Laboratory Services

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Laboratory Services

Providers must be enrolled as a Health First Colorado provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to the Health First Colorado

A certified clinical laboratory means a provider who possesses a certificate of waiver or a certificate of registration from the Centers for Medicare and Medicaid Services or its designated agency as meeting Centers for Medicare and Medicaid Services guidelines and whose personnel and director are qualified to perform laboratory services.

An independent laboratory means a certified clinical laboratory that performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital.

All clinical laboratory providers must furnish their Clinical Laboratory Improvement Amendment (CLIA) certification numbers to the Health First Colorado fiscal agent at the time of enrollment.

Medically necessary, physician-ordered laboratory services are a benefit of the Health First Colorado.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10), for specific information when providing laboratory services.

> ***Important: Laboratory services for Emergency Medicaid (EMS) clients must include the emergency indicator on the claim for the claim to be paid.***

Billing Information

Refer to the General Provider Information manual for general billing information.

General Prior Authorization Requirements

Please consult the General Provider Information Manual on the Department's Billing Manual web page for information about Prior Authorization requirements. More information can be found on the ColoradoPAR website, and contact information can be found on the Department's Provider Contact web page.

Laboratory Prior Authorized Procedure Codes

Below is a list of prior authorized procedure codes for Laboratory billing. Reference the current Fee Schedule for rates.

Note: this table serves only as a reference guide and not a guarantee of payment or coverage. Definitive coverage of a specific procedure code is found on the Fee Schedule.

Last table update: 01/10/2020

Procedure Code	Notes	Procedure Code	Notes
81162	PAR required as of 1/1/2016	81295	PAR required as of 2/10/2020
81163	PAR required as of 1/1/2019	81296	PAR required as of 2/10/2020
81164	PAR required as of 1/1/2019	81297	PAR required as of 2/10/2020
81165	PAR required as of 1/1/2019	81298	PAR required as of 2/10/2020

81166	PAR required as of 1/1/2019	81299	PAR required as of 2/10/2020
81167	PAR required as of 1/1/2019	81300	PAR required as of 2/10/2020
81200	PAR required as of 2/10/2020	81306	PAR required as of 1/1/2019
81201	PAR required as of 7/1/2019	81307	PAR required as of 1/1/2020
81209	PAR required as of 2/10/2020	81308	PAR required as of 1/1/2020
81211	Coverage terminated 12/31/2018	81309	PAR required as of 1/1/2020
81212	PAR required as of 7/1/2015	81312	PAR required as of 1/1/2019
81213	Coverage terminated 12/31/2018	81317	PAR required as of 7/1/2019
81214	Coverage terminated 12/31/2018	81318	PAR required as of 2/10/2020
81215	PAR required as of 7/1/2015	81319	PAR required as of 2/10/2020
81216	PAR required as of 7/1/2015	81321	PAR required as of 7/1/2019
81217	PAR required as of 7/1/2015	81323	PAR required as of 2/10/2020
81220	PAR required as of 2/10/2020	81327	PAR required as of 2/10/2020
81241	PAR required as of 2/10/2020	81380	PAR required as of 2/10/2020
81242	PAR required as of 7/1/2019	81400	PAR required as of 2/10/2020
81243	PAR required as of 2/10/2020	81401	PAR required as of 2/10/2020
81251	PAR required as of 2/10/2020	81402	PAR required as of 2/10/2020
81255	PAR required as of 2/10/2020	81403	PAR required as of 7/1/2019
81256	PAR required as of 2/10/2020	81404	PAR required as of 7/1/2019
81257	PAR required as of 2/10/2020	81405	PAR required as of 7/1/2019
81260	PAR required as of 2/10/2020	81406	PAR required as of 2/10/2020
81277	PAR required as of 1/1/2020	81407	PAR required as of 2/10/2020
81283	PAR required as of 2/10/2020	81408	PAR required as of 7/1/2019
81290	PAR required as of 2/10/2020	81420	PAR required as of 2/10/2020
81292	PAR required as of 7/1/2019	81432	PAR required as of 2/10/2020
81293	PAR required as of 2/10/2020	81522	PAR required as of 1/1/2020
81294	PAR required as of 2/10/2020	81542	PAR required as of 1/1/2020

