FQHC Wrap Payment Guidelines

Overview of Methodology

Managed care organizations (MCO's) will concurrently pay contracted rate, wrap payment, and any fee for service (FFS) payments excluded from the PPS (Prospective Payment System)rate.

1. Services included in PPS rate:

- General Medical
- Health steps
- Behavioral Health
- Case management
- Vision

2. The new reimbursement arrangements will become effective:

STAR/STAR Kids: September 1st, 2017

CHIP: March 24th, 2018 or April 1st, 2018

3. The CMS-1500 will be the standardized across plans and products. Claims billed on a UB-04 will be denied.

Billing Guidelines

FQHC submits claim to MCO with the following minimum requirements for STAR/STAR Kids and CHIP

1. Billing provider taxonomy 261QF0400X.
2. T1015 to flag wrap payment. Claims without this code will not be eligible for wrap payment. The PPS rate will be entered as the line charge for T1015.
3. Appropriate procedure codes, corresponding modifiers, and diagnosis codes. Multiple procedure codes can be billed on the same claim form for a single DOS. However a separate claim form is required for each FQHC service category.
4. Claims received without the subsequent CPT/HCPCS codes will be denied.
5. The following CPT/HCPCS are examples of codes that are paid in addition to the PPS rate:

Mental Health	OB services	After Hours	Family Planning	Family Planning	Family Planning
H0004	59409	99050	J7297	99201	99211
H0005	59430	99051	J7298	99202	99212
	59612	99053	J7300	99203	99213
	59514	99056	J7301	99204	99214
	59620	99058	J7307	99205	99215
		99060			

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

General Medical Office Visit

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS

- 99202-99205: Acute New Patient
- 99211-99215: Acute Established Patient
- 99241-99245: Consultation for New or Established Patient
- 99304-99310: Nursing Facility Visit
- 99318: Annual Nursing Home Assessment
- 99324-99328: Assisted Living Visit for New Patient
- 99334-99337: Assisted Living Visit for Established Patient
- 99341-99346: Home Visit for New Patient
- 99347-99350: Home Visit for Established Patient
- 99385-99387: Preventive Medicine for New Patient
- 99395-99397: Preventive Medicine for Established Patient
- 10003-69999 (excluding 36400-36425)

2. Eligible providers

- Physician
- Physician's Assistant
- Nurse Practitioner
- Certified Nurse Midwife
- Professional

3. Modifiers: Prefer to keep current TMHP modifier structure in place

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

THSteps Services

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS codes

- 99381-99385: Preventive Visit New Patient
- 99391-99395: Preventive Visit Established Patient
- 99429: THSteps Oral Evaluation and Fluoride Varnish
- THSteps Vaccine Admin: 90460-90461, 90471-90474, 96160-96161, 86580

2. Eligible providers

- Physician
- Physician's Assistant
- Nurse Practitioner
- Certified Nurse Midwife

3. Modifiers

- EP for 99381-99385* and 99391-99395* to indicate THSteps Medical Checkup (*for clients who are 18 through 20 years of age)
- EP for 99429 plus U5 modifier to indicate THSteps Oral Exam
- Same structure as General Medical Office Visit to identify provider type

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

Case Management Services

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS codes

- G9012

2. Eligible providers

- Case Managers

3. Modifiers

- U5 and U2: Comprehensive visit
- U5 and TS: Follow up face-to-face
- TS: Follow up telephone

* Federally Qualified Health Center (FQHC) facilities that provide Case Management for Children and Pregnant Women services will use their FQHC number and should not apply for an additional provider number for Case Management for Children and Pregnant Women.

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

Family Planning Services (paid outside PPS encounter rate)

(Centers currently reimbursed at PPS encounter rate) Allowable CPT/HCPCS code with FP modifier

1. Allowable CPT/HCPCS codes

- OB Delivery Codes: 59409, 59612, 59514, 59620
- 59430: Post-Partum Visit Code
- 99201-99205: Acute New Patient
- 99211-99215: Acute Established Patient

2. J codes paid at fee for service rate in addition to PPS rate

IUD J codes

- J7297: IUD (Liletta)
- J7298: IUD (Mirena)
- J7300: IUD (ParaGard)
- J7301: IUD (Skyla)

