Internet Version

Supplies and Durable Medical Equipment

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Benefits

Colorado Medicaid benefits are provided for Supplies and **D**urable **M**edical **E**quipment (DME). DME is defined as equipment that can withstand repeated use and that generally would not be of value to the client in the absence of a disability, illness, or injury. The Medicaid Supply HCFA and Local Codes bulletin, sent to each eligible enrolled provider annually, identifies supply and DME items that require prior authorization.

Supplies and DME must be medically necessary and prescribed by a physician for use by an eligible client residing at home. Prescriptions must be within the scope of the requesting provider's license. The physician's prescription must be retained by the provider and made available for audit by the single state agency, its agents, or representatives.

Most DME and medical supplies that are provided to hospitalized individuals, nursing facility, and group home residents must be provided by the facility and cannot be submitted for direct payment to the medical supplier or pharmacy. Repairs to client-owned wheelchairs prior to the client entering the nursing facility are a benefit.

DME rental

Unless specifically noted in the Supply HCPCS and Local Codes bulletin, the first month's equipment rental does not require prior authorization. The provider must use modifier -XR (first month's rental) in the modifier column on the claim form and one unit of service per procedure code.

Insulin syringes

Insulin syringes are a Colorado Medicaid benefit and do not require prior authorization. Insulin syringes must be billed using HCPCS codes.

Enteral nutrition products

Equipment, supplies, and nutrients for enteral feeding or food supplements are a benefit when prescribed by a physician and prior authorized. Prior authorization requests and claims must identify the calculated number of units as specified in the Supply HCPCS publication. All enteral products must be billed using the HCPCS code on the approved PAR.

Eyeglasses and contact lenses

Medically necessary eyeglasses and contact lenses are a benefit for clients over age 20 only following eye surgery and do not require prior authorization. Opticians must use the modifier -XV for surgery-related eyewear on the claim.

The **E**arly **P**eriodic **S**creening **D**iagnosis and **T**reatment (EPSDT) Program provides the following benefits for clients ages 20 and under:

- Standard eyeglasses (one or two single or multifocal clear glass lenses with one standard frame).
- Eyeglasses dispensed by an optician when ordered by an ophthalmologist or optometrist.
- Replacement or repair of frames or lenses (standard eyeglasses), not to exceed the cost of replacement.
- Contact lenses if medically necessary and prior authorized.
- Ocular prosthetics if prior authorized (statement of medical necessity must accompany the PAR).

There is no yearly maximum for eyeglasses.

Home Intravenous (IV) equipment

Home Intravenous (IV) therapy for **T**otal **P**arenteral **N**utrition (TPN), administration of antibiotics, maintenance of electrolyte balances, or hydration is a Colorado Medicaid benefit. Services must be prescribed by a physician and must be prior authorized. Home IV therapy solutions must be provided by a pharmacist and submitted by the pharmacy using NDC codes.

Oxygen contents and oxygen delivery systems

Oxygen contents and delivery systems used by nursing facility and group home residents must be billed by the supply provider. A Medicaid Certification of Oxygen Use form completed by the nursing facility and a copy of the physician's oxygen prescription for each client must be maintained for a minimum of six years by the supply provider.

Claims for all oxygen services must be submitted using HCPCS codes.

Prosthetics and orthotics

Effective for service dates on and after July 1, 1998, prosthetic and orthotic items are a covered Colorado Medicaid benefit for the adult Medicaid population. The benefit includes such items as braces, artificial limbs, augmentative communication devices, and orthopedic shoes for diabetic clients. These items must be prescribed by the client's physician and prior authorized before services are rendered.

Children (ages 20 and under) may qualify for prosthetics and orthotics when a condition requiring these services is discovered during an EPSDT screening exam. Prosthetics and orthotics must be prior authorized and billed with the appropriate L codes published by HCFA through the Medicare program.

