TERM Provider Claims Resources

Prepared By:

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Optum TERM

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Dear TERM Provider,

Your time and expertise shared in the support of TERM-referred clients is immensely valuable within our community. You play an exceptionally important role in helping to reduce the risk of abuse and neglect in families involved with Child and Family Well-Being (CFWB).

The following resources were developed in partnership with Optum's Claims and Provider Services Departments with the intent to offer concrete support and guidance around submission of claims for services rendered to TERM clients. The resources are provided for informational and instructional purposes and do not constitute billing advice. It is our hope that these resources will assist with streamlining your claims submission practices and more efficiently utilize your time to meet the needs of your clients.

Please feel free to contact us at 877-824-8376 (Option 1) for any questions about TERM related processes. Please be in touch with Optum's Claims Department for any questions specific to reimbursement, denials, and claims processes more generally at 877-824-8376 (Option 2). We also welcome and appreciate you sharing any ideas you might have about how we can better serve you. Thank you for partnering with Optum TERM in serving the clients of the County of San Diego.

Respectfully,

Optum TERM Team

Common Billing Questions – FAQ for TERM providers

- What information should be entered for the Insured's ID in box 1a?
    - For cases funded by CFWB, this information is the client's Case/State ID # listed on the referral form.
    - For cases funded by Medi-Cal, this information is the client's Medi-Cal policy # listed on the referral form.
- Can I sign a Claims form digitally or does it have to be done by hand?
    - Yes, a digital signature is acceptable.
- Is the client's signature required in box numbers 12 and 13?
    - No, the client is not required to sign these boxes. It is adequate to document 'SOF' or 'Signature on File' on these lines.
- How do I bill?
    - Claims can be sent on the CMS1500 form to the following address: CFWB Claims, Attention to: Optum, P.O. Box 600340, San Diego, CA 92160-0340. Claims can also be faxed to 877-364-6945.
- Where do I get the required claims form?
    - The CMS1500 claims form can be purchased from retailers such as Amazon and Staples. These forms can also be requested from Optum's Provider Services Department at no cost by calling 1-877-824-8376, option 3.
- Can I submit claims electronically?
    - Contact Claims directly to discuss options for setting up electronic submission of claims. Please contact Claims at 1-877-824-8376, option 2.
- Why are my claims being denied?
    - For specific questions related to your claims submissions, please begin by referencing the Explanation of Benefits (EOB) for the specific denial explanation. If requiring further assistance, please contact Optum's Claim's Department by calling 1-877-824-8376, option 2.

Helpful Billing and Claims Tips – FAQ for TERM Providers

- Provide accurate data and complete all required fields on the claim.
- Be sure all billing staff are familiar with current billing and contract requirements.
- Familiarize all billing staff with the appropriate client information to document in the insured's ID in box 1a.
- Document 'Homeless' in box 5 of the CSM1500 form if a client is currently homeless.
- Remain aware of and utilize appropriate modifiers for services that require modifiers.
- Verify the effective dates for any authorization and remain aware of how many services are covered within the authorization period.
- For any requests to update any information related to authorized services, dates, and service frequency contact the assigned PSW to discuss the request.

How To Complete the CMS1500 Claim Form

Client Information

Box1:Select "Other"

Box 1a:State ID # (CWFB Funded)or Medi-Cal Policy # (Medi-Cal Funded)

Box 2-6:Client demographics to include Name, DOB, Address, and Gender

Box 12, 13:Enter "Signature on File" or SOF

Provider/Line item details

Box 19:Indicate whether submission is an updated form with comment "Corrected Claim" or whether the service is facilitated by an intern by entering the intern's full name, i.e., Daffy Duck, AMFT.

Box21:Diagnostic Codes according to DSM-V-TR. When CFWB funded, Z-codes are adequate. Medi-Cal funding requires that a Title 9 diagnosis be submitted for reimbursement.

Box 23: Enter the authorization number. When multiple authorizations exist, you may enter a range or list each one individually. The authorization number(s) can be found on the authorization letter sent to you by TERM.

Box 24a:Date(S) of Service. Each CMS-1500 form can reflect up to 6 Dates of Service. Line Item details/charges about services rendered by Provider.

Box 24b:Place of Service. Common approved Places of Service include: 02-Telehealth other than in Client's home, 10- Telehealth in Client's home, 11-Office.

Box 24d:Approved CPT Codes only. Include any approved, relevant modifiers. Common modifiers include: 93- Telephone, 95-Video and Telephone, and TU-Bilingual Rate Applies.

