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Transportation

Benefits

Medical transportation is a Colorado Medical Assistance Program benefit when the member requires transportation. The transportation services must be medically necessary and provided within the scope of the provider's certification and license. Transportation for Colorado Medical Assistance Program members to and from a medical provider is a benefit when the medical service provided is a benefit of the Colorado Medical Assistance Program.

Medical Transportation includes both emergent and non-emergent services.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.
For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (colorado.gov/hcpf/billing-manuals)

Emergency Transportation

Emergency Ambulance and Air Ambulance Transport

All emergency ambulance and air ambulance transportation claims are billed directly to the fiscal agent by the transportation provider. Emergency transportation services require a trip report that must be retained by the transportation provider and is subject to audit for a period up to six (6) years from the date of service.

Exclusions

The following services are not Colorado Medical Assistance Program emergency transportation benefits:

- Waiting time, cancellations, or additional passengers (e.g., family members) except in the case of approved escorts
- Response calls when, upon arrival at the site of the call, no transportation is needed or provided
- Charges when the member is not in the vehicle
- Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary
- Transportation services when medical treatment is not required or provided upon arrival
- Transportation to services located on military reservations
- Transportation to local treatment programs not enrolled in the Colorado Medical Assistance Program
- Pick up or delivery of prescriptions and/or supplies
- Transportation arranged for the member' convenience as opposed to medical necessity

Types of Emergency Transportation

Ambulance services

Emergency ambulance service is a Colorado Medical Assistance Program benefit when the member's condition requires immediate attention.

Air ambulance

Air ambulance benefits are provided when:

- The point of pick up is inaccessible by a land vehicle.
- Great distances or other obstacles prohibit transporting the member by land to the nearest appropriate facility and the member's condition requires immediate attention.

- The patient is suffering from an illness or injury making other forms of transportation inadvisable.

Submit hospital–based emergency ambulance and air ambulance services as an 837 Institutional (837I) electronic transaction.

Non-Emergent Medical Transportation

Non-emergent medical transportation (NEMT) is a Colorado Medical Assistance Program administrative service only for members with no other means of transportation, to transport members to and from medical appointments for Medicaid covered services. NEMT must be to the closest qualified Medicaid provider for a benefit of the Colorado Medical Assistance Program.

The State designated entity explores and utilizes the least costly, medically appropriate means of transportation for each member and arranges those transportation services. The State designated entity submits claims to the fiscal agent for processing and distributes reimbursed funds to the appropriate providers. NEMT includes private vehicles, mobility vehicles, wheelchair vans, buses, trains, air, and non-emergent ambulance.

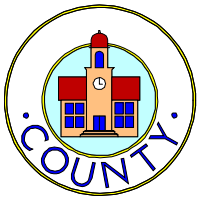
Types of Non-Emergent Medical Transportation

General Instructions

The State designated entity must ensure that all scheduled trips are for Medicaid covered services. The entity maintains records of all appropriate documentation on file for a period of six (6) years. These records must be available and produced for audit and inspection upon request. Transportation providers shall maintain a record of the State designated entity authorization. The authorization must cover the service dates. The State designated entity must submit a Prior Authorization Request (PAR) to the appropriate State authorizing agency for amounts over the State's maximum allowable rate (Over-the-Cap).

Transportation services billed by the State designated entity

The State designated entity submits claims for all non-emergent medical transportation services:



- Mobility vehicle
- Private vehicle
- Wheelchair van
- Non-emergent ambulance
- Bus
- Train services
- Air services
- Ancillary services
- Out-of-state transportation
- Over-the-Cap transportation prior authorized by the State authorizing agency

Private Vehicle

A private vehicle may be provided by a volunteer, (individual or organization, with no member vested interest or a vehicle provided by an individual, (family member, self, neighbor), with a member vested interest. These vehicles are reimbursed mileage using the most direct route to the appointment.

