TERM Provider Claims Resources: CFWB Evaluations

Prepared By:

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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 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

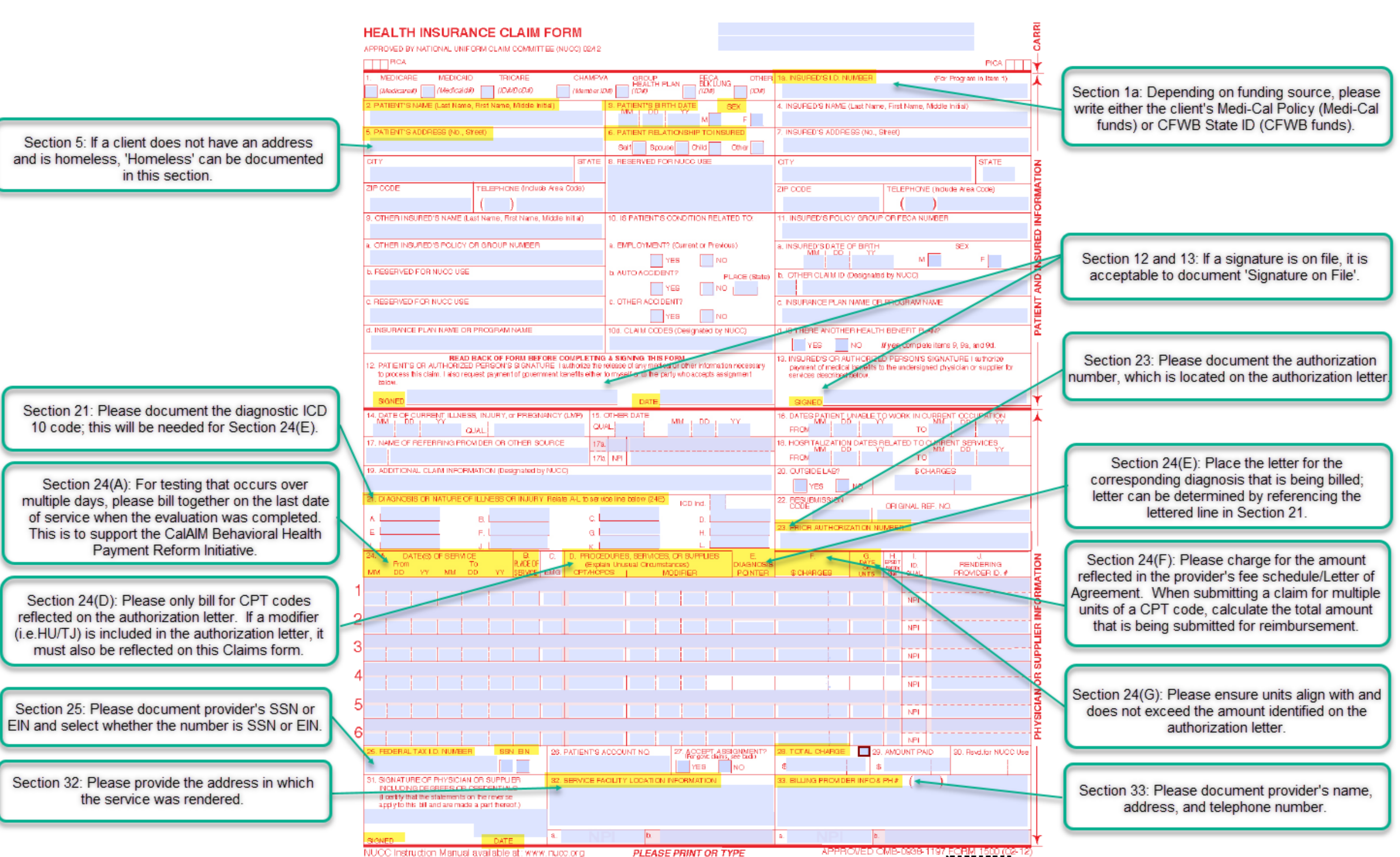
- Can I sign a Claims form digitally or does it have to be done by hand?
  - Yes, a digital signature is acceptable.
- Where do I send my claims form?
  - Claims can be sent on the CMS1500 form to the following address: CFWB Claims, Attention to: Optum, P.O. Box 600340, San Diego, CA 92160-0340. Claims can also be faxed to 877-364-6945.
- Where do I get the required claims form?
  - The CMS-1500 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 Claims Department by calling 1-877-824-8376, option 2.

