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1.0 Description of the Service

Physician fluoride varnish services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations hereinafter specified. **Only the procedure codes listed in this policy are covered under the N.C. Medicaid Physician Fluoride Varnish Program**.

The Division of Medical Assistance (DMA) has adopted procedure codes and descriptions as defined in the most recent edition of *Current Dental Terminology* (CDT-2007/2008). CDT-2007/2008 (including procedure codes, descriptions, and other data) is copyrighted by the American Dental Association. © 2006 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for services as described in this policy.

2.2 Limitations

Refer to **Section 5.2, Procedure Codes and Limitations,** for eligibility limitations for individual procedure codes.

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

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EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.

b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers physician fluoride varnish when it is medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.

b. the procedure can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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3.2 Specific Criteria

Medicaid covers a total of ~~six~~eight oral screening packages (examination, preventive oral health and dietary counseling, and application of fluoride varnish) per patient from the time of tooth eruption until the child is 3½ years of age. These services can be provided at well-child checkups, during a sick visit, or at a separately scheduled visit.

Example of Oral Screening Preventive Package Visits

Well-Child Visit (months)	Procedure Performed
6	Yes (if teeth are erupted)
9	Yes (if teeth are erupted)
12	Yes
18	Yes
24	Yes
36	Yes

Begin providing the services as soon as the first teeth erupt. If services are provided at the 6- or 9-month well-child checkup, providers must wait at least 60 days before providing the service again. Ideally, the service should be performed every 3 to 6 months; however, flexibility is allowed to permit scheduling in conjunction with visits for other health services. Please note that the service can be provided until the recipient reaches age 3½ (or through age 41 months) since typically the 36-month well-child visit does not occur until after the recipient's third birthday.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Physician fluoride varnish is not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure duplicates another provider's procedure;
d. the procedure is experimental, investigational, or part of a clinical trial; or
e. the criteria specified in this policy have not been met.

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5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 American Dental Association Guidelines

Only topical fluoride varnish materials professionally applied as recommended by the guidelines of the American Dental Association Council on Scientific Affairs are accepted for use in the dental care of Medicaid recipients. Specific use of these materials must follow the ADA Council on Scientific Affairs guidelines.

5.2 Prior Approval

Prior approval is not required.

5.3 Procedure Codes and Limitations

By State legislative authority, DMA applies service limitations to ADA procedure codes as they relate to individual recipients. These service limitations are applied without modification of the ADA procedure description. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*) beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21. Refer to **Section 5.2.3 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**.

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5.3.1 Diagnostic Procedure: Clinical Oral Evaluation

Code	Description
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver * **replaced procedure codes D0150, D0120, and D1330 effective January 1, 2007** * includes early caries screening, evaluation of caries susceptibility, and recording of other notable findings in the oral cavity * includes preventive oral health and dietary counseling with the primary caregiver * includes prescribing a fluoride supplement, if needed * providers must document in the patient record the risk factors which indicate that an oral evaluation should be provided more frequently than every six (6) months—e.g., obvious cavitation, areas of demineralization/"white spot lesions," special health care needs, frequent between-meal exposure to sugar/cavity-producing foods and/or liquids * must be billed in conjunction with D1206 * limited to recipients under 3½ years of age * allowed once every 60 days * limited to ~~six~~eight times prior to the recipient reaching 3½ years of age * exempt from third party liability

5.3.2 Preventive Procedure: Topical Fluoride Treatment (Office Procedure)

Topical fluoride **must** be applied to **all** teeth erupted on the date of service. Medicaid will only allow reimbursement for this procedure when teeth are present and fluoride varnish is applied to the teeth.

Code	Description
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients * **replaced procedure code D1203 effective January 1, 2007** * providers must document in the patient record the risk factors which indicate that fluoride varnish application should be provided more frequently than every six (6) months—e.g., obvious cavitation, areas of demineralization/"white spot lesions," special health care needs, frequent between-meal exposure to sugar/cavity-producing foods and/or liquids * must be billed in conjunction with D0145 * limited to recipients under 3½ years of age * allowed once every 60 days * limited to ~~six~~eight times prior to the recipient reaching 3½ years of age * exempt from third party liability

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5.3.3 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Providers may request special approval for a service that is non-covered by the N.C. Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid recipient under age 21. **All such requests must be submitted in writing prior to delivery of the service.** The request must include

a. a completed CMS-1500 claim form,

b. any materials needed to document medical necessity (e.g., radiographs, photographs), and

c. the completed Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age) or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

Requests should be mailed to

Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh NC 27699-2501
FAX: 919-715-7679

If the procedure(s) receives special approval and the recipient is Medicaid-eligible on the date the service is rendered, the provider then can file for reimbursement.