Box 24e: Corresponds to diagnosis in Box 21 A-L.

Box 24f: Charge(s) for the rendered service. Rates are pre-determined during the contracting phase.

Box 24g: Indicate the number of units billed. CPT Code T1017 (Case Management) are billed in units of 15mins. For example, a 30 minute T1017 service would reflect 2 units in box 24g.

24j: NPI

Box 25: Federal Tax ID Number/Social Security Number of "Pay To"

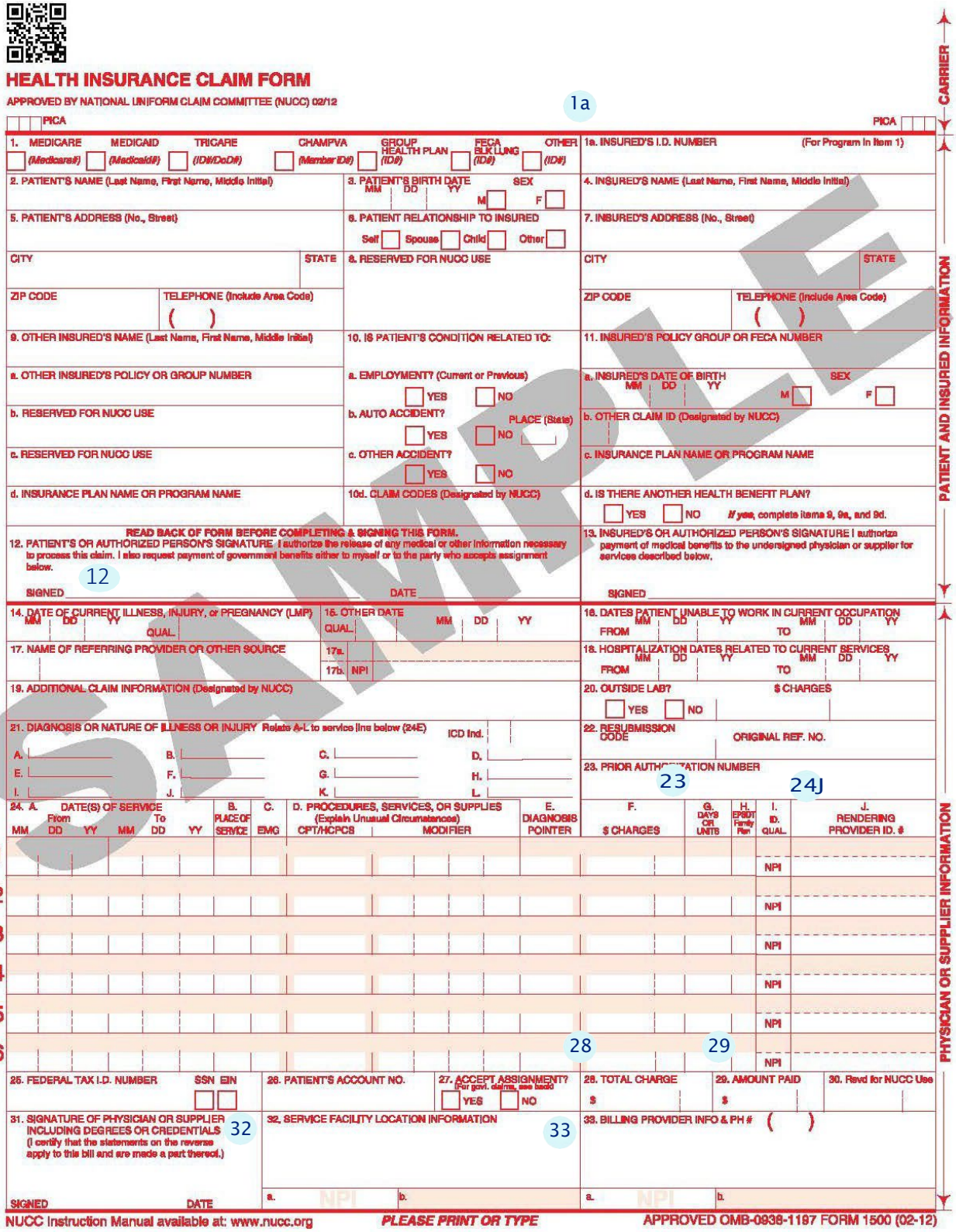
Box 28: Total charge for all services (lines 24a., 1-6) rendered

Box 31: Provider signature and date. Electronic signature is adequate.