Helpful Billing and Claims Tips – FAQ for TERM Providers

- To prevent delays, please ensure to complete all required fields on the claim form and that the information is consistent with the client's authorization letter.
- Be sure all billing staff are familiar with current billing and contract requirements.
- Remain aware of and utilize appropriate modifiers for services that require modifiers (i.e. language, children, and neuropsychological).
- Verify the effective dates for authorizations and remain aware of the authorization period.
- For testing that occurs over multiple days, please bill Dates of Service as the last date when the evaluation was completed. This is to support the CalAIM Behavioral Health Payment Reform Initiative.
- When multiple modifiers are authorized (i.e. TU: language; TJ: child; HU: neuropsychological), the language modifier (TU) should be entered as the primary modifier.
- No-Show Considerations:
    - While client no-shows or late cancellations are not reimbursed, CFWB pre-authorizes a one-time no-show consideration fee per client; please see TERM Provider Handbook for further information.
    - Medi-Cal does not cover no-show consideration fees. Therefore, no-show consideration fees for TERM-referred Medi-Cal beneficiaries are authorized under CFWB funds. When billing Medi-Cal funded evaluations, no-show considerations will need to be submitted for reimbursement separately on a different claims form using the client's CFWB State ID.
    - Modifiers (i.e. TJ) are not required when billing for no-show considerations.
    - If billing separately as a standalone CPT code on the CMS-1500, a diagnosis code of 'R69' and Place of Service code '11' can be used when submitting for reimbursement.
- Feedback Sessions:
    - Specific feedback session and process can be found in the TERM Provider Handbook. For the purposes of completing the CMS-1500, since the authorization will be using CFWB funds, please follow CFWB funded process for submitting reimbursement for this service.

CMS-1500 Claim Form Instructions

*Highlighted Sections are required areas. Please ensure to complete according to the client's authorization letter and assigned provider.



Sample TERM Authorization Letters and CMS-1500 Form

CFWB requested evaluations can use 2 different funding sources: Medi-Cal or CFWB.
This section provides sample authorization letters and CMS-1500 based on funding source.

Medi-Cal Funded

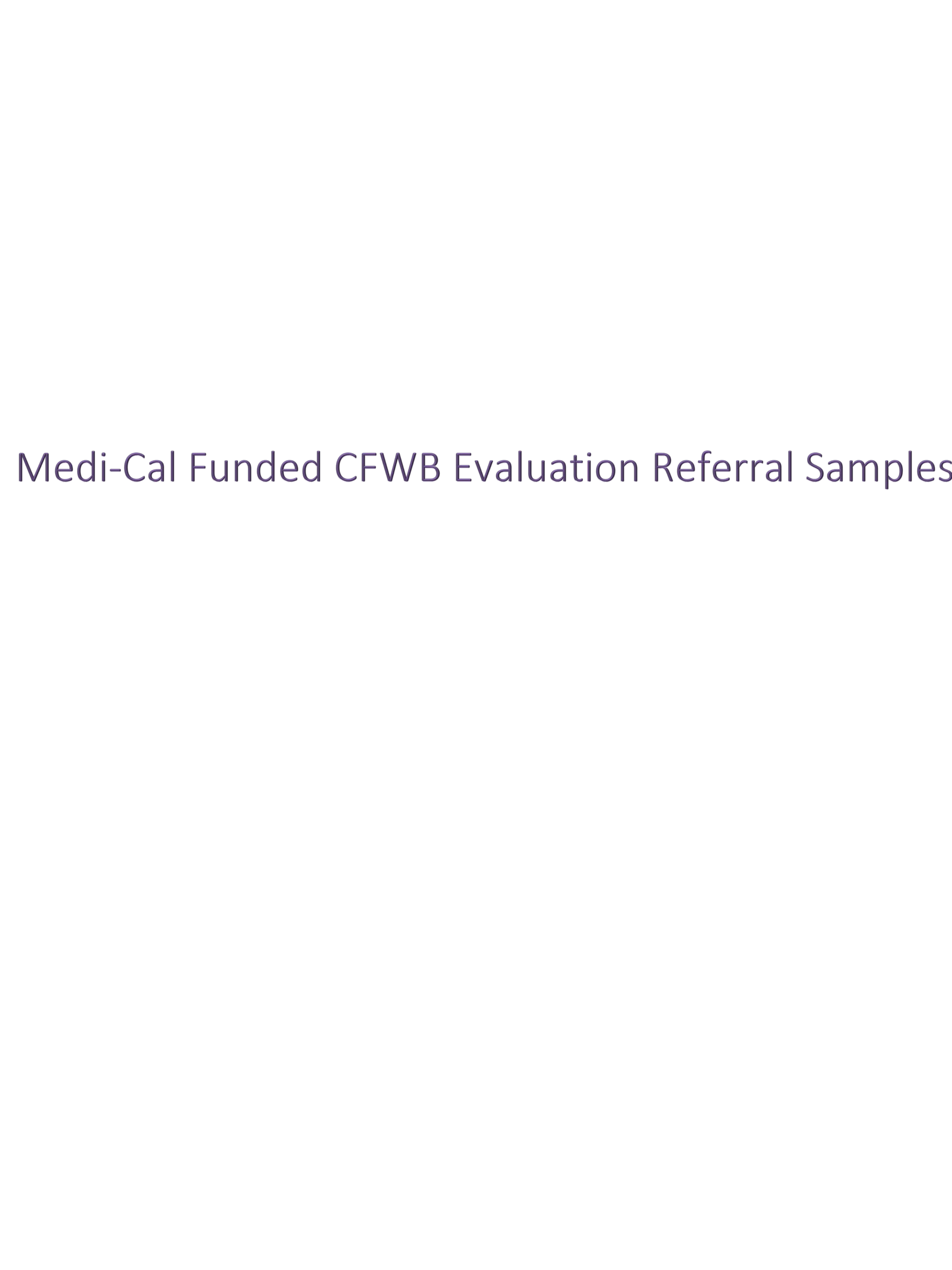
*This section will contain the following documents:

- Sample Authorization Letter
  - Medi-Cal funded requests will be identified as 'CFWB MC' on the top left corner
  - The sample authorization letter highlights areas that are critical to completing the CMS-1500 form that is submitted for reimbursement. Please see attached the 'Authorization Letter Key' for descriptions.
    - No-Show considerations are not reimbursable through Medi-Cal. Therefore, a separate authorization letter using CFWB funds (identified as 'CFWB' on top left corner) will be sent to the provider and a separate CMS-1500 must be submitted when seeking reimbursement for a no-show.
- Sample CMS-1500
  - This sample is based on the sample authorization letter for client Last, First for provider Prov, Termy

CFWB Funded

*This section will contain the following documents:

- Sample Authorization Letter
  - CFWB funded requests will be identified as 'CFWB' on the top left corner
  - The sample authorization letter highlights areas that are critical to completing the CMS-1500 from that is submitted for reimbursement. Please see attached the 'Authorization Letter Key' for descriptions.
- Sample CMS-1500
  - This sample is based on the sample authorization letter for client Last, First for provider TERMY eval, PhD



Medi-Cal Funded CFWB Evaluation Referral Samples

SAMPLE: MEDI-CAL FUNDED AUTHORIZATION LETTER

CFWB MC A

Treatment Authorization

Monday, October 7, 2024

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

Phone: (619) 555-5555
Fax: (619) 444-4444

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	10/21/2024-10/20/2025 I 96130 TJ- PsychTestEval1stHr J	1 Unit	1 Daily
002	10/21/2024-10/20/2025 96131 TJ- PscyhTestEvlAddtl1Hr	5 Units	5 Daily
003	10/21/2024-10/20/2025 96136 TJ- Neuropsych Test Admin1st30Mins	1 Unit	1 Daily
004	10/21/2024-10/20/2025 96137 TJ- NeuropsychTestAdmiAddtl30min	7 Units	7 Daily
Client: **Last, First**		Client ID: 123456789 **Insured ID:**0T000-0	
Authorization #	**Date and Type of Service**	**# of Units**	**Frequency**
K *Comment:*	*Authorized for a Psychological Evaluation*		