Mobility Vehicle

A mobility vehicle is a passenger carrying vehicle for hire, including those designed, constructed, modified or equipped to meet the needs of passengers with medical, physical or mobility impairments and, when medically necessary, their certified escorts. Mobility vehicles, including mobility van, mini-bus, mountain area transports and other non-profit transportation systems, are defined as vehicles certified as a common or contract carrier and regulated by the Public Utilities Commission (PUC), with a call-and-demand limousine authority, or a specialized intra-governmental agency bus substitute service or specialized mobility service. Mobility vans are not regulated by the PUC when used exclusively for individuals confined to a wheelchair.

Based upon this PUC regulation, a mobility vehicle may transport "mixed parties" without the consent of the other passengers and therefore may transport several members at the same time. A mobility vehicle does not calculate charges based upon a meter. Taxi service is not a mobility vehicle; however, a taxi company may also have call-and-demand limousine authority from the PUC and may operate its vehicles under that authority as mobility vehicles.

In this case, the taxi company agrees to the Colorado Medical Assistance Program reimbursement for mobility vehicles. Mobility vehicle services are transportation services provided to individuals who are not wheelchair confined.

Mobility vehicle transportation is a Colorado Medical Assistance Program benefit when the member's physician-certified medical or physical condition precludes the use of member-purchased public or private transportation, or other less costly means of Colorado Medical Assistance transportation.

A mobility vehicle may bill using wheelchair van codes only when the member is a physician-certified wheelchair user and the vehicle has been modified with appropriate wheelchair equipment. If these requirements are not met, the mobility vehicle may not bill using wheelchair van codes.

When a mobility vehicle provides over-the-cap transportation to more than one member, special multiple rider exceptions apply. (See Over-the-Cap)

Wheelchair Van

A wheelchair van is a vehicle for hire that has been specifically designed, constructed, modified, or equipped to accommodate the needs of wheelchair users. Wheelchair van services are a Colorado Medical Assistance Program benefit when ordered by a physician and the member's, physician-certified, medical or physical condition precludes the utilization of member-purchased public or private transportation, or a less costly means of Colorado Medical Assistance Program transportation. Wheelchair van transportation is only for wheelchair-confined members, as certified by a physician, within a vehicle that has been modified to accommodate the wheelchair.

Wheelchair van service is not regulated by the PUC as long as the van is used exclusively for wheelchair members. Any company with a vehicle for hire that has been modified to accommodate a wheelchair may transport wheelchair members without regard to any other authority the company may have from the PUC. When operating as a wheelchair van, the provider agrees to wheelchair van reimbursement.

Oxygen administration is allowed when medically necessary. Wheelchair vans must bill using mobility vehicle codes if the member is not a physician-certified wheelchair user, in which case, the mobility vehicle must also meet PUC requirements for mobility vehicle services. (See Mobility Vehicle)

Non-Emergent Ambulance Services

Non-emergent, pre-planned ambulance service is a Colorado Medical Assistance Program service when the member's condition is such that he or she requires an ambulance in order to be transported safely. Non-emergent ambulance must be certified by a physician and authorized by the State designated entity.

Air Ambulance

Air ambulance benefits are provided when:

- Non-emergency, pre-planned services are authorized by the State authorizing agency. (See air transportation procedure below).
- Great distances or other obstacles prohibit transporting the member by land to the nearest appropriate facility and the member's condition requires immediate attention.
- The member is suffering from an illness or injury making other forms of transportation inadvisable.

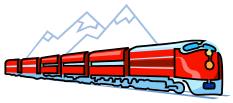
Submit hospital-based ambulance and air ambulance services as an 837I-Institutional electronic transaction.

Over-the-Cap

Over-the-cap transportation includes services that, due to extenuating circumstances, exceed the rate for a particular code. Over-the-cap services should be rarely, if ever, used. Over-the-cap transportation services require State approval which is obtained by the State designated entity. Documentation requirements for over-the-cap authorization must include information demonstrating the mode of transportation is the most appropriate and least costly for the member's condition and that the trip is medically necessary. The State designated entity must document that the care required by the member is not available in the member's local community and that the member is seeing the closest, qualified provider for a Colorado Medical Assistance Program service. The State designated entity must also document that the member qualifies for Colorado Medical Assistance Program transportation as ordered and certified by a qualified healthcare professional.