Wheelchair purchase and equipment repair

Wheelchair and equipment repair costs are a Colorado Medicaid benefit when the client owns the equipment and the repair cost does not exceed the equipment's replacement cost. The make, model, and serial number of the wheelchair or equipment being repaired must be included on the PAR and on the claim. Repairs and labor costing less than $150.00 in a 6-month period do not require prior authorization when billed using procedure code X2975. Wheelchair repairs must be billed on paper.

Claims for a wheelchair purchase must include the manufacturer's name, model name, and serial number of the equipment. PARs for specially sized or constructed wheelchairs must include a full description and relevant information justifying medical necessity. For modified standard wheelchairs, the provider must bill the base and components separately. All customized items must be identified and justified.

A manufacturer's invoice is required for all miscellaneous wheelchair equipment purchases costing more than $35.00.

Transcutaneous or Neuromuscular Electrical Nerve Stimulators (TENS or NMES)

All TENS and NMES rentals are for two-month intervals and require a PAR for both months. A first month rental without a PAR is not available.

Exclusions

The following are not benefits of the Colorado Medicaid Program:

- Charges for repairs to rental equipment
- Convenience/personal care items and supplies
- Delivery fees
- Exercise equipment
- Formula necessary for bulimic conditions
- Jacuzzis/hot tubs

Prior Authorization Requests (PARs) for Supply/DME

Products and items considered to be regular Colorado Medicaid benefits do not require prior authorization. Certain supply and most DME items require prior authorization before they are considered benefits of the Colorado Medicaid Program.

Supply Prior Authorizations are required for designated items in the Medicaid Supply HCFA and Local Codes bulletin including:

- **T**otal **P**arenteral **N**utrition (TPN) and Home IV equipment, supplies, and nutrients.
- Most DME.
- Some disposable supplies.

A client may be required to receive an occupational therapy evaluation to determine appropriateness of the requested equipment. Motorized chairs and lift chairs are examples of items for which an evaluation may be required.

General requirements

Providers are encouraged to submit PARs electronically through the Colorado Medicaid interactive software. Instructions for completing and submitting electronic PARs are available through software help screens. Electronic PAR submission offers the provider:

- Immediate assignment of a PAR number.
- Faster PAR processing.
- Online PAR status inquiries.

PARs that require substantiating letters, reports, and/or photographs may be submitted electronically as long as notations are included in the Comments section that identify the existence of these supportive attachments.

Electronically submitted PARs without the minimally required information are rejected. All submitted PARs are reviewed by the authorizing agent who then approves or denies the submitted services. The status of proposed services is available online. Both the provider and the client receive a PAR letter. Some services may be approved and others denied. **Check the PAR letter carefully.**

The PAR number used on claims must be assigned by the authorizing agent. Do not use the preprinted number (if any).

Requests for prior authorization must be submitted and approved before services are rendered.

The services must be rendered by the Colorado Medicaid enrolled provider identified on the approved PAR, and services rendered must match the approved services exactly.

Approval of a PAR does not guarantee Medicaid payment and does not serve as a timely filing waiver. Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medicaid Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, provider information completed appropriately, required attachments included, etc.) before payment can be made.

When the PAR for medical services is approved, the claim may be submitted to the fiscal agent. Occasionally, the authorizing agent requests that the provider submit a copy of the approved PAR with the claim. When requested, these instructions are on the approved PAR in field 30 (Comments) on the paper PAR.

Enter the required PAR information online, using help screens as needed. Paper PAR forms must be complete and accurate. If an error is noted on an approved request, it should be brought to the attention of the authorizing agent and corrected. Procedure codes, quantities, etc., may be changed or entered by the authorizing agent.

Mail Medicaid PARs to the address listed in Appendix B of this manual.

A copy of the paper Prior Authorization Request form follows these instructions.