Box32:Service facility location information. If services are rendered in Client's home, enter Client's home address.

Box 33: "Pay To" Provider's name, address, and telephone number. Enter Agency or Group address if you are working under an Agency or Group (e.g., The San Diego Outpatient Group). Box 25 should correspond to provider or Agency/Group reflected here.

1500 Claim Type Image



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1a

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2-6

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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.

12

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

23

24J

24

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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

28

29

25

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31

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.)

32

32. SERVICE FACILITY LOCATION INFORMATION

33

33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE

a. NPI b.

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Navigating TERM Authorization Letters: Completing CMS 1500 Claims Form

The following are samples of TERM generated authorization letters that capture key areas used when completing the CMS 1500 Claim Form, as well as areas that orient the provider to understanding how treatment services are funded.

Each sample authorization letter is followed by a letter key that is intended to support the provider's navigation and understanding of the authorization letter.

The first authorization letter reflects a Medi-Cal funded authorization for Child Family Well-Being (CFWB) treatment services that will be rendered to a child. The second authorization letter reflects a CFWB funded authorization of services rendered to a child. Finally, the third authorization letter reflects a CFWB funded authorization of group services.

CFWB MC A

Treatment Authorization

Monday, October 7, 2024

Prov, Termy B
123 Healing Rd.
San Diego, CA 92108

Phone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX

We have authorized the following treatment services:

Client: **Last, First** C Client ID: 123456789 D **Insured ID:**77777777F

Authorization # E	**Date and Type of Service** F	**# of Units** G	**Frequency** H
001	10/21/2024-10/20/2025 I A&E- Child J -A&E- Child Psych Assessment and Med Eval	1 Unit	1 Once a year
Comment:	INDIVIDUAL THERAPY K		

Please bill with the applicable CPT code listed above and what is included in your fee schedule. Please ensure to bill with any applicable modifiers.

Should you have any questions, please contact us at (877) 824-8376 option 3, then option 4.

Disclaimer: Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

Payment for services is subject to client's Medi-Cal eligibility. Authorization is neither a statement of benefit coverage nor a guarantee of payment. Incomplete submissions re not authorized and will not be reimbursed. If a client has other health coverage (OHC), you must bill OHC first. The 'Good Thru' date is the last day authorized. Please submit a request for additional days to Optum Public Sector.

All providers serving children and youth ages 0-21 are REQUIRED to complete Child and Adolescent Needs Assessment and Strengths (CANS) & Pediatric Symptom Checklist (PSC) outcome tools. Please submit completed tools to Optum Public Sector.

Incomplete submissions are not authorized and without authorization, services may not be reimbursed.

Fax to: (866) 220-4495 or
Mail to: Optum Utilization Management at PO Box 601370 San Diego, CA 92160-1370

Medi-Cal Funded Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a Medi-Cal funded authorization.	Funding source will inform the ID number entered in box 1a.
B	Addressee reflects the provider/practice mailing address.	Use the mailing address when completing box 33 of the CMS-1500 form. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this individual's demographic information to complete boxes 2-6.
D	In Medi-Cal funded cases, the Insured ID is the client's 9-digit Medi-Cal Policy ID.	Enter the client's 9-digit Medi-Cal Policy ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23 of the CMS-1500 form. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column reflects that *only* the Psych Assessment and Med Eval is authorized at the start of the authorization period in Medi-Cal funded cases.	CPT coded entered in box D.
G	Number of units authorized during the authorization period. Please request additional units by coordinating with UM. One unit of A&E Child Psych Assessment and Med Eval is authorized in the year.	
H	The number of units that can be billed during the described period. When additional units are needed (ex. Multiple individual sessions in one week) and clinically indicated, coordinate with UM and the assigned PSW.	Enter in box G.
I	Date range reflects the period in which the client is authorized to receive services. Medi-Cal funded therapy is initially authorized for a period of one year.	
J	*Child* designates that the service is authorized to a child. The modifier 'TJ' must be entered for each CPT code authorized and being billed during a child's treatment. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box D.
K	Comment describing the service modality that is authorized. When authorized to a group practice, this area will also reflect the provider who is authorized to render treatment.	Box 31 is signed by the treatment rendering provider designated in the comments section.