Air/Train

Air and train transport are benefits of the Colorado Medical Assistance Program only when a member's, physician-certified, medical or physical condition precludes the use of member-purchased public or private transportation, or when other less costly, medically appropriate means of Colorado Medical Assistance Program transportation are not available. Air and train transport are permissible for out-of-state travel. In extreme circumstances air transport may be available for in state travel when it is the most cost effective, medically appropriate means of transportation for the member's condition.



Procedure for all NEMT Air Transportation (including air ambulance)

The Department has the following approval process for air transportation as part of the Colorado Medical Assistance Program. The approval process is different depending on payer source.

Please note: Members and/or medical professionals in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer or Weld Counties must first contact the NEMT broker to request air transportation. Members and/or medical professionals in all other Counties must first contact their County Department responsible for Medicaid to request air transportation.

1. Colorado Medicaid is the primary payer for inpatient medical care:
    - Member and/or medical professional requesting air transportation shall contact the NEMT broker or the County.
    - The NEMT broker or the County shall submit the documentation to the NEMT policy specialist.
    - The NEMT policy specialist will confirm air transport is the least expensive and/or most appropriate option available.
    - The NEMT policy specialist presents the request to the Department's Chief Medical Officer for review and decision.
    - The NEMT policy specialist will send email notification to the NEMT Broker or County that air transport has been approved or denied.

2. Colorado Medicaid is the primary payer for outpatient medical care.
    - Member and/or medical professional requesting air transportation shall contact the NEMT broker or the County.
    - A letter of Medical Necessity and any appropriate supporting documentation (including reason for air travel) shall be electronically submitted to NEMT broker or the County. The letter shall include the member's name, Medicaid identification number and date of birth.
    - The NEMT broker or the County shall submit the documentation to the NEMT policy specialist.
    - The NEMT policy specialist will forward the information to the Department's Chief Medical Officer for review and approval.
    - The NEMT policy specialist will confirm air transport is the least expensive and/or most appropriate option available.
    - The NEMT policy specialist will send email notification to the NEMT Broker or County that air transport has been approved or denied.

3. A Colorado Medicaid contracted Behavioral Health Organization (BHO) is the primary payer for out-of-state behavioral healthcare.
    - The Behavioral Health Organization requesting air transportation shall contact the NEMT broker or the County.
    - The NEMT broker or the County shall notify the NEMT policy specialist of the request.
    - A copy of an approved BHO service authorization will be electronically submitted to the NEMT policy specialist. Included with the authorization will be the member's name, Medicaid identification number, and date of birth.
    - The NEMT policy specialist will confirm air transport is the least expensive and/or most appropriate option available.
    - The NEMT policy specialist will send email notification to the NEMT Broker or County that air transport has been approved or denied.

4. Colorado Medicaid is the secondary payer to Medicare or a private insurer and Medicare or the private insurer does not cover transportation.
    - Member and/or medical professional requesting air transportation shall contact the NEMT broker or the County.
    - Primary insurer information (Medicare, private insurance) documenting coverage of medical care and rational for out-of-state care shall be electronically submitted to NEMT broker or the County. Documentation will include the member's name, Medicaid identification number and date of birth.
    - The NEMT broker or the County will submit the documentation to the NEMT policy specialist.
    - The NEMT policy specialist will confirm air transport is the least expensive and/or most appropriate option available.
    - The NEMT policy specialist will send email notification to the NEMT Broker or County that air transport has been approved or denied.

Bus

Bus transportation may be a benefit when the member's condition does not allow the member to purchase public or private transportation and when other less costly, medically appropriate means of Colorado Medical Assistance Program transportation are not available.

Out-of-State Transportation

Benefits are provided when:

Routine medical services for members in Colorado border communities are performed across the state line because of closer proximity to the closest qualified provider. All rules and practices for in state travel apply.

Documentation must include information as to why the member cannot obtain treatment in state. Treatment must not be available in the State of Colorado. Out of state travel requests must also include anticipated period of travel as well as the need for meals, lodging and an escort when indicated.