Clinical Laboratory Improvement Amendments (CLIA) Claims

Laboratory providers submitting procedures covered by CLIA must have a CLIA number of the laboratory where the procedure was done on the claim or claim line. Pass-through billing is not allowed per the Laboratory and X-ray rule found at 10 CCR 2505-10 8.660.

- Providers billing on the 837P format should refer to the updated 837P Companion Guide which is posted in the Provider Services Specifications section of the Department's website. Providers billing on the 837P format and billing agents should update their billing systems for 837P transactions.
- Providers billing an 837P through the Health First Colorado Online Portal (Online Portal) are able to enter CLIA numbers on the Detail Line Item tab (claim line).
- Providers billing on the CMS 1500 paper claim form should enter their valid CLIA number in the REMARKS field (# 23). Enter "CLIA" before the CLIA number.

Please note: Only one CLIA number can be included on each paper claim form. It is applied to all CLIA covered procedures on the claim. Procedures covered by different CLIA numbers need to be submitted on separate claims. Enter the CLIA number in the REMARKS field only.

The tax ID (TID) on record with the Centers for Medicare and Medicaid Services (CMS) for the CLIA number must correspond to the TID on record with the Department. Questions regarding claims processing or responses should be directed to DXC Technology (DXC) at 844-235-2387 (toll free).

Handling, Collection and Conveyance Charges

Specimen collection (including venipuncture) is considered to be an integral part of the laboratory testing procedure when performed by a hospital laboratory and is not reimbursable as a separate or additional charge.

Transfer of a specimen from one clinical laboratory to another is a benefit only if the first laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered tests. Modifier -KX used with procedure code 99001 verifies that the lab's equipment is not functioning or that the laboratory is not certified to perform the ordered test.

Specimen collection, handling, and conveyance from the member's home, a nursing facility, or a facility other than the physician's office or place of service is a benefit only if the member is homebound, bedfast, or otherwise non-ambulatory **and** the specimen cannot reasonably be conveyed by mail. A physician's statement explaining the circumstances and medical necessity is required.

Each laboratory will be reimbursed only for those tests performed in the specialties or subspecialties for which it is certified.

Papanicolaou (Pap) Smears

Health First Colorado allows one pap smear screening/examination per 12-month period in women under 40 years of age. Benefit for more than one Pap smear in a 12-month period is allowed for women ages 40 and over; women with a history of diethylstilbestrol exposure in utero; women with malignancy of the cervix, vagina, uterus, fallopian tubes or ovaries; women with cervical polyps, cervicitis, neoplastic disease of the pelvic organs, vaginal discharge or bleeding of unknown origin, postmenopausal bleeding, or vaginitis; or if the physician determines that more frequent testing is needed and is medically necessary. Claims will deny if the diagnosis code entered on the claim does not support the testing frequency.

See the Women's Heath Services rule at 10 CCR 2505-10 8.731.

Drug Testing Unit Limitations and Documentation Requirements

On or after October 1, 2017:

Current Procedural Terminology (CPT) codes 80305, 80306 and 80307 have a unit limit of four (4) per month per client for each code. This unit limit applies to all provider types.

When performed outside of the hospital setting, substance-specific confirmatory tests, CPT codes 80320 – 80377, will be reimbursed only if they meet the medical necessity standard. See 10 C.C.R. 2505-10, § 8.076.1.8. If a provider is unable to demonstrate that a confirmatory test meets the definition of medical necessity, the test will not be eligible for reimbursement.

A positive or inconclusive presumptive test will be considered evidence of medical necessity for confirmatory tests. The presumptive test must have been administered within two (2) days prior to the confirmatory test. The positive or inconclusive results of the presumptive test must be scanned and attached to the claim for the confirmatory test.