Note: A copy of the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age) can be found on the EPSDT provider page. The Web address is specified below.

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

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6.0 Providers Eligible to Bill for the Service

6.1 Conditions of Participation

Licensed physicians who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for physician fluoride varnish when this service is within the scope of their practice. Designated physician extenders (physician assistant, nurse practitioner, registered nurse, and licensed practical nurse) who meet Medicaid's training requirement can render this service in eligible physicians' offices. All providers participating in the Medicaid program must provide services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are made available at the time of provider enrollment.

6.2 Provider Training and Continuing Education

Provider training is required as a condition of participation. Providers must receive Medicaid recognized training to prepare for the delivery of this service. Only providers who have been trained are allowed to render the services and submit claims for payment.

7.0 Additional Requirements

7.1 Oral Screening Requirements

a. Early caries screening and detection of notable findings (obvious pathology of hard and soft tissues) in the oral cavity using a dental mirror and directed light.

b. Counseling and educational materials on good oral hygiene practices and diet/nutrition for children.

c. Prescribing a fluoride supplement, if indicated, per the guidelines of the American Association of Pediatrics: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/1113

   Note: It is critical to have the recipient's drinking water tested for fluoride content if the level of fluoride in the source of drinking water is unknown. Providers should refer the recipient to a dentist for continued treatment at the appropriate age based on the recipient's need for dental services.

d. Application of the fluoride varnish to all erupted primary teeth, beginning at tooth eruption until the recipient is 3½ years of age.

e. Documentation in the patient's medical chart should include a record of the following:

   1. an oral evaluation and any notable findings
   2. caries-risk factors and an overall assessment of risk status (low, moderate, or high)
   3. preventive oral health and dietary counseling with the primary caregiver
   4. application of fluoride varnish
   5. referral to a dentist, if appropriate

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7.2 Place of Service

The oral screening package is allowed in the physician's office, health department clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and the recipient's residence.

7.3 Application of the Fluoride Varnish

Fluoride varnish is practical, safe, and easy to apply to the teeth of infants and very young children and is extremely useful in the prevention of early childhood caries. Teeth should be wiped with a 2" x 2" gauze pad prior to fluoride varnish application. The varnish is then applied in a thin layer to all surfaces of the teeth using a disposable brush.

7.4 Medical Record Documentation

Providers are responsible for maintaining all financial, medical and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations or agreements. The provider must furnish upon request appropriate documentation, including recipient records, supporting material, and any information regarding payments claimed by the Provider, for review by the DMA, its agents, the Centers for Medicare and Medicaid, the State Medicaid Fraud Control Unit of the Attorney General's Office, and/or other entities as required by law. Providers cannot charge for records requested by Medicaid.

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 2001

Revision Information:

Date	Section Revised	Change
11/01/2007	Section 3.2	The coverage criteria was revised to indicate that the procedure is limited to once every 60 days and the treatment can be covered through the age of 3½ years effective with date of service 01/01/2007.
	Sections 3.2, 5.3.1 ,5.3.2, and 7.1	Revised policy to allow for a maximum of eight visits before age 42 months. Provided additional guidance to providers regarding requirements for the documentation of risk factors/status in the patient record.

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Attachment A: Claims-Related Information

Instructions for Filing a Physician Fluoride Varnish Claim (CMS-1500)

Instructions for completing the standard CMS-1500 claim form are listed below. Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at www.nucc.org. Refer to National Provider Identifier (NPI) publications for NPI implementation dates.

Instructions for Filing a Physician Fluoride Varnish Claim (CMS-1500)		
Block	**Block Name**	**Explanation**
1.	Type of Coverage	Place an (X) in the Medicaid block.
1a.	Insured's ID Number	Enter the recipient's 10-character identification number found on the MID card.
2.	Patient's Name	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	Patient's Birth Date Sex	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960, would be entered as 07191960). Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims. Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).
5.	Patient's Address Telephone	Enter the recipient's street address including city, state and ZIP code. Entering the recipient's telephone number is optional.
9.	Other Insured's Name	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
10.	Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident?	If applicable, check the appropriate block.