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 Evaluation Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded evaluations 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 evaluation.	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 CPT codes that are authorized.	CPT codes are entered in box 24D.
G	Number of units authorized during the authorization period.	Enter the number of units rendered for the corresponding CPT code in box 24G. Do not exceed the number of authorized units.
H	The number of units that can be billed during the described period.	Do not exceed the number of units that can be billed.
I	Date range reflects the period in which the client is authorized to receive evaluation services.	All services must be on the same date of service. Enter in box 24A. For testing that occurs over multiple days, please bill together on the last date of service when the evaluation was completed.
J	*TJ* 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 evaluation. The Modifier HU designates neuropsychological evaluation. When multiple modifiers apply, the language Modifier, TU, must be primary (ex. TU, TJ, HU).	The modifier(s) is entered in box 24D.
K	Comment describing the evaluation service that is authorized. When authorized to a group practice, this area will also reflect the provider who is authorized to render the service. Medi-Cal does not reimburse No-Shows. No-shows are authorized under CFWB funds. In a group practice, *Comment* may also identify the authorized provider.	Please use a separate CMS-1500 and follow CFWB Claim submission guidelines when submitting a claim for No-Show reimbursement. Box 31 is signed by the rendering evaluator designated in the comments section.

SAMPLE: CFWB FUNDED NO SHOW CONSIDERATION FOR A MEDI-CAL FUNDED EVALUATION REFERRAL

Treatment Authorization

Monday, October 7, 2024

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

Phone: (619) 555-5555
Fax: (619) 444-4444

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	10/21/2024-01/21/2025 99499 – No Show- Psych Eval	1 Unit	1 Daily
K *Comment:*	*Authorized for one CFWB No Show Reimbursement*		

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.

*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 No-Show for a Medi-Cal Funded Evaluation
Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source. This authorization is specific to CFWB MC funded evaluation as No-Show reimbursement is only fulfilled by CFWB funds.	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	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 evaluation services/CPT codes the client is authorized to receive.	CPT code entered in box 24D.
G	Number of units authorized during the authorization period.	Enter the number of units rendered for the corresponding CPT code in box 24G. Do not exceed the number of authorized units.
H	The maximum number of units that can be billed during the described period.	
I	Date range reflects the period in which the client is authorized to receive evaluation services. The authorization period for CFWB funds is 3 months.	All services must be on the same date of service. Enter in box 24A.
J	Description of reimbursement authorized. All CFWB requested evaluations are also authorized for 1 CFWB No Show reimbursement. In a group practice, *Comment* may also identify the authorized provider.	. Box 31 is signed by the rendering evaluator designated in the comments section.

SAMPLE CMS-1500 FOR MEDI-CAL FUNDED CFWB EVALUATION REFERRAL

*No Show Consideration fee needs to be completed on a separate CMS-1500 form; please see next page

HEALTH INSURANCE CLAIM FORM

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

This CMS-1500 form is an example based on the corresponding Medi-Cal funded evaluation authorization letter for client Last, First.

No-Show Consideration Fees are funded by CFWB. Therefore, please follow CFWB billing process with a separate CMS-1500 form.

1. OTHER: X
1a. INSURED'S I.D. NUMBER: 123456789A

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

3. PATIENT'S BIRTH DATE: 10 01 2001 — SEX: M X

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

6. PATIENT RELATIONSHIP TO INSURED: Self X

CITY: Wonderful World — STATE: CA

ZIP CODE: 54321

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE — SIGNED: Signature on File — DATE: 10/31/2024

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE — SIGNED: Signature on File

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: A. F43.10

23. PRIOR AUTHORIZATION NUMBER: 001-005 or 001, 002, 003, 004, 005

Line	From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	CPT/HCPCS	Modifier	Diagnosis Pointer	$ Charges	Days or Units	ID Qual	Rendering Provider ID #
1	10	31	24	10	31	24	11		96130	TJ	A.	180.00	1	NPI	5279384
2	10	31	24	10	31	24	11		96131	TJ	A.	900.00	5	NPI	5279384
3	10	31	24	10	31	24	11		96136	TJ	A.	90.00	1	NPI	5279384
4	10	31	24	10	31	24	11		96137	TJ	A.	630.00	7	NPI	5279384
5														NPI	
6														NPI	