Note: IUD Insertions/Removals must be reported with the following CPT codes to get PPS Encounter Rate Reimbursement:

- 58300: IUD Insertion
- 58301: IUD Removal

Contraceptive Implant J-Code

- J7307: Contraceptive Implant System (including implant and supplies)

Note: Contraceptive implant insertions/removals must be reported with the following CPT codes to get PPS rate:

- 11981: Insertion of Contraceptive Implant
- 11983: Removal and Reinsertion of Contraceptive Implant
- 11976, 11982: Removal of Contraceptive Implant

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

Family Planning Services (paid outside PPS encounter rate)

3. Eligible providers

- Physician
- Physician's Assistant
- Nurse Practitioner
- Certified Nurse Midwife

4. Modifier

- FP
- J1050 with U1 modifier also
- All other J codes with U8 modifier also

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

Behavioral Health Services

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS codes

- 90791-90792: Psychiatric Evaluation
- 90832, 90834, 90837, 90839: Individual Psychotherapy
- 90833 (30 min), 90836 (45 min) and 90838 (60 min) are add-on psychotherapy codes based on the length of time of the psychotherapy provided. These do not trigger an encounter rate.
- 90846: Family Psychotherapy (without Patient)
- 90847: Family Psychotherapy (with Patient)
- 90853: Group Psychotherapy
- 90899: Unlisted Psychiatric Service or Procedure
- 96101-96118: Psychological Assessment and Intervention
- 96150-96155: Behavioral Health Assessment and Intervention
- 99201-99205: E&M Office Visit with BH Diagnosis for New Patient
- 99211-99215: E&M Office Visit with BH Diagnosis for Established Patient
- 99408: Alcohol and/or drug services, brief intervention (15+ minutes) contains a note stating FQHCs should submit claims using SBIRT procedure codes for informational purposes only.
- H0049: Alcohol and SA screening (required if screening results are negative)
- H0050: Alcohol and SA Brief Intervention (Ambulatory outpatient detoxification)

Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

Behavioral Health Services

2. Substance abuse therapy codes are paid fee for service only

- H0004: Individual Substance Abuse Therapy. H0004 reimburses $14.50 for 15 min of services
- H0005: Group Substance Abuse Therapy. H0005 reimburses $18 for 60 minutes of service.