If no presumptive test is performed prior to a confirmatory test, the provider is required to include supporting documentation that demonstrates the medical necessity of the confirmatory test when submitting the claim.

Confirmatory tests without the corresponding positive or inconclusive presumptive test attached to the claim may not be eligible for reimbursement.

Newborn Metabolic Screening

Costs associated with Newborn Metabolic Screening (NMS) are included in the inpatient hospital diagnosis related grouper (DRG) calculation and the birthing center facility payment and may not be billed separately by the hospital or birth center. Billing S3620 while receiving the a DRG or facility payment for the delivery is duplicative.

S3620 may only be billed by providers, not reimbursed for the delivery, who submit a second-specimen screen and are charged for an initial-specimen screen by Colorado Department of Public Health and Environment (CDPHE) because the second-specimen could not be linked to an initial-specimen. S3620 does not require a CLIA certification.

Because the NMS are performed by CDPHE's laboratory and not the provider collecting and submitting the specimen, unbundling the NMS and billing for the individual tests performed by CDPHE's laboratory is not allowed per the Laboratory and X-ray rule found at 10 CCR 2505-10 8.660.

BRCA Screening and Testing

Per the Womens's Health Services rule found at 10 CCR 2505-10 8.731, the following are requirements for BRCA screening and testing:

- BRCA screening, genetic counseling, and testing is only covered for clients over the age of 18.
- BRCA screening is covered and must be conducted prior to any BRCA-related genetic testing.
- The provider shall make genetic counseling available to clients with a positive screening both before and after genetic testing, if the provider is able, and genetic counseling is within the provider's scope of practice. If the provider is unable to provide genetic counseling, the provider shall refer the client to a genetic counselor*.
- Genetic testing for breast cancer susceptibility genes BRCA1 and BRCA2 is covered for clients with a positive screening

* *Genetic Counselors cannot be directly reimbursed for services. A supervising physician may be reimbursed. The services require direct supervision if done by a genetic counselor, with the supervisor on site.*

Prenatal Testing

Per the Maternity Services rule at 10 CCR 2505-10 8.732.4.E. prenatal genetic screening tests are available for women carrying a singleton gestation who meet one or more of the following conditions:

- Maternal age 35 years or older at delivery;
- Fetal ultrasonographic findings indicated an increased risk of aneuploidy;
- History of a prior pregnancy with a trisomy;
- Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen; or
- Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or 21.

General Requirements

- Fees for blood drawing, specimen collection, or handling are not reimbursable to laboratories.
- The provider who actually performs the laboratory procedure is the only one who is eligible to bill and receive payment. Physicians may only bill for tests actually performed in their office or clinic. Tests performed by laboratories or hospital outpatient laboratories must be billed by the performing laboratory.
- CPT identifies tests that can be and are frequently done as groups and combinations ("profiles") on automated multi-channel equipment. For any combination of tests among those listed, use the appropriate Level 1 or Level 2 CMS codes.
- For organ or disease-oriented panels (check CPT narrative), use the appropriate Level 1 CMS codes. These tests are not to be performed or billed separately when ordered in a group/combination and must be billed with one unit of service.

Procedure/HCPCS Codes Overview

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Health First Colorado members and represent services that may be provided by enrolled certified Health First Colorado providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services Provider Bulletins section. To receive electronic provider bulletin notifications, an email address can be entered into the Online Portal in the (*MMIS) Provider Data Maintenance* area or by completing and submitting a Publication Email Preference Form in the Provider Services Forms section. Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

Procedure Codes

Services must be reported using HCPCS procedure codes. Use procedure codes listed in the most recent Practitioner HCPCS bulletin located in the Provider Services Provider Bulletins section.

The fiscal agent updates and revises CMS codes through Health First Colorado bulletins.

CMS 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 claim form.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "yes", enter the policy or group number.

