation

## CA PCP Effective 5/18/2007

<b>Form Locator</b>	<b>Description</b>	<b>Required Field</b>	<b>Value</b>
<b>78 (large box)</b>	<b>NPI</b>	<b>Yes</b>	<b>CA PCP NPI</b>
<b>78 (small box)</b>	<b>Qualifier</b>	<b>No</b>	
<b>78 (large box)</b>	<b>Referring Taxonomy</b>	<b>No</b>	
<b>78 Last</b>	<b>Referring Provider Name</b>	<b>No</b>	
<b>78 First</b>	<b>Referring Provider Name</b>	<b>No</b>	

# UB-04 Implementation

CA Override Effective 5/18/2007

<b>Form Locator</b>	<b>Description</b>	<b>Required Field</b>	<b>Value</b>
<b>78 (large box)</b>	<b>NPI</b>	<b>No</b>	
<b>78 (small box)</b>	<b>Qualifier</b>	<b>Yes</b>	<b>Qualifier: "1D"</b>
<b>78 (large box)</b>	<b>CA Override #</b>	<b>Yes</b>	<b>CA Override #</b>
<b>78 Last</b>	<b>Referring Provider Name</b>	<b>No</b>	
<b>78 First</b>	<b>Referring Provider Name</b>	<b>No</b>	

# Question/Answer Session

**QUESTIONS ?**



We Appreciate Your Time!

Please Complete Your Evaluation