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

27. ACCEPT ASSIGNMENT? YES X

28. TOTAL CHARGE: $ 1800.00 — 29. AMOUNT PAID: $ 0.00

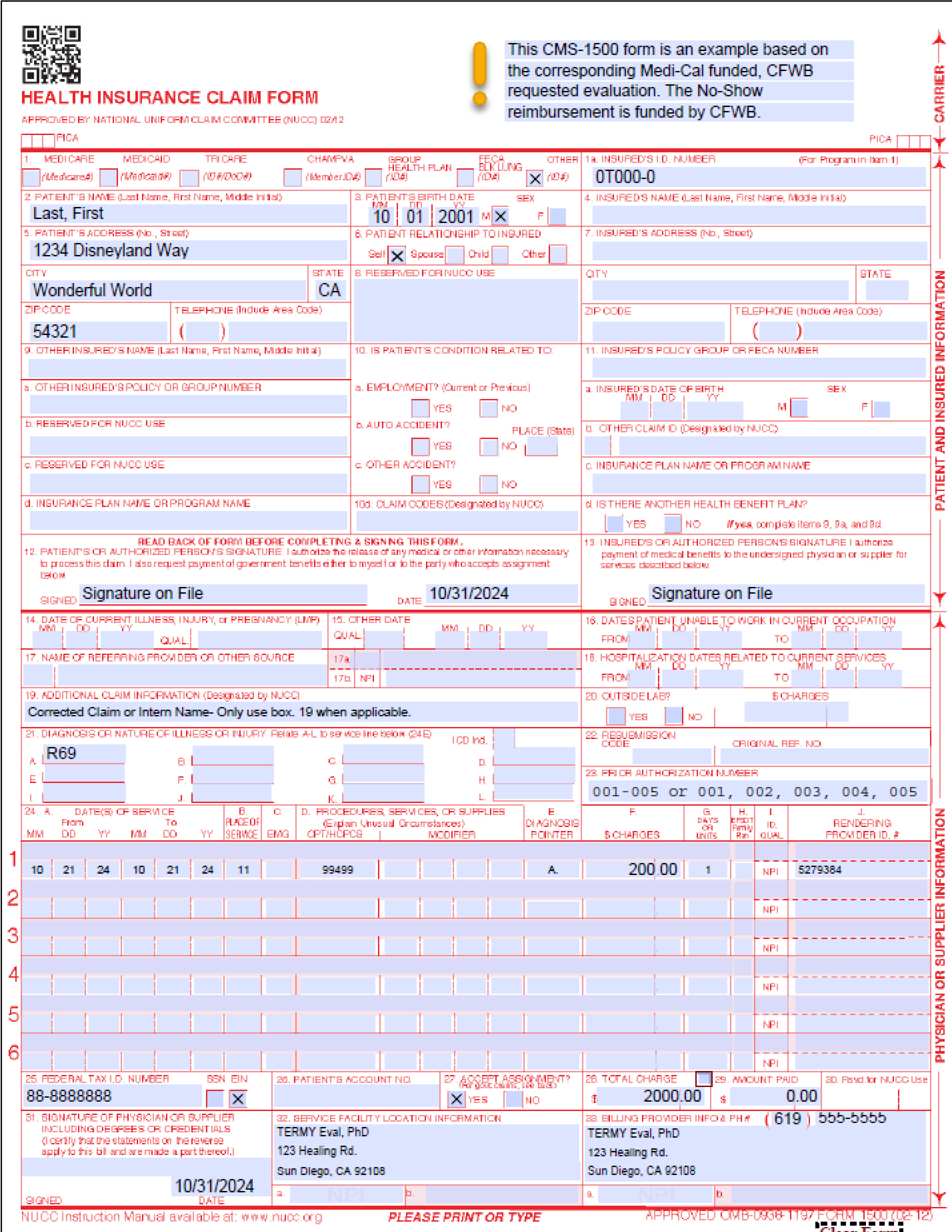
31. SIGNATURE OF PHYSICIAN OR SUPPLIER — DATE: 10/31/2024

32. SERVICE FACILITY LOCATION INFORMATION:
TERMY Eval, PhD
123 Healing Rd.
San Diego, CA 92108

33. BILLING PROVIDER INFO & PH # (619) 555-5555:
TERMY Eval, PhD
123 Healing Rd.
San Diego, CA 92108

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE CMS-1500 FOR NO-SHOW CONSIDERATION FOR MEDI-CAL FUNDED CFWB REFERRAL



HEALTH INSURANCE CLAIM FORM

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

This CMS-1500 form is an example based on the corresponding Medi-Cal funded, CFWB requested evaluation. The No-Show reimbursement is funded by CFWB.

PICA | PICA | CARRIER

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): 0T000-0

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

3. PATIENT'S BIRTH DATE MM DD YY: 10 01 2001 SEX M [X] 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 | STATE

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 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.