Prior Authorization Request form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST
(PAR)

INVOICE/ PAT. ACCOUNT NUMBER

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)
2. CLIENT IDENTIFICATION NUMBER
3. SEX ☐ M ☐ F
4. DATE OF BIRTH (MM/DD/YY)
5. CLIENT ADDRESS (Street, City, State, Zip Code)
6. CLIENT TELEPHONE NUMBER ( )
7. PRIOR AUTHORIZATION NUMBER*
8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)
9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ Yes ☐ No
10. GROUP HOME NAME IF PATIENT RESIDES IN A GROUP HOME
11. DIAGNOSIS (must include Diagnosis, Prognoisis, Clinical Information and other Medications presently prescribed)
12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY CLIENT - MUST INDICATE SERIAL NUMBER
13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E. HOW LONG WILL THIS EQUIPMENT BE NEEDED?
14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED **(See Reverse for Denial Reasons)**

15. LINE NO.	16. DESCRIBE PROCEDURE. SUPPLY. OR DRUG TO BE PROVIDED - INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE. SUPPLY OR DRUG CODE*	18. NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK**)	20. A=APPROVED B-L=DENIED X2000=DENIED (LEAVE BLANK**)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME
TELEPHONE NUMBER
23. PCP PROVIDER NUMBER
22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, Zip Code)
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION
26. REQUESTING PHYSICIAN SIGNATURE
27. DATE SIGNED
25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE
TELEPHONE NUMBER ( )
28. REQUESTING PHYSICIAN PROV. NUMBER
TELEPHONE NUMBER ( )
29. SERVICE PROVIDER NUMBER

If services were provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim form.

30. COMMENTS OR REASONS FOR DENIAL OF BENEFITS** **(See Reverse for Denial Reasons)**

☐ ATTACH COPY OF THIS PAR TO CLAIM(S)**

SIGNATURE OF STATE AGENCY REPRESENTATIVE**
DATE**
31. PA NUMBER BEING REVISED**

*THIS NUMBER SHOULD BE REPORTED ON THE CLAIM FORM WHEN BILLING FOR THE SERVICES
** THESE FIELDS WILL BE COMPLETED BY THE AUTHORIZING AGENT

Paper PAR instructional reference

FIELD LABEL	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for fiscal agent use only.		
INVOICE/PAT ACCOUNT NUMBER Optional	Text	Enter up to 12 characters (numbers, letters, hyphens) which help identify the claim or client.
1. CLIENT NAME Required	Text	Enter the client's last name, first name, and middle initial exactly as it appears on the eligibility verification. Example: Adams, Mary A.
2. CLIENT IDENTIFICATION NUMBER Required	7 characters, a letter prefix followed by six numbers	Enter the client's state identification number exactly as it appears on the eligibility verification. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. SEX Required	Check box ☐ M ☐ F	Enter an "X" in the appropriate box.
4. DATE OF BIRTH Required	6 digits (MMDDYY)	Enter the client's birth date exactly as it appears on the eligibility verification using MMDDYY format. Example: January 1, 1978 = 010178.
5. CLIENT ADDRESS Required	Characters: numbers and letters	Enter the client's full address: Street, city, state, and zip code.
6. CLIENT TELEPHONE NUMBER Optional	Text	Enter the client's telephone number.
7. PRIOR AUTHORIZATION NUMBER System assigned		
8. DATES COVERED BY THIS REQUEST Optional	6 digits for From date and 6 digits for Through date (MMDDYY)	Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agent. Authorized services must be provided within these dates.
9. DOES CLIENT RESIDE IN A NURSING FACILITY? Required	Check Box ☐Yes ☐No	Check the appropriate box.