CMS Field #	Field Label	Field is?	Instructions
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "yes", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.

CMS Field #	Field Label	Field is?	Instructions
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Conditional	Complete if all laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if any laboratory work was performed in the office. Practitioners may not request payment for services performed by a hospital laboratory.

CMS Field #	Field Label	Field is?	Instructions
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**CLIA** When applicable, enter the word "CLIA" followed by the number. **Prior Authorization** Enter the six-character prior authorization number from the approved Prior Authorization Request (PAR). 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.
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).

CMS Field #	Field Label	Field is?	Instructions
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To **01** **01** **15** Or From To **01** **01** **15** **01** **01** **15** Span dates of service From To **01** **01** **15** **01** **31** **15** Practitioner claims must be consecutive days. Single Date of Service: Enter the six-digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 81 Lab

CMS Field #	Field Label	Field is?	Instructions
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.

24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **Mod** **Description** 26 **Professional component** Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. TC **Technical component** Use with diagnostic codes to report technical component services billed separately from professional component services. Report separate technical and professional component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. KX **Specific required documentation on file** Use with laboratory codes to certify that the laboratory's equipment is not functioning, or the laboratory is not certified to perform the ordered test. The KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test", or "I certify that this laboratory is not certified to perform the requested test".

CMS Field #	Field Label	Field is?	Instructions
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Health First Colorado bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.

CMS Field #	Field Label	Field is?	Instructions
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		

CMS Field #	Field Label	Field is?	Instructions
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 Laboratory Services Claim Example with CLIA Number

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | 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): D444444

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

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 45 SEX M F X

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

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

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

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

CITY | STATE | 8. RESERVED FOR NUCC USE | CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( ) | ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X 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 10/1/16

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 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)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0

A. Z04 .8 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 01D1000000

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 01 16	10 01 16	81		G0307		A	100 00	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.: Optional

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

28. TOTAL CHARGE $ 100 00

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 Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Independent Laboratory
100 Any Street
Any City

a. 1234567890 b.

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

PATIENT AND INSURED INFORMATION

CMS 1500 Laboratory Services Crossover Claim Example with CLIA Number

HEALTH INSURANCE CLAIM FORM

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

PICA — CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | 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): D444444

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

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 45 — SEX: M / F X

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

5. PATIENT'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code)

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

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

b. AUTO ACCIDENT? YES / NO — PLACE (State)

c. OTHER ACCIDENT? YES / NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: Medicare Policy Number

a. INSURED'S DATE OF BIRTH MM DD YY: 10 16 45 — SEX: M / F X

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO X — 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: 10/1/16

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 — 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)

20. OUTSIDE LAB? YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. Z04.8 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 01D000000

	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 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 01 16	10 01 16	81		G0307		A	100 00	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

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

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $ 80 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: Signature — DATE: 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION — a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Independent Laboratory
100 Any Street
Any City

a. 1234567890 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Laboratory Services Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manuals Comment Log v0_2.xlsx*	*5, 10*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1, 6*	*DXC*
2/9/2018	*Removed NDC supplemental qualifier - not relevant for independent laboratory providers*	*12*	*DXC*
6/25/2018	*Updated general billing and timely to point to general manual*	*1-3, 20*	*HCPF*
12/21/2018	*Clarification to signature requirements*	*16*	*HCPF*
2/22/19	*Add Section on Drug Testing Unit Limitations and Documentation Requirements* *Added term dates and new codes to PAR table*	*2-5*	*HCPF*
3/18/2019	*Clarification to signature requirements*	*16*	*HCPF*
5/6/19	*Add Section on Newborn Metabolic Screening* *Update Title to Laboratory Services*	*1, 4*	*HCPF*
5/22/19	*Add Codes to Prior Authorization Table*	*2-3*	*HCPF*
9/16/19	*Updated Drug Limitations section*	*3*	*HCPF*
1/10/2020	*Added BRCA/Prenatal section, added codes to PAR table*	*1-4*	*HCPF*

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.*