SIGNED: Signature on File DATE: 10/31/2024

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

PATIENT AND INSURED INFORMATION

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 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected Claim or Intern Name- Only use box. 19 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. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 001-005 or 001, 002, 003, 004, 005

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 10	21	24	10	21	24	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 $ 2000.00

29. AMOUNT PAID $ 0.00

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.)

SIGNED DATE: 10/31/2024

32. SERVICE FACILITY LOCATION INFORMATION: TERMY Eval, PhD, 123 Healing Rd., Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555: TERMY Eval, PhD, 123 Healing Rd., Sun Diego, CA 92108

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Clear Form

CFWB Funded Evaluation Referral Samples

SAMPLE AUTHORIZATION LETTER FOR CFWB FUNDED REFERRAL

CFWB A

Treatment Authorization

October 21, 2024

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

Phone: (619) 555-5555
Fax: (619) 444-4444

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	10/21/2024-01/21/2025 I 96130 TJ- PsychTestEval1stHr J	1 Unit	1 Daily
002	10/21/2024-01/21/2025 96131 TJ- PscyhTestEvlAddtl1Hr	5 Units	5 Daily
003	10/21/2024-01/21/2025 96136 TJ- Neuropsych Test Admin1st30Mins	1 Unit	1 Daily
004	10/21/2024-01/21/2025 96137 TJ- NeuropsychTestAdmiAddtl30min	7 Units	7 Daily
005	10/21/2024-01/21/2025 99499 – No Show- Psych Eval	1 Unit	1 Daily
Client: **Last, First**	Client ID: 123456789 **Insured ID:**0T000-0		
Authorization #	**Date and Type of Service**	**# of Units**	**Frequency**
Comment: K	*Authorized for a CFWB Psychological Evaluation*		

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.

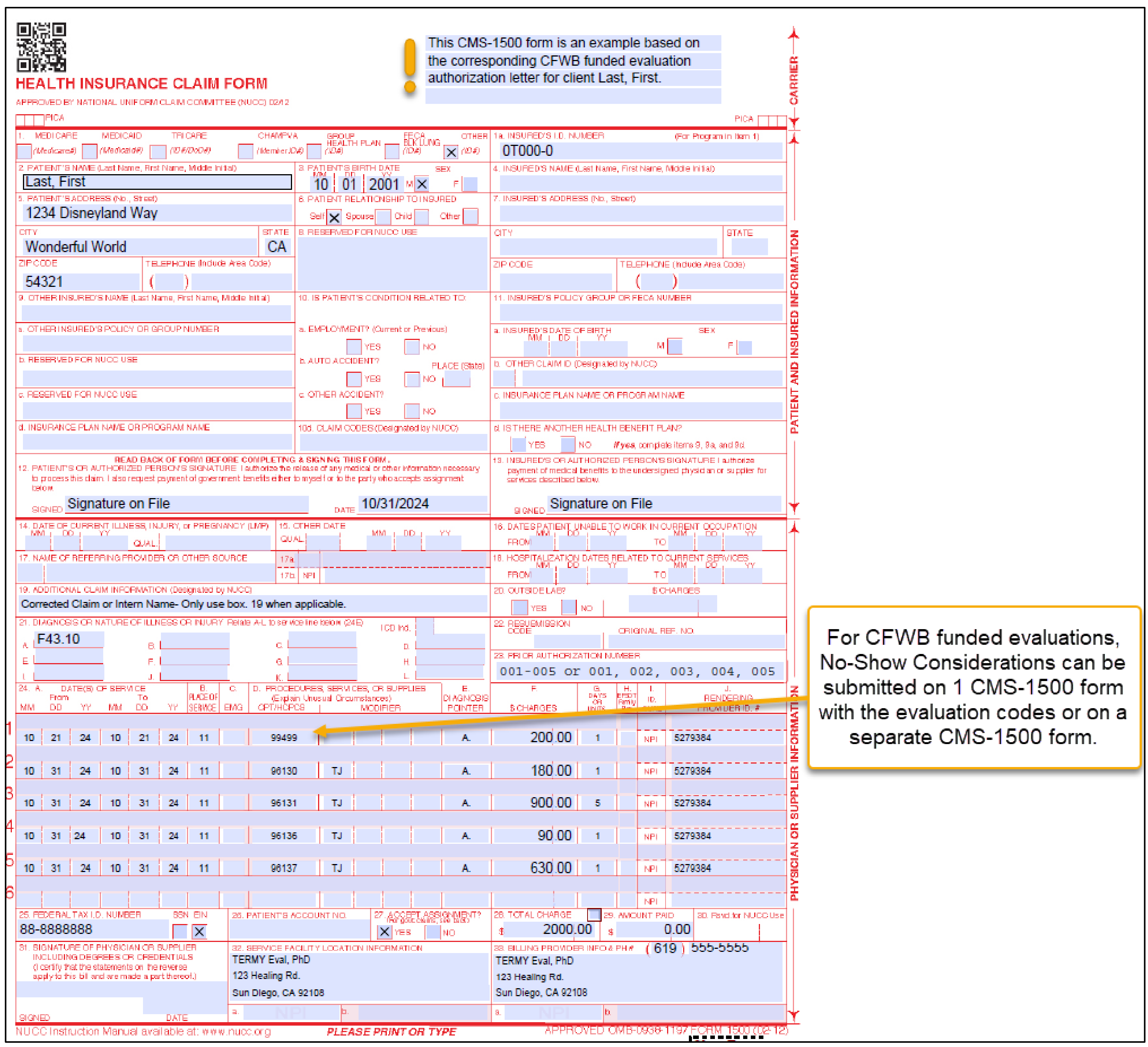
* All CFWB Initial Treatment Plans and Group Intake Assessments are due 14 days from the authorization start date.
* All treatment plan updates are due every 12 weeks thereafter.
* Discharge summaries should be submitted on completion or termination of services.
* CFWB psychological evaluations are due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