CFWB A

Treatment Authorization

Monday, October 7, 2024

Prov, Termy B
123 Healing Rd.
San Diego, CA 92108

Phone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX

We have authorized the following treatment services:

Client: **Last, First** C Client ID: 123456789 D **Insured ID:**0T000-0

Authorization # E	**Date and Type of Service** F	**# of Units** G	**Frequency** H
001	10/21/2024-04/21/2025 I A&E- Child J -A&E-Child Psych Assessment and Med Eval	1 Unit	1 Once a year
002	10/21/2024-04/21/2025 CM-Child- CM- Child Team Conference	12 Units	1 Twice a month
003	10/21/2024-04/21/2025 TCM- Child- TCM-Child Targeted Case Management	12 Units	1 Twice a month
004	10/21/2024-04/21/2025 INDIV-Child – INDIV- Child Therapy	23 Units	1 Weekly

Please bill with the applicable CPT code listed above and that is included in your fee schedule. Please ensure to bill with any applicable modifiers: 93-Telephone, 95-Telehealth, TU-Bilingual rate applies, TJ-Child and/or Adolescent. K

Should you have any questions, please contact us at (877) 824-8376.

Disclaimer: This authorization is being issued on behalf of Child and Family Well-Being. Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

*All CFWB Initial Treatment Plans and Group Intake Assessments are due 14 days from the authorization start date.
*All treatment plan updates are due every 12 weeks thereafter.
*Discharge summaries should be submitted on completion or termination of services.
*CFWB psychological evaluations are due 30 days from the authorization or receipt of background records from CFWB.

Fax to: (877) 624-8376
Mail to: Optum TERM at PO Box 601340 San Diego, CA 92160-1340

CFWB Funded Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a CFWB funded authorization.	Funding source will inform the ID number entered in box 1a.
B	Addressee reflects the provider/practice mailing address.	Use the mailing address when completing box 33. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this individual's demographic information to complete boxes 2-6
D	In CFWB funded cases, the Insured ID is the client's State ID.	Enter the client's State ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23 of the CMS-1500 form. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column will reflect the services/CPT codes the client is authorized to receive. CFWB funded cases will be authorized to receive Psych Assessment and Med Eval, Team Conference, Targeted Case Management, and Therapy.	CPT code entered in box D.
G	Number of units authorized during the authorization period.	
H	The number of units that can be billed during the described period. When additional units are needed (ex. Multiple sessions during a one week period) and clinically indicated, coordinate with the assigned PSW.	Enter in box G.
I	Date range reflects the period in which the client is authorized to receive services. CFWB funded therapy is initially authorized for a period of 6 months.	
J	*Child* designates that the service is authorized for a child. The modifier TJ must be entered for each CPT code authorized and being billed during a child's treatment. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box D.
K	Consider any applicable modifiers. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box D.

CFWB A

Treatment Authorization

Monday, October 7, 2024

THE BEST GROUP PRACTICE INC B

123 Healing Rd.
San Diego, CA 92108

Phone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX

We have authorized the following treatment services:

Client: **Last, First** C Client ID: 123456789 D **Insured ID:**0T000-0

Authorization # E	**Date and Type of Service** F	**# of Units** G	**Frequency** H
001	10/21/2024-04/21/2025 I A&E- A&E Psych Assessment and Med Eval	1 Unit	1 Once a year
002	10/21/2024-04/21/2025 DVIA- DV- Additional 30min for Intake/Assessment for DV	1 Unit	1 Once a year
003	10/21/2024-04/21/2025 CM-CM- Team Conference	12 Units	2 Monthly
004	10/21/2024-04/21/2025 TCM- TCM- Targeted Case Management	12 Units	2 Monthly
005	10/21/2024-04/21/2025 GROUP- GROUP- Group Therapy	26 Units	1 Weekly
Client: Last, First	Client ID:123456789 Insured ID: 0T000-0		
Authorization #	**Date and Type of Service**	**# of Units**	**Frequency**
Comment:	*AUTHORIZING PROVIDER: TERMY PROV DOMESTIC VIOLENCE VICTIM GROUP* J		

Please bill with the applicable CPT code listed above and that is included in your fee schedule. Please ensure to bill with any applicable modifiers: 93-Telephone, 95-Telehealth, TU-Bilingual rate applies, TJ-Child and/or Adolescent.

Should you have any questions, please contact us at (877) 824-8376.