Ancillary Services

An escort is a Colorado Medical Assistance Program benefit when the member's medical or physical condition necessitates an escort, as certified by the member's physician, and the member qualifies for Colorado Medical Assistance Program transportation services.

Minors who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel alone with a written release from their parent or guardian, as long as an adult is present to receive the minor at the destination and at the return location. Minors under thirteen (13) years old shall not travel without an escort.

Meals and lodging are a benefit for the member only when the member qualifies for Colorado Medical Assistance Program transportation and travel cannot be completed in one calendar day for in-state treatment.

Both member and escort are eligible for meals and lodging when the qualifying member is traveling out-of-state for treatment and does not receive these services as part of an in-patient stay. Meals, lodging and round trip transportation expenses for the escort are covered only during transit to

and from the destination of medical treatment, unless the escort's continued stay is authorized for a minor child or an at risk adult, unable to make medical determinations or provide necessary self-care.

Exclusions

The following services are not Colorado Medical Assistance Program non-emergent medical transportation benefits:

- Waiting time, cancellations, or additional passengers (e.g., family members) except in the case of approved escorts
- Response calls when, upon arrival at the site of the call, no transportation is needed or provided.
- Charges when the member is not in the vehicle
- Transportation to non-benefit services
- Transportation to services located on military reservation.
- Transportation arranged for the member's convenience as opposed to medical necessity
- Ancillary services when member is receiving in-patient treatment and receives these benefits as part of the in-patient stay.

Authorization Requests for Transportation

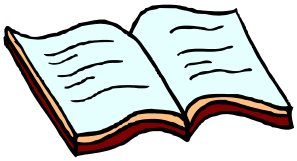
The Colorado Medical Assistance Program requires authorization for certain non-emergent medical transportation services. Services requiring State authorization include:

- Over-the-cap Services
- Transport by air

Refer to the appropriate sections in this manual regarding the process for each service.

Procedure Coding

Transportation HCPCS codes



The Colorado Medical Assistance Program uses the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program members and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

HCPCS are used to identify and reimburse transportation services.

The Department updates and revises HCPCS codes through Colorado Medical Assistance Program the appropriate billing manuals.

The series of local procedure codes used to bill for mobility van services (X6022-X6030) are no longer available. Providers should use HCPCS A0120 plus modifier TK (Extra member or passenger) to bill for mobility van services. Use the appropriate number of units to identify the actual number of riders.

The XU-Split unit modifier is no longer valid.

Transportation Codes and PAR Requirements

Code	Description	PAR Requirements
A0021	Ambulance service, outside state per mile, transport- Emergency	No PAR
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	No PAR
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	No PAR
A0100	Nonemergency transportation; taxi	No PAR
A0110	Nonemergency transportation and bus, intra- or interstate carrier	No PAR
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	No PAR
A0130	Nonemergency transportation: wheelchair van	No PAR
A0140	Nonemergency transportation and air travel (private or commercial), intra- or interstate	No PAR
A0180	Nonemergency transportation: ancillary: lodging - recipient	No PAR
A0190	Nonemergency transportation: ancillary: meals - recipient	No PAR
A0200	Nonemergency transportation: ancillary: lodging - escort	No PAR
A0210	Nonemergency transportation: ancillary: meals - escort	No PAR
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way	No PAR
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	No PAR
A0425	Ground mileage, per statute mile	No PAR
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	No PAR
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)	No PAR
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	No PAR
A0429	Ambulance service, basic life support, emergency transport (BLS - emergency)	No PAR
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	No PAR
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	No PAR

Code	Description	PAR Requirements
A0433	Advanced life support, level 2 (ALS 2)	No PAR
A0434	Specialty care transport (SCT)	No PAR
S0209	Wheelchair van, mileage, per mile	No PAR
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	No PAR
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	No PAR
T2005	Nonemergency transportation; stretcher van	No PAR
T2049	Nonemergency transportation; stretcher van, mileage; per mile	No PAR

Transportation Billing Instructions

The 837 Professional (837P) transaction should be utilized for electronic billing.