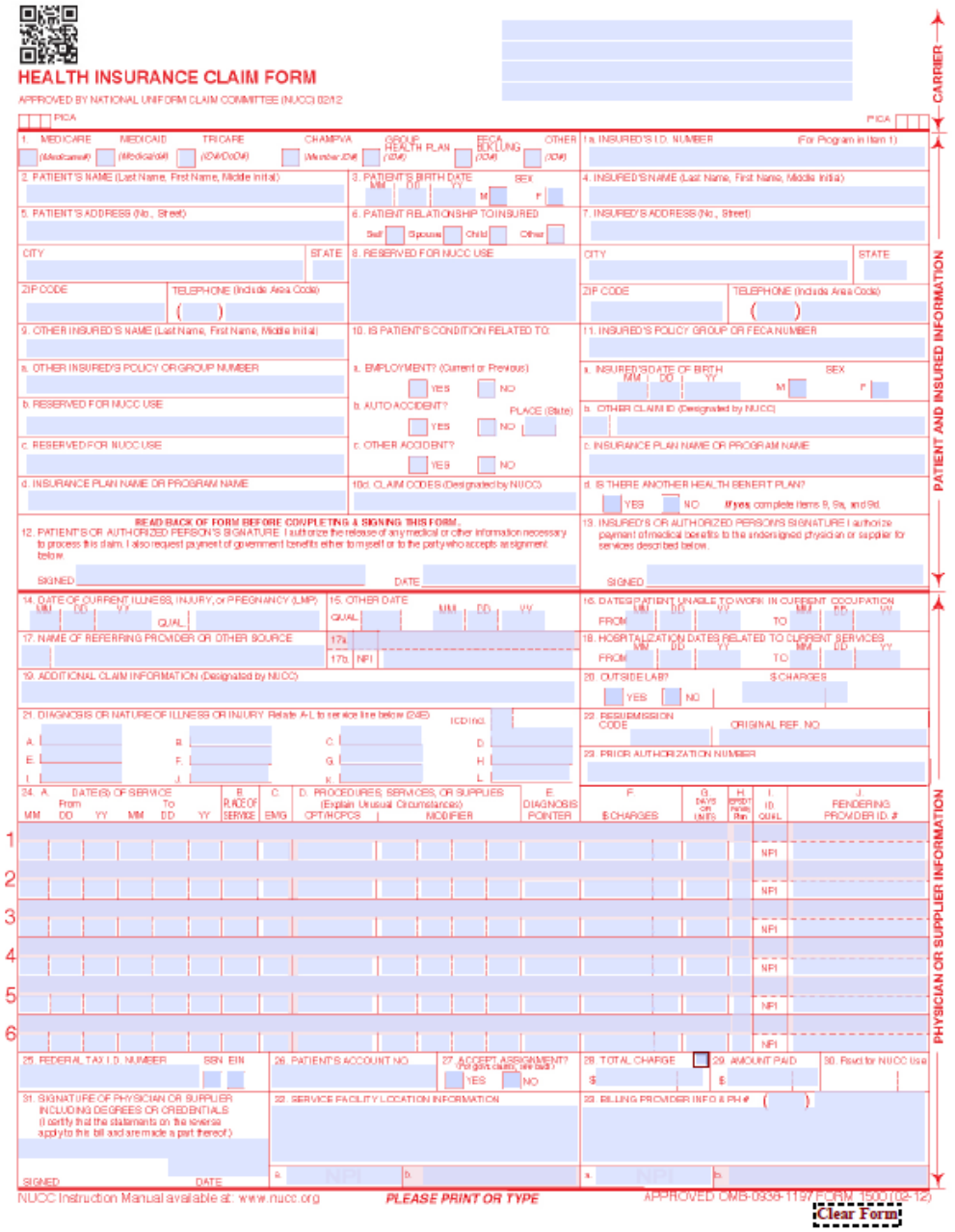
3. Eligible providers

- Physician (E&M only)
- Physician's Assistant (E&M only)
- Nurse Practitioner (E&M only)
- Certified Nurse Midwife (E&M only)
- Psychiatrist
- Clinical Psychologist
- Psychiatric Nurse Practitioners
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Alcohol and Drug Abuse Counselors (Substance Abuse Therapy only)

4. Modifiers

- Prefer to keep current TMHP modifier structure in place

Standard CMS 1500 Claim 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#)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. 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? PLACE (State) YES NO

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

22. 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										NPI	
2										NPI	
3										NPI	
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) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