Disclaimer: This authorization is being issued on behalf of Child and Family Well-Being. Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

Fax to: (877) 624-8376
Mail to: Optum TERM at PO Box 601340 San Diego, CA 92160-1340

CFWB Funded GROUP Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a CFWB funded authorization as all groups are CFWB funded.	Funding source will inform the ID number entered in box 1a.
B	Addressee reflects the provider/practice mailing address.	Use the mailing address when completing box 33. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this name to complete boxes 2-6.
D	In CFWB funded cases, the Insured ID is the client's State ID.	Enter the client's State ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column will reflect the services/CPT code the client is authorized to receive and bill. CFWB funded group cases will be authorized to receive Psych Assessment and Med Eval, Intake/Assessment Additional 30 min, Team Conference, Targeted Case Management, and Group Therapy.	CPT code entered in box D.
G	Number of units authorized during the authorization period.	
H	The number of units that can be billed during the described period. When additional units are needed (ex. Intake/Assessment) and clinically indicated, coordinate with the assigned PSW.	Enter in box G.
I	Date range reflects the period in which the client is authorized to receive services. CFWB funded group therapy is initially authorized for a period of 6 months.	
J	Comment describing the service authorized. When authorized to a group practice, this area will also reflect the provider who is authorized to render treatment.	Box 31 is signed by the treatment rendering provider designated in the comments section.

Sample CMS 1500 Claims Form

Individual Therapy

The following two pages include sample CMS 1500 Claims Forms to capture how a provider would submit claims for individual therapy services. In the first sample, the individual therapy was rendered to an adult while the second sample reflects individual therapy with a child. Both samples include submission of claims for reimbursement of three separate services rendered to the client.

1) CPT Service Code 90791 for the Initial Intake Assessment
2) CPT Service Code 99366 for the provider's attendance at a CFT meeting
3) CPT Service Code 90837 for Individual Therapy lasting 60 minutes

Both samples also include use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the samples, Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The child sample includes the use of the 'TJ' Modifier code to denote that the service was rendered to a child. The required use of this Modifier is effective as of 9/1/2024. The 'TJ' Modifier is not required when billing CPT codes H0032 (CFWB Report), 99499 (No Shows- Psych Eval).

When multiple Modifiers are being documented by the provider, the language Modifier should be entered as the primary Modifier.

These samples further illustrate usage of Modifiers to capture services rendered via telehealth through use of the '95' Modifier code.

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while the Client is in the community (02-Place of Service).

Line 3 CPT Code 90837 depicts an individual therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Codes 90791 and 90837. Up to six dates can be captured per CMS 1500 Claims Form.

If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1993 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

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

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

CITY: Wonderful World

STATE: CA

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 54321

TELEPHONE (Include Area Code): ( )

ZIP CODE

TELE (Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. IN OLICY GROUP OR FECA NU

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURE F BIRTH MM YY M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐

ER CLA ate)

c. RESERVED FOR NUCC USE

c. OTHER ACCID NT?

URANCE PLA OGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. C Signated

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COM & SIGNI F

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I ase of a al rmation n to process this claim. I also request payment of governme self or rty assignme below.

SIGNED Signature on File 12/15/2023

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 Signature on File

14. DATE OF CURRENT ILLNESS, I PREGNANCY (LM HER MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PRO RCE

17b

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMA signated Corrected Claim or Intern Name - Only Use When Applicable

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF IL Relate to service line below (24E) ICD Ind.

F43.10

B. C. D.

F. G. H.

J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1333325-326 or 1333325, 1452658

24. A. DATE(S) O 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	12 15 23	12 15 23	10		90791	TU 95	A.	250.00	1		NPI 5279384
2	12 22 23	12 22 23	02		99366	95	A.	75.00	1		NPI 5279384
3	12 23 23	12 23 23	10		90837	TU 95	A.	150.00	1		NPI 5279384
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: 88-8888888 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 475.00

29. AMOUNT PAID $ 0

30. Rsvd for NUCC Use

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.)

Termy Prov LMFT

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (XXX)XXX-XXXX

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).
Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while Client is in the community (02-Place of Service).
Line 3 CPT Code 90837 depicts an individual therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).
Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Code 90791. Up to six service dates can be captured per CMS 1500 Claims Form.
Services provided to a child must be accompanied by the 'TJ' modifier, as noted below in CPT Codes 90791, 90837. The 'TJ' modifier must follow the language modifier. Up to six service dates can be captured per CMS 1500 Claims Form.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / (Medicaid#) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) X	Medi-Cal Policy ID or CFWB State ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client Name	3. PATIENT'S BIRTH DATE MM DD YY: 04 01 2016 SEX: X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial):	
5. PATIENT'S ADDRESS (No., Street): 1234 Disneyworld Avenue	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street):	
CITY: Wonderful World STATE: CA	8. RESERVED FOR NUCC USE
CITY:	
ZIP CODE: 54321 TELEPHONE (Include Area Code): ( )	
ZIP CODE: TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY: SEX: F	
b. RESERVED FOR NUCC USE:	b. AUTO ACCIDENT? YES
b. OTHER CLAIM ID (Designated by NUCC):	
c. RESERVED FOR NUCC USE:	c. OTHER ACCIDENT?
c. INSURANCE PLAN NAME OR PROGRAM NAME:	
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. CLAIM CODES (Designated by NUCC):
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.	