Diagnosis Codes

A diagnosis is required on all claims. Enter code R68.89 for all claims. Do not fill unused spaces with zeroes. The diagnosis must be referenced to each detail line by placing a "1" in the diagnosis indicator field.

Dates of Services

Each detail line includes space to enter two (2) dates of service: a 'From' Date Of Service (FDOS) and a 'To' Date Of Service (TDOS). Both dates must be completed on the electronic record. For services rendered on a single date, complete the FDOS and the TDOS with the same date.

Span Billing

Span billing is not allowed for transportation services.

Place of Service Codes

Use CMS place of service codes. Use place of service code 41-land transportation and code 42-air transportation.

Procedure Codes

Each detail line must include a valid procedure code.

Units of Service

Units represent the number of services provided.

Transportation by Bus, Train, or Air and Special Transportation Services

Units represent the number of one-way trips taken. Do not bill for mileage.

Meals and Lodging

Please refer to the latest Fee Schedule for the most current rates.

Required Attachments

Claims that require attachments must be billed on paper.

Timely Filing

The Colorado Medical Assistance Program timely filing period is 120 days from the date of service.

If the original timely filing (120 day) period expires, claims must be submitted within 60 days of the last remittance statement or adverse action. Refer to the General Claim Requirements section for complete information on timely filing.

CMS 1500 Paper Claim Reference Table

The following paper claim form reference table shows required, optional, and conditional fields and detailed field completion instructions for transportation claims on 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 Colorado Medical Assistance Program 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 patient'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**		

CMS Field #	Field Label	Field is?	Instructions
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.
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	

CMS Field #	Field Label	Field is?	Instructions
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 for electronic claims. Paper claims must have a wet signature. Enter the date the claim form was signed.
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**	Not Required	
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

CMS Field #	Field Label	Field is?	Instructions
			member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing. **TRANSPORTATION** When applicable, enter the word "TRANSPORT CERT" to certify that you have a transportation certificate or trip sheet on file for this service.
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 an independent or hospital laboratory.
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 **Transportation** Enter diagnosis code R68.89.
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, 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	Enter the six character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR

CMS Field #	Field Label	Field is?	Instructions
			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).
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 <u>Single Date of Service</u>: 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. <u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates. **County transportation and Waiver services**

CMS Field #	Field Label	Field is?	Instructions
			Providers should refer to specific billing instructions on the use of span billing. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes 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 Colorado Medical Assistance Program accepts the CMS place of service codes. 41 Transportation – Land 42 Transportation – Air or Water
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).

CMS Field #	Field Label	Field is?	Instructions
			Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Not Required	
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 (1) 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 four (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 (1) 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 (1) procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.

CMS Field #	Field Label	Field is?	Instructions
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 Colorado Medical Assistance Program 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. **Transportation** Units represent the number of one-way trips taken. Do not bill for mileage. **Meals and Lodging** Report units as the number of days of lodging and days of meals provided. Do not complete units to represent the number of meals provided. When the HCPCS code narrative indicates a round trip, bill one unit.
24H	**EPSDT/Family Plan**	Not Required	
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Not Required	
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).

CMS Field #	Field Label	Field is?	Instructions
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**		
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. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal 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: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.

CMS Field #	Field Label	Field is?	Instructions
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 Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
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 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

CMS 1500 Transportation Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 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 1/1/15

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): TRANS CERT

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 780 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	01	01	15	01	01	15	41	Y	A0429					A	150 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) YES [X] NO

28. TOTAL CHARGE $ 150 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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Transportation
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Transportation Third Party Claim - No Mileage Example

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) [X] 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): D444444

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 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): Client, Ima A

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 010101010

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: A-OK Insurance

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 1/1/15

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): TRANS CERT

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 780 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	01 01 15	01 01 15	41	Y	A0429		A	20 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 $ 20 00

29. AMOUNT PAID $ 10 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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Transportation
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Transportation Crossover Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) [X] 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): D444444

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

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

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

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: Medicare Policy Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM 10 DD 16 YY 45 SEX M [ ] F [X]

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 1/1/15

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 MM DD YY QUAL.