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

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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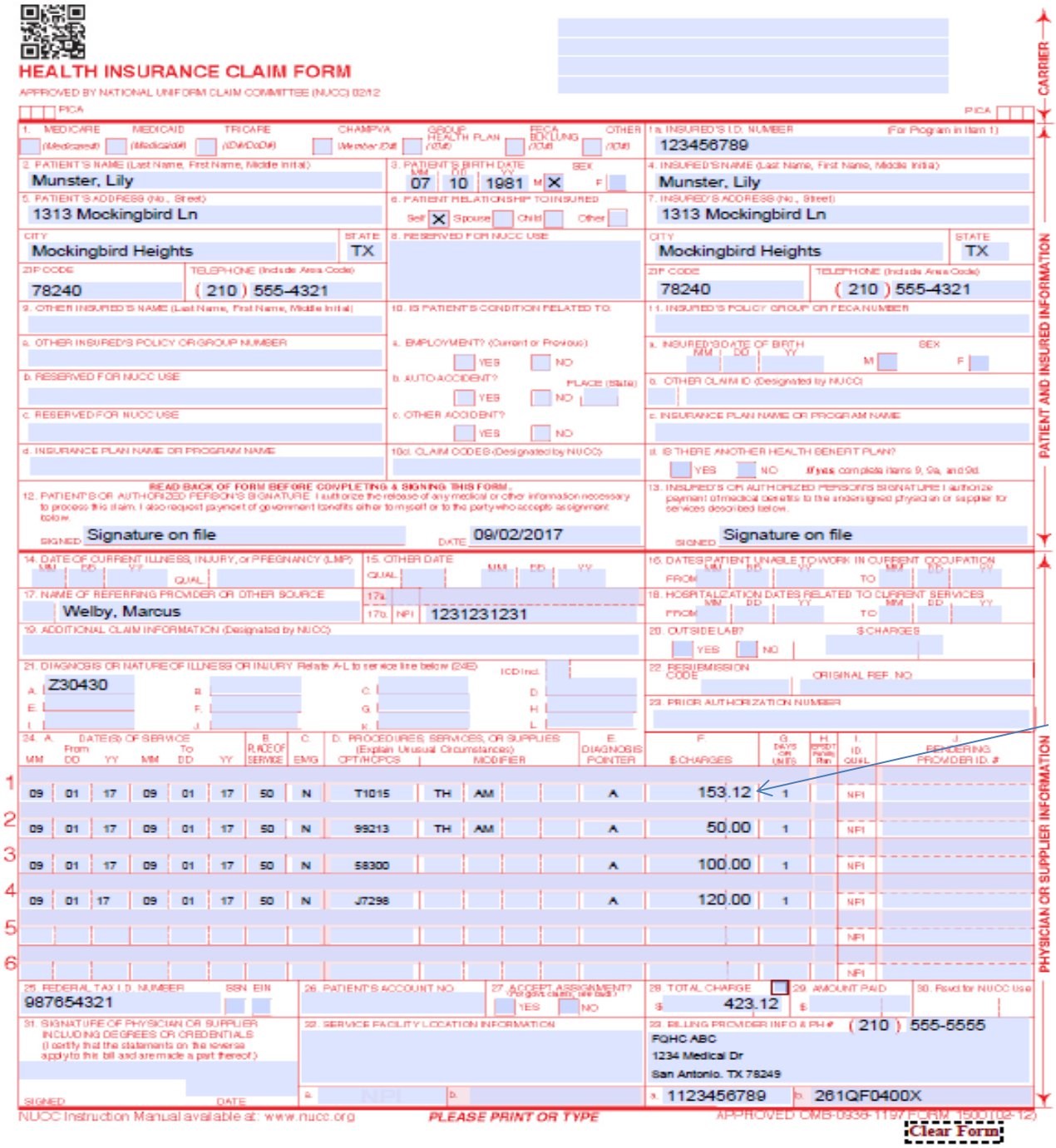
Clear Form

- Box 24 B: Use location 50 to identify place of service
- Box 24 I: Rendering provider taxonomy
- Box 24 J: Leave rendering provider area blank
- Box 28: Reflects the total cost of all services provided during the encounter, not just the PPS rate
- Box 30: Reflect the PPS/encounter reimbursement rate
- Box 32 a: Facility NPI
- Box 32 b: Facility taxonomy
- Box 33: Physical billing address. A PO Box is not allowed per HIPPA guidelines
- Box 33 a: Billing NPI
- Box 33 b: Billing Taxonomy (261QF0400X)

Claim Example: LARC Example
FQHC ABC PPS RATE - $153.12



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#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

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

3. PATIENT'S BIRTH DATE: 07 10 1981 | SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 1313 Mockingbird Ln

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

7. INSURED'S ADDRESS (No., Street): 1313 Mockingbird Ln

CITY: Mockingbird Heights | STATE: TX

8. RESERVED FOR NUCC USE

CITY: Mockingbird Heights | STATE: TX

ZIP CODE: 78240 | TELEPHONE (Include Area Code): (210) 555-4321

ZIP CODE: 78240 | TELEPHONE (Include Area Code): (210) 555-4321

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: 09/02/2017

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Welby, Marcus

17a.

17b. NPI 1231231231

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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. Z30430 B. C. D. E. F. G. H. I. J. K. L.

22. 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	09 01 17	09 01 17	50	N	T1015	TH	AM		A	153.12	1		NPI	
2	09 01 17	09 01 17	50	N	99213	TH	AM		A	50.00	1		NPI	
3	09 01 17	09 01 17	50	N	58300				A	100.00	1		NPI	
4	09 01 17	09 01 17	50	N	J7298				A	120.00	1		NPI	
5													NPI	
6													NPI	

PPS Rate

25. FEDERAL TAX I.D. NUMBER: 987654321 | SSN | EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 423.12

29. AMOUNT PAID $

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

a. NPI b.