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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 Signature on File 12/15/2023

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 Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected Claim or Intern Name - Only Use When Applicable		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.): A. F43.10 B. C. D. F. G. H. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: 1333325-326 or 1333325, 1452658

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 12 15 23	12 15 23	10		90791	TU 95 TJ	A.	250.00	1		NPI	5279384
2 12 22 23	12 22 23	02		99366	95	A.	75.00	1		NPI	5279384
3 12 23 23	12 23 23	10		90837	95 TJ	A.	150.00	1		NPI	5279384
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
88-8888888	X		X YES NO	$ 475	$ 0	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (XXX) XXXXXXX
Termy Prov LMFT	Termy Prov, LMFT 123 Healing Rd. Sun Diego, CA 92108	Termy Prov, LMFT 123 Healing Rd. Sun Diego, CA 92108
SIGNED DATE 12/23/23	a. NPI b.	a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

Sample CMS 1500 Claims Form

Group Therapy

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for group therapy services. The sample include submission of claims for reimbursement of three separate services rendered to the client.

1) CPT Service Code 90791 for the Initial Intake Assessment
2) CPT Service Code 99366 for the provider's attendance at a CFT meeting
3) CPT Service Code 90853 for Group Therapy

The sample also includes use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the sample, language Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The sample further illustrates usage of Modifiers to capture services rendered via telehealth through use of the '95' Modifier code.

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while the Client is in the community (02-Place of Service).

Line 3 CPT Code 90853 depicts a group therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Codes 90791 and 90837. Up to six dates can be captured per CMS 1500 Claims Form.

If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) — X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM DD YY: 05 01 1990 SEX: X M F

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

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

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

CITY: Wonderful World

STATE: CA

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 54321

TELEPHONE (Include Area Code): ( )

ZIP CODE

TELEPHONE (Include Area Code): (

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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 Signature on File 12/15/2023

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 Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY

15. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected Claim or Intern Name - Only Use When Applicable

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.)

A. F43.10 B. C. D.

F. G. H.

J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1333325-326 or 1333325, 1452658

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	12	15	23	12	15	23	10		90791	TU 95	A.	250.00	1		NPI	5279384
2	12	22	23	12	22	23	02		99366	95	A.	75.00	1		NPI	5279384
3	12	23	23	12	23	23	10		90853	TU 95	A.	75.00	1		NPI	5279384
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 88-8888888 SSN EIN X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 400.00

29. AMOUNT PAID $ 0

30. Rsvd for NUCC Use

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.)

Termy Prov LMFT

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (XXX) XXX-XXXX

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

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APPROVED OMB-0938-1197 FORM 1500 (02-12)

31. if it's agroup, we need provider who rendered services in box 31.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample CMS 1500 Claims Form

Conjoint Therapy and Case Management

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for conjoint therapy and case management services. The sample include submission of claims for reimbursement of three separate services rendered to the client.

1) CPT Service Code 90791 for the Initial Intake Assessment
2) CPT Service Code 90847 for Conjoint Therapy
3) CPT Service Code T1017 for Case Management

Case Management services are billed in units of 15 minutes. For example, a 30-minute Case Management service should be documented with the number '2' under column 24g on the CMS 1500 form.

The sample also includes use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the sample, language Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The sample further illustrates usage of Modifiers to capture services rendered via telephone through use of the '93' Modifier code and telehealth through use of the '95' Modifier code.

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).
Line 2 CPT 90847 depicts a conjoint service rendered via telehealth (modifier 95) while the Client is at home (10- Place of Service).
Line 3 CPT T1017 depicts 1 unit of Case Management service rendered via telephone (modifier 93) while the Client is in the community (02- Place of Service).

Services rendered in languages other than English are captured with the 'TU' modifier, as noted below in Line 2 CPT Code 90847. Up to six services can be captured per CMS 1500 Claims Form.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1993 SEX X M F

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

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

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

CITY: Wonderful World

STATE: CA

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 54321

TELEPHONE (Include Area Code): ( )

ZIP CODE

TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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 Signature on File 12/15/2023

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 Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY

QUAL. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Corrected Claim or Intern Name - Only use when applicable

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.