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): TRANS CERT

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 780 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	01	01	15	01	01	15	41	Y	A0429				A	20 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 $ 20 00

29. AMOUNT PAID $ 10 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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )
ABC Transportation
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

UB-04 Paper Claim Instructional Reference Table

The paper claim reference table below lists required and conditional fields for the paper UB-04 claim form for Hospital based transportation claims. For complete UB-04 paper claim instructions, see the Paper Claim Instructional Reference in the IP/OP Hospital Billing manual.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837I (wpc-edi.com), 837I Companion Guide (in the Provider Services Specifications section of the Department's Web site), and in the Web Portal User Guide (via within the portal).

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Inpatient/ Outpatient – Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Inpatient/Outpatient - Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Inpatient/Outpatient - Optional Enter the number assigned to the patient to assist in retrieval of medical records.

Form Locator and Label	Completion Format	Instructions
4. Type of Bill	3 digits	Required. Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): Digit 1 — Type of Facility 1 — Hospital Digit 2 — Bill Classification (Except clinics & special facilities): 3 — Outpatient Digit 3 — Frequency: 1 — Admit through discharge claim Enter 131.
5. Federal Tax Number	N/A	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required. Enter the From (beginning) date and Through (ending) date of service covered by this bill using MMDDYY format. *For Example:* January 1, 2014 = 0101014 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier	None	Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required. Enter the member's last name, first name and middle initial.
9a. Patient Address - Street	Characters Letters & numbers	Required. Enter the member's street/post office box as determined at the time of admission.

Form Locator and Label	Completion Format	Instructions
9b. Patient Address – City	Text	Inpatient/ Outpatient - Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Inpatient/ Outpatient - Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Inpatient/ Outpatient - Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Inpatient/ Outpatient - Optional
10. Birthdate	8 digits (MMDDCCYY)	Required. Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Required. Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	N/A	N/A
13. Admission Hour	N/A	N/A
14. Admission Type	N/A	N/A
15. Source of Admission	N/A	N/A
16. Discharge Hour	N/A	N/A
17. Patient Discharge Status	N/A	N/A

18-28.Condition Codes	2 Digits	Conditional. Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. <u>Condition Codes</u> 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 APR-DRG (Day outlier) <u>Renal dialysis settings</u> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility <u>Special Program Indicator Codes</u> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge

Form Locator and Label	Completion Format	Instructions
18-28.Condition Codes (continued)	2 Digits	PRO Approval Codes C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization Claim Change Reason Codes D3 Second/Subsequent interim PPS bill
29. Accident State	2 digits	Optional State's abbreviation where accident occurred
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. Occurrence Codes: 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 30 Preadmission testing 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date (continued)	2 digits and 6 digits	Occurrence Codes: A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 **Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information*
35-36. Occurrence Span Code From/ Through	N/A	N/A
38. Responsible Party Name/ Address	None	Submitted information is not entered into the claim processing system.
39-41. Value Code-Code Value Code-Amount	N/A	N/A
42. Revenue Code	4 digits	Required Complete for hospital based transportation. Use revenue code range 540-549.
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/HIPPS Rate Codes	5 digits	Conditional. Use only State assigned transportation codes. Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Do not use revenue codes. HCPCS codes must be identified for the following revenue codes: ▪ 054X Ambulance
27. Service Date	6 digits	Required. Not required for single date of service claims.

Form Locator and Label	Completion Format	Instructions
28. Service Units	3 digits	Required. The number of units cannot exceed 9,999,999 on a single detail line.
29. Total Charges	9 digits	Required. Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
30. Non-Covered Charges	N/A	N/A Non-covered charges cannot be billed for hospital based transportation services.
50. Payer Name	1 letter and text	Required. Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.

Form Locator and Label	Completion Format	Instructions
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID	N/A	Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Colorado Medical Assistance Program line. Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.

Form Locator and Label	Completion Format	Instructions
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number	N/A	Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).