33. BILLING PROVIDER INFO & PH # (210) 555-5555

FQHC ABC
1234 Medical Dr
San Antonio, TX 78249

a. 1123456789 b. 261QF0400X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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Clear Form

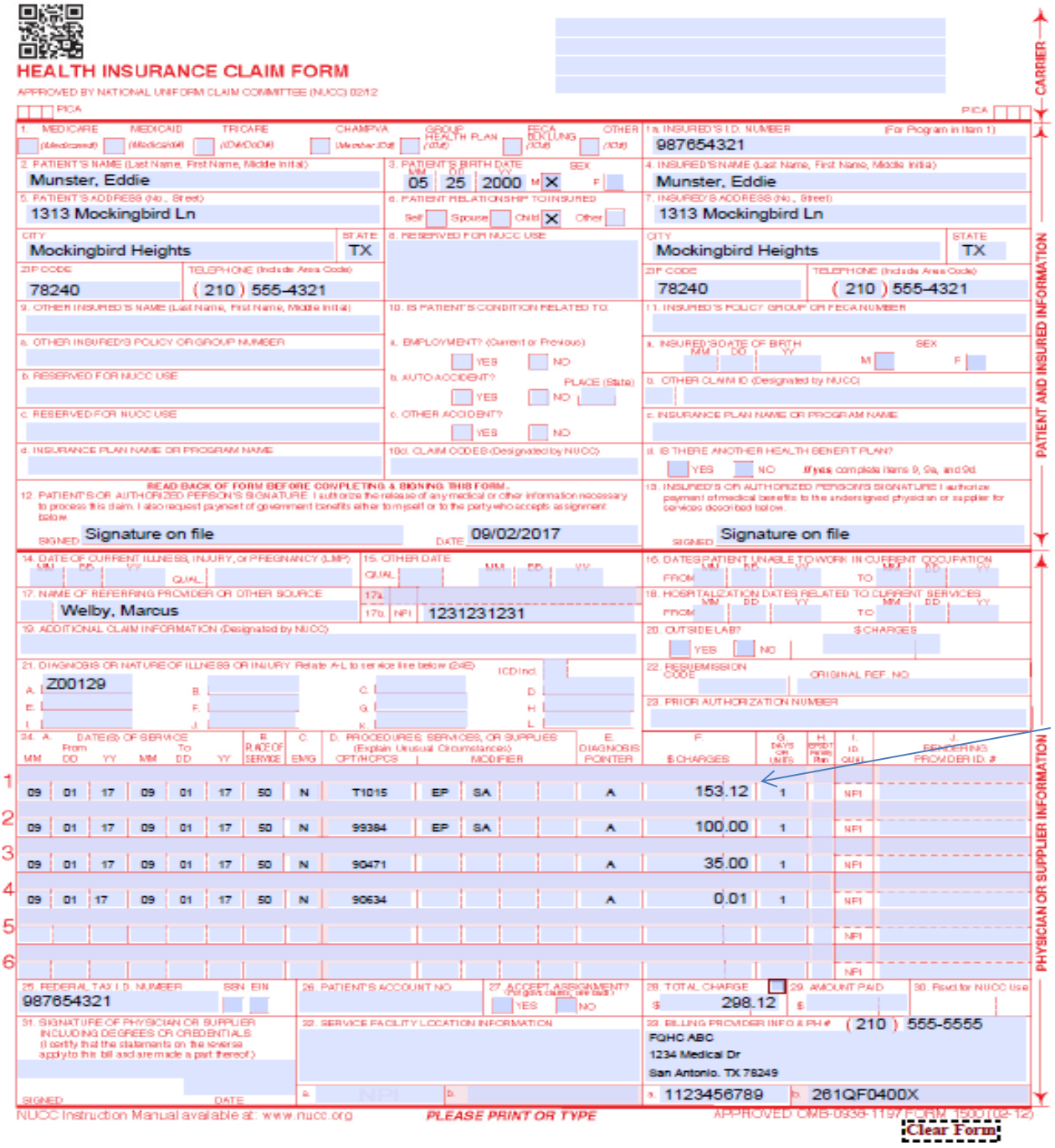
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Code	Modifier 1	Modifier 2	Billed Amount	Paid Amount	Notes	Explanation Code
T1015	TH	AM	$153.12	$70.44	Contractual	EX2B – Negotiated Flat Payment
99213	TH	AM	$50.00	$82.69	Wrap	EXD1 – Wrap Payment
58300			$100.00	$0.00	Global	EX04 – Included In Global Rate
J7298			$120.00	$85.00	Not part of wrap	EX01 – Paid per Contractual Agreement