A. F43.10 B. C. D.

F. G. H.

J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 1333325-326 or 1333325, 1452658

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 12 15 23	12 15 23	02		90791	95	A.	175.00	1		NPI	5279384
2 12 22 23	12 22 23	10		90847	TU 95	A.	150.00	1		NPI	5279384
3 12 23 23	12 22 23	02		T1017	93	A.	30.00	1		NPI	5279384
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 88-8888888 SSN EIN X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 355.00

29. AMOUNT PAID $ 0

30. Rsvd for NUCC Use

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.)

Termy Prov LMFT

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (XXX) XXX-XXXX

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

31. if it's agroup, we need provider who rendered services in box 31.

Sample CMS 1500 Claims Form

Evaluation No-Show Consideration Fee

TERM evaluators accepting Child and Family Well-Being evaluation referrals (CFWB, formerly CWS) through Optum TERM will be pre-authorized for one unit CPT code 99499 (no-show) and sent to providers by Optum with the referral form and questions. Evaluators that did not receive this information with the aforementioned documents should follow up directly with TERM by contacting the TERM provider line: 877-824-8376 (Option 1).

There will be only one $200 no-show fee reimbursed per client per evaluator. This no-show consideration fee only pertains to CFWB/Probation evaluation referrals at the time of this document's publishing.

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for an evaluation no-show consideration fee (CPT Service Code 99499). This no-show consideration fee is reimbursed at a rate of $200 considering the time blocked out for the missed evaluation and does not reimburse the provider at the same rate as a completed evaluation, attended by the client.

As displayed on the sample, Evaluators are to document the code '11' for the Place of Service and a diagnosis code of R69 when submitting for reimbursement of the evaluation no-show consideration fee.

Please Note: When granted, evaluation no-show consideration fees will be paid using CFWB funding. Therefore, a CFWB case number must be used when submitting for this fee. If evaluation services are financed by Medi-Cal, the 99499 must be reported on a different claims form than the evaluation services because it is paid for separately using CFWB funding.

Line 1 CPT Code 99499 depicts a claims submission for compensation related to a CFWB Evaluation that was not attended by the client. This reflects the Evaluator seeking reimbursement for the CFWB evaluation no-show consideration fee.

If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): CFWB State ID

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 1972 SEX: X M F

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

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

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

CITY: Wonderful World

STATE: CA

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 54321

TELEPHONE (Include Area Code): ( )

ZIP CODE

TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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 Signature on File 12/15/2023

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 Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY

15. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected Claim or Intern Name - Only Use When Applicable

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.

A. R69 B. C. D.

F. G. H.

J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1333325-326 or 1333325, 1452658

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 12 15 23	12 15 23	11		99499		A.	200. 00	1		NPI	5279384
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 88-8888888 SSN EIN X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 200. 00

29. AMOUNT PAID $ 0

30. Rsvd for NUCC Use

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.)

Termy Prov PhD

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, PhD
123 Healing Rd.
San Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (XXX)XXX- XXXXX

Termy Prov, PhD
123 Healing Rd.
San Diego, CA 92108

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-1197 FORM 1500 (02-12)

31. if it's agroup, we need provider who rendered services in box 31.

TERM Provider Authorization Letter to CPT Code Crosswalk

Psychiatric Diagnostic Procedures (Intake Assessment)

Provider Auth Letter Description	CPT Code	Description	Minutes
A&E Psych Assessment and Med Eval	90791	Psychiatric diagnostic evaluation	50
A&E Psych Assessment and Med Eval	90791TU	Psychiatric diagnostic evaluation - **Bilingual**	50

Psychotherapy (Individual, Conjoint, and Family Therapy)

Provider Auth Letter Description	CPT Code	Description	Minutes
INDIV Therapy	90834	Psychotherapy, 45 minutes with patient	45
INDIV Therapy	90834TU	Psychotherapy, 45 minutes with patient - **Bilingual**	45
INDIV Therapy	90837	Psychotherapy, 60 minutes with patient	60
INDIV Therapy	90837TU	Psychotherapy, 60 minutes with patient - **Bilingual**	60
CONJ Conjoint Therapy	90846	Family psychotherapy (without the patient present), 50 minutes	50
CONJ Conjoint Therapy	90846TU	Family psychotherapy (without the patient present), 50 minutes - **Bilingual**	50
CONJ Conjoint Therapy	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	50
CONJ Conjoint Therapy	90847TU	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes - **Bilingual**	50