Form Locator and Label	Completion Format	Instructions
66. Diagnosis Version Qualifier	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeroes to the diagnosis code. The Present on Admission (POA) indicator is required for inpatient claims. Document the POA in the gray area to the right side of the principal diagnosis code. Allowed responses are limited to: ✓ Y = Yes – present at the time of inpatient admission ✓ N = No – not present at the time of inpatient admission ✓ U = Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission ✓ W = Clinically Undetermined – the provider is unable to clinically determined whether the condition was present at the time of inpatient admission or not ✓ "1" on UB-04 ("Blank" on the 837I) = Unreported/Not used – diagnosis is exempt from POA reporting Outpatient Hospital Laboratory May use diagnosis code Z04.9 Hospital Based Transportation May use diagnosis code R68.89
67. Principal Diagnosis Code	Up to 6 digits	Required. Hospital based transportation claims enter diagnosis code. Provider may use code R68.89.
67A- Other 67Q. Diagnosis	N/A	N/A
69. Admitting Diagnosis Code	N/A	N/A
70. Patient Reason Diagnosis	N/A	N/A
71. PPS Code	N/A	Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
75. Unlabeled Field	N/A	N/A
76. Attending **NPI – Conditional** **QUAL - Conditional** ID - (Colorado Medical Assistance Provider #) – Required Attending - Last/ First Name	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Required. NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program. QUAL – Enter "1D " for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating-NPI/QUAL/ID	N/A	Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Conditional (see below) Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the Colorado Medical Assistance Program member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code QUAL/CODE/VALUE (a-d)	N/A	Submitted information is not entered into the claim processing system

UB-04 Transportation Claim Example

1 City Hospital
100 Saginaw St.
Anytown, CO 80000
333-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #

4 TYPE OF BILL: 131

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 01/10/14 THROUGH: 01/10/14

7

8 PATIENT NAME a b Client, Ian

9 PATIENT ADDRESS a 123 Main Street b Anytown c CO d 80000 e

10 BIRTHDATE: 11/11/1955

11 SEX: M

12 ADMISSION DATE

13 HR

14 TYPE: 1

15 SRC: 7

16 DHR

17 STAT: 09

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE a b

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE AMOUNT a b

40 VALUE CODES CODE AMOUNT c

41 VALUE CODES CODE AMOUNT d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	540	Ambulance	A0428	01/20/14	1	97:35		
2	549	Mileage	A0425	01/20/14	15	24:00		
3–22								
23		PAGE 1 OF 1	CREATION DATE		TOTALS	121:35		

50 PAYER NAME: A D - Medicaid

51 HEALTH PLAN ID: 12345678

52 REL. INFO

53 ASG. BEN.

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56 NPI

57 OTHER PRV ID

58 INSURED'S NAME: A Client, Ian

59 P. REL.

60 INSURED'S UNIQUE ID: A123456

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX: 780 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

75

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS

81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section of the Department's website.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements.

Billing Instruction Detail	Instructions
	Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.

Billing Instruction Detail	Instructions
	File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services Billing Manuals section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare

Billing Instruction Detail	Instructions
	coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

COLORADO
Department of Health Care Policy & Financing

Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ **Date:** _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a) (1-2) to be attached to paper claims submitted on the UB-04.

Transportation Billing Manual Revisions Log

Revision Date	Section/Action	Pages	Made by
01/17/2014	*Created*	*All*	*jg*
01/21/2014	*Added 2 new HCPCS: S9960 and S9961*	*13*	*cc*
01/22/2014	*Reformatted* *Updated claim examples* *Added PAR Requirements for S9960 and S9961* *Updated TOC*	*Throughout* *25, 26, 27 & 40* *13* *i & ii*	*Jg*
08/29/2014	*Updated web links for the Department's new website*	*Throughout*	*MM*
04/29/2015	*Updated formatting and reviewed for wording. Verified processes with policy specialist. Removed Authorization Request requirement for Trains. Updated and removed wording around Prior Authorization requests and processes as the policy specialist has removed PARs and will individually review air transport.*	*Throughout*	*JH*
05/01/2015	*Minor formatting throughout*	*Throughout*	*Bl*
9/2/15	*Removed mention of ICD 9 and replaced ICD-9 with 10 codes*	*11, 15, 34*	*JH*
09/08/2015	*Accepted changes and updated TOC*	*Throughout*	*bl*

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.