FIELD LABEL	Completion Format	Instructions
10. GROUP HOME NAME IF PATIENT RESIDES IN A GROUP HOME Conditional	Text	Complete if client resides in a group home. Enter the name of the group home or residence.
11. DIAGNOSIS Required	Text	Enter the diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc., to justify a Medicaid determination of medical necessity. Approval of the PAR is based on documented medical necessity. Attach documents as required.
12. REQUESTING AUTHORIZATION FOR REPAIRS Conditional	Text	Complete if requesting repairs for equipment owned by the client. Enter the serial number of the equipment.
13. INDICATE LENGTH OF NECESSITY Conditional	Text	Complete if renting equipment. Provide best estimate of how long equipment will be needed.
14. ESTIMATED COST OF EQUIPMENT Conditional	Digits	Complete if purchasing, replacing, or repairing equipment. Provide best estimate of cost for labor and replacement part(s) for repair or cost for purchases.
15. SERVICES TO BE AUTHORIZED Preprinted.	None	Do not alter preprinted lines. No more than five items can be requested on one form.
16. DESCRIBE PROCEDURE, SUPPLY, OR DRUG TO BE PROVIDED Required	Text	Enter the description of the service/procedure to be provided.
17. PROCEDURE, SUPPLY OR DRUG CODE Required	HCPCS	Enter the HCPCS code for each item that will be billed on the claim form. The authorizing agent may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. NUMBER OF SERVICES Required	Digits	Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agent will complete with one unit.
19. AUTHORIZED NO. OF SERVICES	None	The authorizing agent indicates the number of services authorized which may or may not equal

FIELD LABEL	Completion Format	Instructions
Leave Blank		number requested in Field 18 (Number Of Services).

20. A=APPROVED/D=DENIED Leave Blank	None	No longer used. Providers should check the PAR on-line or refer to the PAR letter.
21. PRIMARY CARE PHYSICIAN (PCP) NAME Conditional	Text	Complete if client has a PCP. Enter the PCP's name as it appears on the current eligibility verification.
TELEPHONE NUMBER Optional	Text	Enter the PCP's telephone number.
22. PRIMARY CARE PHYSICIAN ADDRESS Conditional	Text	Complete if client has a PCP. Enter the PCP's complete address.
23. PCP PROVIDER NUMBER Conditional	8 Digits	Complete if client has a PCP. Enter the PCP's eight-digit Colorado Medicaid provider number. This number must be obtained by contacting the PCP for the necessary authorization.
24. NAME AND ADDRESS OF PROVIDER REQUESTING PRIOR AUTHORIZATION Required	Text	Enter the complete name and address of the physician requesting prior authorization (the physician ordering/writing the prescription).
25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE Required	Text	Enter the name, address, and telephone number of the supplier who will render the service.
26. SIGNATURE Required	Text	The requesting provider must sign the PAR and must be the physician ordering the service. Under unusual circumstances, when the prescribing physician is not available, a legible copy of a signed prescription may be attached in place of the signature of the requesting provider. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached. Do not send the original prescription; send a photocopy on an 8½ x 11 sheet. A rubber stamp facsimile signature is not acceptable on the PAR.
TELEPHONE NUMBER	Text	Enter the telephone number of the requesting

FIELD LABEL	Completion Format	Instructions
Required		provider.
27. DATE SIGNED Required	6 Digits	Enter the date the PAR form is signed by the requesting provider.
28. PROVIDER NUMBER Required	8 Digits	Enter the eight-digit Colorado Medicaid provider number of the requesting provider.
29. SERVICE PROVIDER NUMBER Required	8 Digits	Enter the eight-digit Colorado Medicaid provider number of the rendering provider. The rendering provider must be Colorado Medicaid enrolled.
30. COMMENTS OR REASONS FOR DENIAL OF BENEFITS Leave Blank	None	Providers should check the PAR on-line or refer to the PAR letter.
31. PA NUMBER BEING REVISED Conditional	Text	Complete if revising the original PAR. Enter the prior authorization number of the original PAR that is being revised.

After the PAR is reviewed, the approved or denied PAR is available online. A PAR letter, with the prior authorization number, is returned to the rendering provider. **Do not render or bill for services until the PAR has been processed.** The claim **must** contain the PAR number for payment.

If the PAR is denied, direct inquiries to the authorizing agent.

