Beginning Billing Workshop
CMS 1500

Colorado Medicaid
2016
Training Objectives

• Billing Pre-Requisites
  ➢ National Provider Identifier (NPI)
    • What it is and how to obtain one
  ➢ Eligibility
    • How to verify
    • Know the different types

• Billing Basics
  ➢ How to ensure your claims are timely
  ➢ When to use the CMS 1500 paper claim form
  ➢ How to bill when other payers are involved
What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes
What is an NPI? (cont.)

• How to Obtain & Learn Additional Information:
  ➢ CMS web page (paper copy)-
  ➢ National Plan and Provider Enumeration System (NPPES)-
    ▪ [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)
  ➢ Enumerator-
    ▪ 1-800-456-3203
    ▪ 1-800-692-2326 TTY
Department Website

www.colorado.gov/hcpf

For Our Providers
Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals
Provider Enrollment

**Question:**
What does Provider Enrollment do?

**Answer:**
Enrolls providers into the Colorado Medical Assistance Program, *not* members.

**Question:**
Who needs to enroll?

**Answer:**
Everyone who provides services for Medical Assistance Program members.

- Additional information for provider enrollment and revalidation is located at the Provider Resources website.
Rendering Versus Billing

Rendering Provider
Individual that provides services to a Medicaid member

Billing Provider
Entity being reimbursed for service
Verifying Eligibility

• Always print & save copy of eligibility verifications
• Keep eligibility information in member’s file for auditing purposes
• Ways to verify eligibility:

Colorado Medical Assistance Web Portal
Fax Back 1-800-493-0920
CMERS/AVRS 1-800-237-0757
Medicaid ID Card with Switch Vendor
Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number
Eligibility Request Response (271)

Information appears in sections:
- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

Successful inquiry notes a Guarantee Number:
- Print copy of response for member’s file when necessary

Reminder:
- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

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CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/2022
Contact Information for Questions on Request:
Provider Relations Number: 800-237-0753

Requesting Provider:
Provider ID:
Name:

Client Details:
Name:
State ID:

PREPARED HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date: 04/06/2011 - 04/06/2011
Messages:

MHPROV Services

Provider Names:
COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number:
800-804-5008
Medicaid Identification Cards

- Provider may begin seeing the newly branded cards as early as March 20, 2016
- Older branded cards are valid
- Identification Card does not guarantee eligibility
Eligibility Types

• Most members = Regular Colorado Medicaid benefits
• Some members = different eligibility type
  ➢ Modified Medical Programs
  ➢ Non-Citizens
  ➢ Presumptive Eligibility
• Some members = additional benefits
  ➢ Managed Care
  ➢ Medicare
  ➢ Third Party Insurance
Eligibility Types
Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services
Eligibility Types

Non-Citizens

• Only covered for admit types:
  ➢ Emergency = 1
  ➢ Trauma = 5

• Emergency services (must be certified in writing by provider)
  ➢ Member health in serious jeopardy
  ➢ Seriously impaired bodily function
  ➢ Labor / Delivery

• Member may not receive medical identification care before services are rendered

• Member must submit statement to county case worker

• County enrolls member for the time of the emergency service only
What Defines an “Emergency”?

• Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
  ➢ Active labor & delivery
  ➢ Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
    ▪ Placing health in serious jeopardy
    ▪ Serious impairment to bodily functions
    ▪ Dysfunction of any bodily organ or part
**Eligibility Types**

**Presumptive Eligibility**

- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers Durable Medical Equipment (DME) and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental
Eligibility Types

Presumptive Eligibility (cont.)

• Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available

• Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757

• CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101
Managed Care Options

- Program of All-Inclusive Care for the Elderly (PACE)
- Managed Care Organizations (MCOs)
- Behavioral Health Organization (BHO)
Managed Care Options
Managed Care Organization (MCO)

• Eligible for Fee-for-Service if:
  ➢ MCO benefits exhausted
    • Bill on paper with copy of MCO denial
  ➢ Service is not a benefit of the MCO
    • Bill directly to the fiscal agent
  ➢ MCO not displayed on the eligibility verification
    • Bill on paper with copy of the eligibility print-out
Managed Care Options

Behavioral Health Organization (BHO)

• Community Mental Health Services Program
  ➢ State divided into five (5) service areas
    ▪ Each area managed by a specific BHO
  ➢ Colorado Medical Assistance Program Providers
    ▪ Contact BHO in your area to become a Mental Health Program Provider
Medicare

- Medicare members may have:
  - Part A only - covers Institutional Services
    - Hospital Insurance
  - Part B only - covers Professional Services
    - Medical Insurance
  - Part A and B - covers both services
  - Part D - covers Prescription Drugs
Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other Third Party Liability (TPL)
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid (QMB+)- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim
Medicare

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always payer of last resort
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denial(s) for six (6) years
Third Party Liability

• Colorado Medicaid pays Lower of Pricing (LOP)
  ➢ Example:
    ▪ Charge = $500
    ▪ Program allowable = $400
    ▪ TPL payment = $300
    ▪ Program allowable - TPL payment = LOP