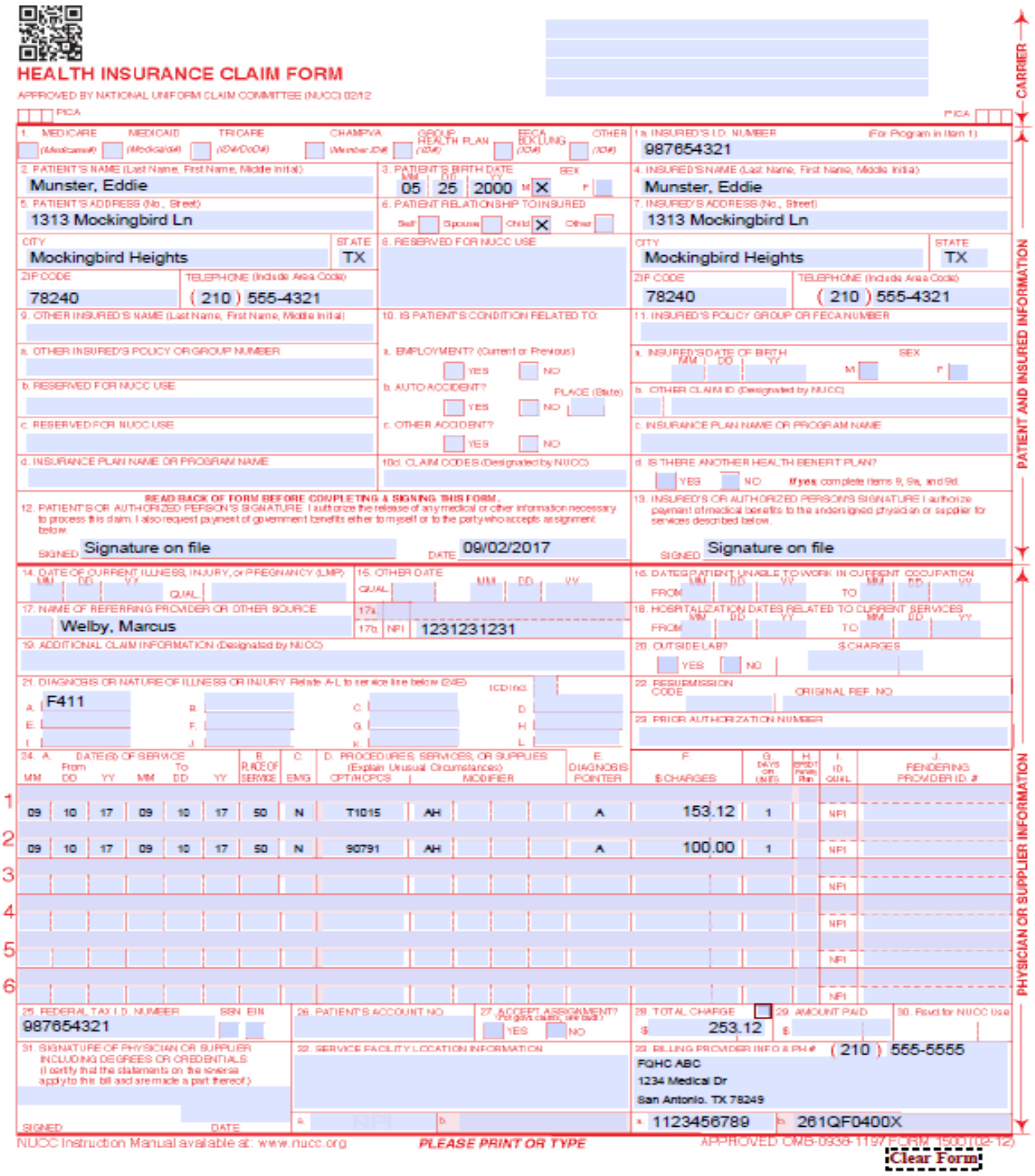
Claim Example: THSteps
FQHC ABC PPS RATE - $153.12