Colorado 1500 claim form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)

2. CLIENT DATE OF BIRTH

3. MEDICAID ID NUMBER (CLIENT ID NUMBER)

4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NUMBER

5. CLIENT SEX

MALE FEMALE

6. MEDICARE ID NUMBER (HIC OR SSN)

7. CLIENT RELATIONSHIP TO INSURED

SELF SPOUSE CHILD OTHER

8. CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT

EMPLOYER NAME

POLICYHOLDER NAME

GROUP

9. OTHER HEALTH INSURANCE COVERAGE - INSURANCE COMPANY NAME, ADDRESS, PLAN NAME AND POLICY NUMBER(S)

TELEPHONE NUMBER

10. WAS CONDITION RELATED TO:

A. CLIENT EMPLOYMENT

YES

B. ACCIDENT

AUTO OTHER

C. DATE OF ACCIDENT

11. CHAMPUS SPONSORS SERVICE/SSN

9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NUMBER

DURABLE MEDICAL EQUIPMENT

Line No Make Model Serial Number

12. PREGNANCY PHP NURSING FACILITY RESIDENT

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:

ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)

14. MEDICARE DENIAL

BENEFITS EXHAUSTED NON-COVERED SERVICES

14A. OTHER COVERAGE DENIED

NO YES

PAY/DENY DATE

15. NAME OF SUPERVISING PHYSICIAN

PROVIDER NUMBER

16. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES

ADMITTED: DISCHARGED:

17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

PROVIDER NUMBER

17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE PHYSICIAN'S OFFICE

YES

18. ICD-9-CM

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4

1.
2.
3.
4.

TRANSPORTATION CERTIFICATION ATTACHED

YES

PRIOR AUTHORIZATION #:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMER-GENCY	K FAMILY PLAN-NING	L. EPSDT

20. TOTAL CHARGES

LESS

MEDICARE EOMB DATE

21. MEDICARE PAID

22. THIRD PARTY PAID

23. NET CHARGE

24. MEDICARE DEDUCTIBLE

25. MEDICARE COINSURANCE

26. MEDICARE DISALLOWED

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) and DATE

28. BILLING PROVIDER NAME

29. BILLING PROVIDER NUMBER

30. REMARKS

COL-101

FORM # 94320 (REV. 9/98)

COLORADO 1500

Paper Colorado 1500 supply instructional reference

Supply/DME providers bill using the paper Colorado 1500 claim form **or** the electronic Colorado 1500 Supply format. For complete instructions, see the CO 1500 Billing Instructions, Paper Claim Instructional Reference.

FIELD LABEL	Instructions
1. CLIENT NAME	Required.
2. CLIENT DATE OF BIRTH	Required.
3. MEDICAID ID NUMBER	Required.
5. CLIENT SEX	Required.
DURABLE MEDICAL EQUIPMENT MODEL/SERIAL NUMBER	Conditional. Complete for wheelchair purchases, repairs, and labor. Enter the model and serial number of the wheelchair.
18. ICD-9-CM	Required.
PRIOR AUTHORIZATION NUMBER	Conditional. Complete for medical equipment and supplies that require prior authorization. Enter the 6 or 7-character system-assigned prior authorization number from the approved prior authorization request (PAR). Do not use the preprinted PAR number (if any). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent. Do not combine PAR services with non-PAR services on a single claim form.
19A. DATE OF SERVICE	Required. The field accommodates the entry of two dates - a beginning or from date of service and an ending or to date of service. The From and To date of service must represent the last date of the rental period.
19B. PLACE OF SERVICE	Required.
19C. PROCEDURE CODE (HCPCS)	Required.
MODIFIER	Conditional. Enter the appropriate procedure related modifier that applies to the billed service. Two modifiers may be entered. Always enter modifiers that change the way that claim payment is calculated in the first position. Pricing modifiers are identified below by the