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded evaluations 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 evaluations, 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 evaluation services/CPT codes the client is authorized to receive.	CPT code entered in box 24D.
G	Number of units authorized during the authorization period.	Enter the number of units rendered for the corresponding CPT code in box 24G. Do not exceed the number of authorized units.
H	The maximum number of units that can be billed during the described period.	
I	Date range reflects the period in which the client is authorized to receive evaluation services.	All services must be on the same date of service. Enter in box 24A. For testing that occurs over multiple days, please bill together on the last date of service when the evaluation was completed.
J	*TJ* 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 evaluation. The Modifier HU designates neuropsychological evaluation. When multiple modifiers apply, the language Modifier, TU, must be primary (ex. TU, TJ, HU).	The modifier(s) is entered in box 24D.
K	Description of evaluation services authorized. All CFWB requested evaluations are also authorized for 1 CFWB No Show reimbursement. In a group practice, *Comment* may also identify the authorized provider.	Box 31 is signed by the rendering evaluator designated in the comments section.

SAMPLE CMS-1500 FORM FOR CFWB FUNDED REFERRALS



HEALTH INSURANCE CLAIM FORM

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

This CMS-1500 form is an example based on the corresponding CFWB funded evaluation authorization letter for client Last, First.

PICA | PICA | CARRIER

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): 0T000-0

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

3. PATIENT'S BIRTH DATE (MM DD YY): 10 01 2001 — SEX: M [X] 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 — STATE

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 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.

SIGNED: Signature on File — DATE: 10/31/2024

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

PATIENT AND INSURED INFORMATION

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 — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected Claim or Intern Name- Only use box. 19 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. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 001-005 or 001, 002, 003, 004, 005

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 21 24	10 21 24	11		99499		A.	200.00	1		NPI	5279384
2	10 31 24	10 31 24	11		96130	TJ	A.	180.00	1		NPI	5279384
3	10 31 24	10 31 24	11		96131	TJ	A.	900.00	5		NPI	5279384
4	10 31 24	10 31 24	11		96136	TJ	A.	90.00	1		NPI	5279384
5	10 31 24	10 31 24	11		96137	TJ	A.	630.00	1		NPI	5279384
6											NPI	

For CFWB funded evaluations, No-Show Considerations can be submitted on 1 CMS-1500 form with the evaluation codes or on a separate CMS-1500 form.

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: $ 2000.00

29. AMOUNT PAID: $ 0.00

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.) SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION: TERMY Eval, PhD, 123 Healing Rd., Sun Diego, CA 92108 — a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555: TERMY Eval, PhD, 123 Healing Rd., Sun Diego, CA 92108 — a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-1197 FORM 1500 (02-12)