PPS Rate

Code	Modifier 1	Modifier 2	Billed Amount	Paid Amount	Notes	Explanation Code
T1015	EP	SA	$153.12	$70.44	Contractual	EX2B – Negotiated Flat Payment
99384	EP	SA	$100.00	$82.69	Wrap	EXD1 – Wrap Payment
90471			$35.00	$0.00	Global	EX04 – Included In Global Rate
90634			$0.01	$0.00	TFVC	EX7I – Drug Covered Through TVFC Program

Claim Example: Mental Health
FQHC ABC PPS RATE - $153.12



HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

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): 987654321

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

3. PATIENT'S BIRTH DATE MM DD YY: 05 25 2000 | SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 1313 Mockingbird Ln

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

7. INSURED'S ADDRESS (No., Street): 1313 Mockingbird Ln

CITY: Mockingbird Heights | STATE: TX

8. RESERVED FOR NUCC USE

CITY: Mockingbird Heights | STATE: TX

ZIP CODE: 78240 | TELEPHONE (Include Area Code): (210) 555-4321

ZIP CODE: 78240 | TELEPHONE (Include Area Code): (210) 555-4321

PATIENT AND INSURED INFORMATION

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: 09/02/2017

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.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Welby, Marcus

17a.

17b. NPI 1231231231

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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. F411 B. C. D. E. F. G. H. I. J. K. L.

22. 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	09 10 17	09 10 17	50	N	T1015	AM		A	153.12	1		NPI	
2	09 10 17	09 10 17	50	N	90791	AM		A	100.00	1		NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 987654321 SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 253.12

29. AMOUNT PAID $

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

a. NPI b.