FIELD LABEL	Instructions
	notation **. -01** DME rental (after 1st month) -XR** 1st month DME rental -XV Surgery-related eyewear -XD Manufacturer's invoice price See the Colorado 1500 Paper Claim Form Instructions for more detail.
19F. DIAGNOSIS	Required. For each billed service, indicate which of the diagnoses in field 18 are Primary, Secondary, or Tertiary .
19G. CHARGES	Required.
19H. DAYS OR UNITS	Required. Rental limited to 1 unit per month.
20. TOTAL CHARGES	Required.
21. MEDICARE PAID	Conditional. Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.
THIRD PARTY PAID	Conditional. Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher. Do not enter Medicaid copayment in this field or anywhere else on the claim form.
23. NET CHARGE	Required.
24. MEDICARE DEDUCTIBLE	Conditional. Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.
25. MEDICARE COINSURANCE	Conditional. Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.
26. MEDICARE DISALLOWED	Conditional. Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.

FIELD LABEL	Instructions
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) AND DATE	Required.
28. BILLING PROVIDER NAME	Required.
29. BILLING PROVIDER NUMBER	Required.
30. REMARKS	Conditional. For wheelchair purchases and repairs, use to document equipment model and serial number on old claim forms.

Supply claim

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: 11223344
SPECIAL PROGRAM CODE:

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Smith, Joseph
2. CLIENT DATE OF BIRTH: 08 10 30
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): A123456
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [X] FEMALE [ ]
6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. [ ] CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
   EMPLOYER NAME
   POLICYHOLDER NAME
   GROUP
9. OTHER HEALTH INSURANCE COVERAGE - INSURANCE COMPANY NAME, ADDRESS, PLAN NAME AND POLICY NUMBER(S)
   TELEPHONE NUMBER
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: BENEFITS EXHAUSTED [ ] NON-COVERED SERVICES [ ]
14A. OTHER COVERAGE DENIED: NO [ ] YES [ ] PAY/DENY DATE
15. NAME OF SUPERVISING PHYSICIAN
PROVIDER NUMBER
16. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED: DISCHARGED
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE PHYSICIANS OFFICE YES [ ]

18. ICD-9-CM
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1. 8 2 1 0 0 Fracture, femur
2.
3.
4.

TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERG-ENCY	K. FAMILY PLAM-NING	L. EPSDT
12 31 98		12	E 0 1 1 2	01	12345678	23456789	1			15 00	1				

DME claim

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: Williams-B55
SPECIAL PROGRAM CODE:

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Williams, Bryan
2. CLIENT DATE OF BIRTH: 5 16 68
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): B554433
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE [X] FEMALE [ ]
6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. [ ] CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
EMPLOYER NAME
POLICYHOLDER NAME
GROUP
9. OTHER HEALTH INSURANCE COVERAGE - INSURANCE COMPANY NAME, ADDRESS, PLAN NAME AND POLICY NUMBER(S)
TELEPHONE NUMBER
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES [ ]
B. ACCIDENT AUTO [ ] OTHER [ ]
C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: BENEFITS EXHAUSTED [ ] NON-COVERED SERVICES [ ]
14A. OTHER COVERAGE DENIED: NO [ ] YES [ ] PAY/DENY DATE
15. NAME OF SUPERVISING PHYSICIAN
PROVIDER NUMBER
16. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED: DISCHARGED
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE PHYSICIANS OFFICE YES [ ]

18. ICD-9-CM — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1. 741 Spina bifida
2.
3.
4.

TRANSPORTATION CERTIFICATION ATTACHED YES [ ]

DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
01 Tuff Care Hemi Deluxe 1234-5A Adult

PRIOR AUTHORIZATION NO. 002627

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
12 01 98	12 15 98	12	K0002	XD		56498732	1			500 00	1				
12 01 98	12 15 98	12	X2360	XD			1			100 00	1				
12 01 98	12 15 98	12	X2350	XD			1			37 50	1				

20.-. TOTAL CHARGES 637 50

LESS
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 637 50
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED
MEDICARE EOMB DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature 12/1/98
28. BILLING PROVIDER NAME
ABC Medical Supply
29. BILLING PROVIDER NUMBER
87654321
30. REMARKS

COL-101

COLORADO 1500