    $400.00
    - $300.00
    = $100.00
Commercial Insurance

• Colorado Medicaid always payer of last resort
• Indicate insurance on claim
• Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party’s insurance
Co-Payment Exempt Members

Nursing Facility Residents

Children and Former Foster Care Eligible*

Pregnant Women

*former foster care eligible still has a pharmacy co-pay
Co-Payment Facts

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- A provider may not deny services to an individual when such members are unable to immediately pay the co-payment amount. However, the member remains liable for the co-payment at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- Youth from birth to 18 years old are considered children
- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS
  - Transportation
  - Emergency Services
  - Family Planning Services
  - Behavioral Health Services
## Specialty Co-payments

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<td>DME / Supply</td>
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<tr>
<td>Outpatient</td>
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<tr>
<td>Inpatient</td>
<td>$10.00 per covered day or 50% of average allowable daily rate - whichever is less</td>
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<tr>
<td>Psych Services</td>
<td>.50 per unit of service, 1 unit = 15 minutes</td>
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Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing
Record Retention

• Providers must:
  ➢ Maintain records for at least six (6) years
  ➢ Longer if required by:
    ▪ Regulation
    ▪ Specific contract between provider & Colorado Medical Assistance Program
  ➢ Furnish information upon request about payments claimed for Colorado Medical Assistance Program services
• Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements
Submitting Claims

• Methods to submit:
  ➢ Electronically through Web Portal
  ➢ Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  ➢ Paper only when:
    ▪ Pre-approved (consistently submits less than five (5) per month)
    ▪ Claims require attachments
ICD-10 Implementation

- Claims with Dates of Service (DOS) on or before 9/30/15: Use ICD-9 codes
- Claims with Dates of Service (DOS) on or after 10/1/2015: Use ICD-10 codes
- Claims submitted with both ICD-9 and ICD-10 codes: Will be rejected
Providers Not Enrolled with EDI

Providers must be enrolled with EDI to:

• use the Web Portal
• submit HIPAA compliant claims
• make inquiries
• retrieve reports electronically
  ➢ Select Provider Application for EDI Enrollment

Colorado.gov/hcpf/EDI-Support
Crossover Claims

Automatic Medicare Crossover Process:

- Crossovers may not happen if:
  - NPI not linked
  - Member is a retired railroad employee
  - Member has incorrect Medicare number on file
Crossover Claims

Provider Submitted Medicare Crossover Process:

• Additional Information:
  - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - Crossovers may be submitted on paper or electronically
  - Provider must submit copy of Standard Paper Remittance Advice (SPR) with paper claims
  - Provider must retain SPR for audit purposes
**Payment Processing Schedule**

**Monday (Mon.):**
- Payment information is transmitted to the State’s financial system.
- Accounting processes Electronic Funds Transfers (EFT) & checks.

**Tuesday (Tue.):**
- Paper remittance statements & checks dropped in outgoing mail.

**Wednesday (Wed.):**
- EFT payments deposited to provider accounts.

**Thursday (Thur.):**
- Weekly claim submission cutoff.
- Fiscal Agent processes submitted claims & creates PCR.
Electronic Funds Transfer (EFT)

Advantages

- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- Colorado.gov/hcpf/provider-forms → Other Forms

Colorado.gov/hcpf/provider-forms
The ColoradoPAR Program reviews PARs for the following categories or services and supplies: diagnostic imaging, durable medical equipment, inpatient out-of-state admissions, medical services (including transplant and bariatric surgery), physical and occupational therapy, pediatric long term home health, private duty nursing, Synagis®, vision, audiology and behavioral therapy.

- Please note: for the above categories, all PARs for members age 20 and under are reviewed according to EPSDT guidelines.
- ColoradoPAR does not process PARs for dental, transportation, pharmacy, or behavioral health services covered by the Behavioral Health Organizations.

**Website:**

[www.ColoradoPAR.com](http://www.ColoradoPAR.com)

**Phone:**

Phone: 1.888.801.9355

FAX: 1.866.940.4288
Electronic PAR Information

• PARs/revisions processed by the ColoradoPAR Program must be submitted via eQSuite®
• The ColoradoPAR Program will process PARs submitted by phone only if provider fills out the eQSuite® Exception Request Form and has been granted an exception from using eQSuite® when:
  ➢ Provider is out-of-state, or the request is for an out-of-area service
  ➢ Provider submits, on average, five or fewer PARs per month and would prefer to submit a PAR by telephone or facsimile
  ➢ Provider is visually impaired
PAR Letters/Inquiries

- Final PAR determination letters are mailed to members and providers by the Department’s fiscal agent.
- Letter inquiries should be directed to the fiscal agent, not ColoradoPAR.
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the fiscal agent
  - ensure you have the right PAR type
    - e.g. Medical PAR may have been requested but processed as a Supply PAR.
PARs Reviewed by the Department

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is the ONLY number accepted when submitting claims
- Long Term Care Nursing Facility PARs only
Waiver PARs

**Division for Intellectual & Developmental Disabilities (DIDD) Waivers**

- Supported Living Services (SLS)
- Developmental Disabilities (DD)
- Children’s Extensive Support (CES)

**Local County Department of Human Services DIDD Waiver**

- Children’s Habilitation Residential Program (CHRP)
Waiver PARs (cont.)