33. BILLING PROVIDER INFO & PH # (210) 555-5555

FQHC ABC
1234 Medical Dr
San Antonio, TX 78249

a. 1123456789 b. 261QF0400X

NUCC Instruction Manual available at: www.nucc.org

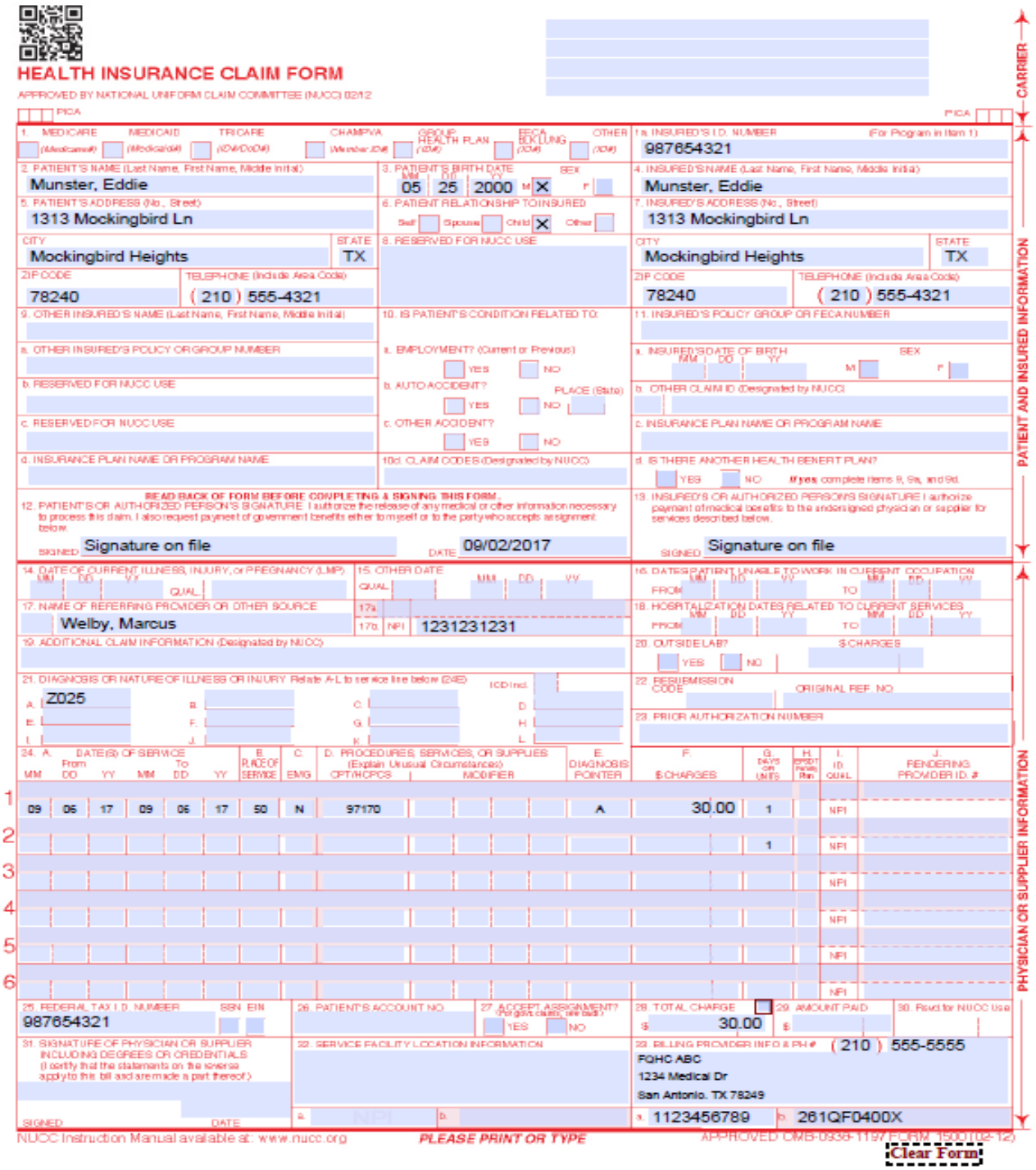
PLEASE PRINT OR TYPE

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

Clear Form

Code	Modifier 1	Modifier 2	Billed Amount	Paid Amount	Notes	Explanation Code
T1015	AM		$153.12	$70.44	Contractual	EX2B – Negotiated Flat Payment
90791	AM		$100.00	$82.69	Wrap	EXD1 – Wrap Payment

Claim Example: Sports Physical
FQHC ABC



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 987654321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Munster, Eddie	05 25 2000	M X F	Munster, Eddie

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1313 Mockingbird Ln	Self Spouse Child X Other	1313 Mockingbird Ln

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Mockingbird Heights	TX		Mockingbird Heights	TX

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
78240	(210) 555-4321	78240	(210) 555-4321

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? PLACE (State) YES NO	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: 09/02/2017

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	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Welby, Marcus	17a. 17b. NPI 1231231231	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		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. Z025 B. C. D. E. F. G. H. I. J. K. L.		22. 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	09	06	17	09	06	17	50	N	97170			A	30.00	1		NPI	
2														1		NPI	
3																NPI	
4																NPI	
5																NPI	
6																NPI	

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 $ 30.00	29. AMOUNT PAID $	30. Rsvd for NUCC Use
987654321					

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 # (210) 555-5555
SIGNED DATE	a. NPI b.	FQHC ABC 1234 Medical Dr San Antonio, TX 78249 a. 1123456789 b. 261QF0400X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Clear Form

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Code	Modifier 1	Modifier 2	Billed Amount	Paid Amount	Notes	Explanation Code
97170			$30.00	$30.00	Value Add	EXVN – Value Add Benefit

Encounter with COB

Any TPL(Third Party Liability) will be applied first to the wrap payment and then to the contracted rate. For example:

PPS rate: $200
FFS: $75
TPL: $100

$200 PPS - $75 FFS/flat = 4125 wrap
$125 wrap - $100 TPL = $25 wrap

Or alternatively:

$200 PPS - $100 TPP = $100 balance
$100 - $75 FFS/flat = $25 wrap

If the TPL is more than the wrap but less than the PPS, it can then also be applied to the MCO payment:

$200 PPS - $75 FFS/flat = $125 wrap
$125 wrap - $150 TPL = $0 wrap - $25 TPL
$75 FFS/flat - $25 TPL = $50 FFS/flat

Or alternatively:

$200 PPS - $150 TPP = $50 balance
$50 - $50 FFS/flat = $0 balance (+ $0 wrap)