Group Therapy (All TERM Group Therapy Services)

Provider Auth Letter Description	CPT Code	Description	Minutes
A&E Psych Assessment and Med Eva	90791	Intake/Assessment for Group	N/A
A&E Psych Assessment and Med Eva	90791TU	Intake/Assessment for Group - **Bilingual**	N/A
DVIA DV Intake Assessment	90785	Additional 30 min. for Intake/Assessment for Domestic Violence Offender and Victim Group	30
DVIA DV Intake Assessment	90785TU	Additional 30 min. for Intake/Assessment for Domestic Violence Offender and Victim Group - **Bilingual**	30
GROUP Group Therapy	90853	Group Therapy Session	N/A
GROUP Group Therapy	90853TU	Group Therapy Session - **Bilingual**	N/A

TERM Provider Authorization Letter to CPT Code Crosswalk

Quarterly Treatment Report

Provider Auth Letter Description	CPT Code	Description	Minutes
Report Preparation	90889	Quarterly Treatment Report – 4x per year	N/A
PLDV Plan Development	H0032	CFWB Report(s) – Initial Treatment Plan, Treatment Plan Update and Discharge Summary for TERM CWS Clients (per report)	N/A

Care Coordination (CFT Meeting Attendance and Case Management)

Provider Auth Letter Description	CPT Code	Description	Minutes
CM Team Conference	99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional. Includes Child, Family and Interdisciplinary Team (CFT) meetings for CWS clients. **(1 unit per day maximum)**	N/A
CM Team Conference	99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional/ **(1 unit per day maximum)**	N/A
TCM Targeted Case Management	T1017	Targeted case management, each 15 minutes	15

CANS

Provider Auth Letter Description	Billing/CPT Code	Description
CANS Report Preparation	90889	Submission of an appropriate CANS Report (1 each/1 unit)

Psychological Testing

Provider Auth Letter Description	CPT Code	Description	Minutes
Psych Test Eval 1st Hr	96130	* Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (Max 1 unit/1	60
Psych Test Eval 1st Hr	96130TU	* Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (Max 1 unit/1 hour) - **Bilingual**	60
Psych Test Eval Addtl 1 Hr	96131	Each additional 1 unit/1 hour (services as described in 96130)	60
Psych Test Eval Addtl 1 Hr	96131TU	Each additional 1 unit/1 hour (services as described in 96130) - **Bilingual**	60
Neuropsych Test Admin 1st 30 Minutes	96136	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit)	30
Neuropsych Test Admin 1st 30 Minutes	96136TU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit) - **Bilingual**	30
Neuropsych Test Admin Addtl 30 Minutes	96137	Each additional 1 unit/30 minutes (services as described in 96136)	30

TERM Provider Authorization Letter to CPT Code Crosswalk

Neuropsych Test Admin Addtl 30 Minutes	96137TU	Each additional 1 unit/30 minutes (services as described in 96136) - **Bilingual**	30
No Show- Psych Eval	99499	No Show Consideration Fee for Psychological Evaluations	N/A

Neuorpsychological Testing

Provider Auth Letter Description	CPT Code	Description	Minutes
NeuorpsyTesting Evaltion1stHr	96132	* Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	60
NeuorpsyTesting Evaltion1stHr	96132TU	* Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour - **Bilingual**	60
NeuropsyTestingEvalAdd1Hr	96133	Each additional 1 unit/1 hour (services as described in 96132)	60
NeuropsyTestingEvalAdd1Hr	96133TU	Each additional 1 unit/1 hour (services as described in 96132) - **Bilingual**	60
Neuropsych Test Admin 1st 30 Minutes	96136HU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit)	30
Neuropsych Test Admin 1st 30 Minutes	96136HU TU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit) - **Bilingual**	30
Neuropsych Test Admin Addtl 30 Minutes	96137HU	Each additional 1 unit/30 minutes (services as described in 96136)	30
Neuropsych Test Admin Addtl 30 Minutes	96137HU TU	Each additional 1 unit/30 minutes (services as described in 96136) - **Bilingual**	30
No Show- Psych Eval	99499	No Show Consideration Fee for Psychological Evaluations	N/A

Psychiatric Evaluations

Provider Auth Letter Description	CPT Code	Description	Minutes
Psychiatric Evaluation 1 Hour	90899	Psychiatric Evaluations	N/A
Psychiatric Evaluation 1 Hour	90899TU	Psychiatric Evaluations - **Bilingual**	N/A