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Instructions for Filing a Physician Fluoride Varnish Claim (CMS-1500)		
Block	**Block Name**	**Explanation**
15.	If Patient Has Had Same or Similar Illness, Give First Date	Leave blank EXCEPT when billing for: OB Antepartum Care Package Codes: Enter the first date recipient care was rendered for current pregnancy. Health Check: The next screening date (NSD) may be entered in block 15. Dialysis Treatment or Supervision: Enter the dialysis start date. If the date the provider enters in block 15 is within the periodicity schedule, the system will keep this date. If the NSD entered by the provider is out-of-range with the periodicity schedule or the provider chooses one of the three options listed below, an appropriate NSD will be systematically entered during claims processing according to the Medicaid periodicity schedule. To leave block 15 blank: Place zeros in block 15 (example: 00/00/0000), or Place all ones in block 15 (11/11/1111). Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.
16.	Dates Patient Unable to Work in Current Occupation "From" and "To"	If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time per follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the April 1999 Special Bulletin II, Modifiers, for billing guidelines.
17.	Name of Referring Provider or Other Source	Use for referring provider's name.
17a.	Other ID Number	Use for CA override or current Medicaid provider number with qualifier 1D, or taxonomy code with qualifier ZZ.
17b.	NPI	Use for referring provider or Carolina ACCESS PCP's NPI.
19.	Reserved for Local Use	Please be aware that Medicaid will no longer use block 19 for Carolina ACCESS.
20.	Outside Lab?	Check "yes" or "no." "No" indicates that the lab work was performed in the office.

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Instructions for Filing a Physician Fluoride Varnish Claim (CMS-1500)		
Block	**Block Name**	**Explanation**
21.	Diagnosis or Nature of Illness or Injury	The written description of the primary diagnosis is not required unless using diagnosis code V900. However, the claim must be ICD-9-CM coded to describe the primary diagnosis.
23.	Prior Authorization Number	Any provider billing for laboratory services must enter the CLIA number in this field. It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
24A.	Date(s) of Service "From" and "To"	Enter the eight-digit date of service in the "From" block. Example: Record the date of service Jan. 31, 2003, as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.
24B.	Place of Service	Enter the appropriate code from the Place of Service Code Index.
24C.	Emergency Indicator	Not used at this time.
24D.	Procedures, Services or Supplies	Enter the appropriate five-digit CDT or HCPCS code. **Note:** Providers mandated to bill modifiers can bill up to three modifiers per procedure code, if applicable. Health Check claims may also contain modifiers. Refer to guidelines listed in the April 2006 Special Bulletin I, Health Check Billing Guide 2006.
24F.	Charges	Enter the usual and customary charge for each service rendered.
24G.	Days or Units	Enter the number of visits or units.
24H.	EPSDT Family Plan	If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F."
24I. (upper shaded portion)	Qualifier	Enter qualifier 1D if entering Medicaid provider number or ZZ if entering taxonomy.
24J. (upper shaded portion)	Rendering Provider ID Number	Enter Medicaid attending provider number or taxonomy.
24J. (lower unshaded portion)	Rendering provider ID number	Enter attending provider NPI.

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Instructions for Filing a Physician Fluoride Varnish Claim (CMS-1500)		
Block	**Block Name**	**Explanation**
26.	Patient's Account No.	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric), but only the first 9 characters of this number will appear on the RA.
28.	Total Charge	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has third-party coverage.)
29.	Amount Paid	For dates of service after Oct. 1, 2002, but before Sept. 6, 2004, enter the total amount received from Medicare, including penalties and outpatient psychiatric reductions and other third-party payment source(s) (TPL). If there is a payment from Medicare and a TPL, leave block 29 blank and submit the claim with the appropriate EOBs attached. Refer to the Sept. 2002 Draft Special Bulletin IV (Revised Nov. 14, 2002) Medicare Part B Billing Guidelines, for detailed instructions on billing for Medicare Part B. Effective with date of service Sept. 6, 2004, professional charges will be reimbursed a specific percentage of the co-insurance and deductible in accordance with the Part B reimbursement schedule. Do not enter Medicare payments on the claim. Attach the Medicare voucher when submitting the claim to Medicaid. Refer to the August 2004 Special Bulletin V, Medicare Part B Billing, for detailed instructions.
31.	Signature of Physician or Supplier Including Degrees or Credentials	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script-style stamps and black ink stamp pads are acceptable), or 3. if a Provider Certification for Signature on File form has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in denied claims.
32.	Service Facility Location Information	Enter the ZIP + 4 Code.