Case Management Agency Adult & Children HCPF Waivers

- Elderly Blind and Disabled (EBD)
- Community Mental Health Services (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Children's Home Community Based Services (CHCBS)
- Children With Autism (CWA)
- Children with Life Limiting Illness (CLLI)
Transaction Control Number

Receipt Method
0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

Batch Number

Document Number

Year of Receipt

Julian Date of Receipt

Adjustment Indicator
1 = Recovery
2 = Repayment

0 16 129 00 150 0 00037
Timely Filing

• 120 days from Date of Service (DOS)
  ➢ Determined by date of receipt, not postmark
  ➢ PARs are not proof of timely filing
  ➢ Certified mail is not proof of timely filing
  ➢ Example - DOS January 1, 20XX:
    ➢ Julian Date: 1
    ➢ Add: 120
    ➢ Julian Date = 121
    ➢ Timely Filing = Day 121 (May 1st)
Timely Filing

From “through” DOS:
- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From delivery date:
- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

From DOS:
- FQHC Separately Billed and additional Services
• 60 days from date on:
  ➢ Provider Claim Report (PCR) Denial
  ➢ Rejected or Returned Claim
  ➢ Use delay reason codes on 837P transaction
  ➢ Keep supporting documentation

• Paper Claims
  ➢ CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)
Medicare/Medicaid Enrollees

**Timely Filing**

Medicare pays claim:
120 days from Medicare payment date

Medicare denies claim:
60 days from Medicare denial date
Timely Filing Extensions

• Extensions may be allowed when:
  ➢ Commercial insurance has yet to pay/deny
  ➢ Delayed member eligibility notification
    ▪ Delayed Eligibility Notification Form
  ➢ Backdated eligibility
    ▪ Load letter from county
Timely Filing Extensions

Commercial Insurance

• 365 days from DOS
• 60 days from payment/denial date
• When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available
Timely Filing Extensions

Delayed Notification

• 60 days from eligibility notification date
  ➢ Certification & Request for Timely Filing Extension - Delayed Eligibility Notification Form
    ▪ Located in Forms section
    ▪ Complete & retain for record of LBOD

• Bill electronically
  ➢ If paper claim required, submit with copy of Delayed Eligibility Notification Form

• Steps you can take:
  ➢ Review past records
  ➢ Request billing information from member
Timely Filing Extensions

Backdated Eligibility

• 120 days from date county enters eligibility into system
  ➢ Report by obtaining State-authorized letter identifying:
    ▪ County technician
    ▪ Member name
    ▪ Delayed or backdated
    ▪ Date eligibility was updated
CMS 1500

Who completes the CMS 1500?

HCBS/Waiver providers
Vision providers
Physicians/Other Practitioners
Supply providers
Surgeons
Transportation providers
CMS 1500
Common Denial Reasons

- **Timely Filing**: Claim was submitted more than 120 days without a LBOD
- **Duplicate Claim**: A subsequent claim was submitted after a claim for the same service has already been paid
- **Bill Medicare or Other Insurance**: Medicaid is always the “Payer of Last Resort” - Provider should bill all other appropriate carriers first
Common Denial Reasons

- PAR not on file
- No approved authorization on file for services that are being submitted
- Total Charges invalid
- Line item charges do not match the claim total
Claims Process - Common Terms

Reject
Claim has primary data edits - not accepted by claims processing system

Denied
Claim processed & denied by claims processing system

Accept
Claim accepted by claims processing system

Paid
Claim processed & paid by claims processing system
Claims Process - Common Terms

Adjustment
Correcting under/overpayments, claims paid at zero & claims history info

Rebill
Re-bill previously denied claim

Suspend
Claim must be manually reviewed before adjudication

Void
“Cancelling” a “paid” claim (wait 48 hours to rebill)
Adjusting Claims

• What is an adjustment?
  ➢ Adjustments create a replacement claim
  ➢ Two step process: Credit & Repayment

Adjust a claim when

• Provider billed incorrect services or charges
• Claim paid incorrectly

Do not adjust when

• Claim was denied
• Claim is in process
• Claim is suspended
Adjustment Methods

- **Web Portal**
  - Preferred method
  - Easier to submit & track

- **Paper**
  - Complete field 22 on the CMS 1500 claim form
Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal
Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate: $2.61/page for business address
    - $2.86/page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not
### Provider Claim Reports (PCRs)

**Paid**

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THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63, '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

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**COLORADO**

Department of Health Care Policy & Financing
### Provider Claim Reports (PCRs)

#### Adjustments

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#### Voids

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#### Repayment

**Net Impact**: 21.42

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**COLORADO**

Department of Health Care Policy & Financing
Provider Services

Xerox
1-800-237-0757

- Claims/Billing/Payment
- Forms/Website
- EDI
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training
Thank you!