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Instructions for Filing a Physician Fluoride Varnish Claim (CMS-1500)		
Block	**Block Name**	**Explanation**
33.	Billing Provider Info and Phone Number	Enter the billing provider's name, street address including ZIP + 4 Code and phone number.
33a.	NPI	Enter the billing provider's NPI.
33b.	Other ID Number	Enter the taxonomy with ZZ qualifier or Medicaid provider number with 1D qualifier.

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Attachment B: Examples of a Completed CMS-1500 Claim

Example 1: Periodic Oral Screening as a Separate Procedure

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999-99-9999A

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

3. PATIENT'S BIRTH DATE MM 05 DD 10 YY 06 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: City STATE: NC

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

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): (919) 555-5555

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 _____

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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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. 472.2 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 13 CCYY 05 13 CCYY 11			D0145			38 07			ZZ NPI	XXXXXXXXXX 9999999999
2 05 13 CCYY 05 13 CCYY 11			D1206			15 44			ZZ NPI	XXXXXXXXXX 9999999999
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 01999B

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

28. TOTAL CHARGE $ 53 51

29. AMOUNT PAID $

30. BALANCE DUE $ 53 51

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 Bill James, MD DATE 05.16.YY

32. SERVICE FACILITY LOCATION INFORMATION
James Medical Center
123 Any Street
City, NC 29999-9999
a.

33. BILLING PROVIDER INFO & PH # (919) 999-9999
Bill James, MD
123 Any Street
City, NC 29999-9999
a. 9999999999 b. ZZ-XXXXXXXXXX

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

DRAFT

Example 2: Periodic Oral Screening in Conjunction with an Office Visit

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 111-11-1111A

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

3. PATIENT'S BIRTH DATE MM 04 DD 03 YY 06 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: City STATE: NC

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

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): (919) 555-5555

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 _____

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 PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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. 382.9 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	04 25 CCYY	04 25 CCYY	11		99212			75 00			ZZ NPI	XXXXXXXXXX 9999999999
2	04 25 CCYY	04 25 CCYY	11		D0145			38 07			ZZ NPI	XXXXXXXXXX 9999999999
3	04 25 CCYY	04 25 CCYY	11		D1206			15 44			ZZ NPI	XXXXXXXXXX 9999999999
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 03124P

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

28. TOTAL CHARGE $ 128 51

29. AMOUNT PAID $

30. BALANCE DUE $ 128 51

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 Phillip Jones, MD DATE 04-26-YY

32. SERVICE FACILITY LOCATION INFORMATION
Jones Medical Center
123 Any Street
City, NC 29999-9999
a.

33. BILLING PROVIDER INFO & PH # (919) 999-9999
Phillip Jones, MD
123 Any Street
City, NC 29999-9999
a. 9999999999 b. ZZ XXXXXXXXXX

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

DRAFT

Example 3: Periodic Oral Screening in Conjunction with Health Check Screening

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 222-22-2222A

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

3. PATIENT'S BIRTH DATE MM 06 DD 15 YY 06 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: City STATE: NC

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

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): (919) 555-5555

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

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 PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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. 420.2 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 06 23 CCYY 06 23 CCYY	11		99392	EP		80 33		E	ZZ NPI	XXXXXXXXXX 9999999999
2 06 23 CCYY 06 23 CCYY	11		D0145			38 07			ZZ NPI	XXXXXXXXXX 9999999999
3 06 23 CCYY 06 23 CCYY	11		D1206			15 44			ZZ NPI	XXXXXXXXXX 9999999999
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 09878C

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

28. TOTAL CHARGE $ 133 84

29. AMOUNT PAID $

30. BALANCE DUE $ 133 84

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 William Smith, MD DATE 6-24-YY

32. SERVICE FACILITY LOCATION INFORMATION
Smith Medical Center
123 Any Street
City, NC 29999-9999
a. b.

33. BILLING PROVIDER INFO & PH # (919) 999-9999
William Smith, MD
123 Any Street
City, NC 29999-9999
a. 9999999999 b. ZZ XXXXXXXXXX

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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register. Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.