Colorado Choice Transitions (CCT) Program Reference Manual

Colorado Choice Transitions Program (CCT)

Program Overview

Colorado Choice Transitions (CCT), part of the federal Money Follows the Person Rebalancing Demonstration, is a five-year grant program. The primary goal is facilitating the transition of Health First Colorado (Colorado's Medicaid Program) members from nursing and other long-term care (LTC) facilities to the community using home and community based (HCBS) services and supports. Services are intended to promote independence, improve the transition process, and support individuals in the community. Participants of the CCT program will have access to qualified waiver services as well as demonstration services. They will be enrolled in the program for up to 365 days after which time they will enroll into one of five HCBS waivers so long as they remain Medicaid eligible. Days in a hospital or LTC facility for a period of less than 30 days during the enrollment period will not count towards the 365 days. Qualified services are HCBS waiver services that will continue once the CCT program has ended if the member continues to be eligible for HCBS. Demonstration services are enhanced services provided during an individual's enrollment in the demonstration program post-transition and end on the last day of CCT enrollment. The grant funding will also be used to streamline and improve the HCBS systems in Colorado.

Health First Colorado members participating in CCT must meet long-term care Health First Colorado eligibility requirements (which include functional and financial eligibility); reside in a long-term care facility for a period of no less than ninety days (90) not counting days for rehabilitation; have been Medicaid eligible for one day; and be willing to move to qualified housing as defined in federal statute. To participate, members must meet financial, medical, and program criteria to access services through the CCT program and be willing to receive services in their homes or communities. A member who receives services through the CCT program is also eligible for all Health First Colorado State Plan services. When a member chooses to receive services under a waiver and the CCT program, the services must be provided by certified Health First Colorado providers.

The CCT program will complement the Elderly, Blind, and Disabled Waiver, Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Persons with Developmental Disabilities Wavier, and Supported Living Services Waiver. The populations that will be transitioned through the program include: elderly adults aged 65 years or older residing in Health First Colorado nursing facilities; adults aged 18-64 with physical disabilities residing in Health First Colorado nursing facilities; adults aged 18 and older with developmental disabilities residing in Intermediate Care Facilities (ICFs) and Health First Colorado nursing facilities; and adults 65 years and older and individuals under 22 residing in institutions for mental disease (IMDs).

Note: The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

Policy Guidance for Services

The Services and Supports Desk Reference offers essential information on CCT demonstration services to providers, members, and stakeholders. The information includes service definitions, minimum provider qualifications, service rates, and other pertinent information. The Department may periodically modify policy guidance.

Providers are notified of changes in policy guidance in the monthly HCBS Provider Bulletin and other Department communications.

Provider Participation

Before claims can be accepted for payment of goods and services provided to eligible members, the provider of goods and services must be enrolled in the Health First Colorado and assigned a provider number.

Prior Authorization Requests (PARs) for CCT

All CCT services require prior approval before they can be reimbursed by the Health First Colorado. Case management agencies (CMA) complete the Prior Authorization Request for CCT according to instructions provided by the Department.

The case management agencies responsibilities include, but are not limited to:

1. Assessing needs;
2. Determining CCT program eligibility;
3. Service planning and authorization;
4. Care coordination;
5. Risk mitigation;
6. Service monitoring;
7. Monitoring the health, welfare and safety of the member;
8. Promotion of member's self-advocacy; and
9. Coordination of the member's transition from the CCT program to one of the existing HCBS waivers at the end of the member's participation on the CCT program, as long as the member remains eligible.

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

Prior approvals must be completed thoroughly and accurately. If an error is noted on an approved request, it should be brought to the attention of the member's case manager and the Department for corrections. Procedure codes, quantities, etc., may be changed or entered by the member's case manager.

The authorizing agent or case management agency is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

PAR Submission

All CCT PAR forms are filed via the "Bridge" which directly interfaces with the Colorado interChange System. Access to the Bridge is accomplished via the Medicaid Enterprise User Provisioning System (MEUPS) which can be found at https://home.co-meups.xco.dcs-usps.com/home/.

Consumer Directed Attendant Support Services (CDASS)

For members authorized to receive CDASS, case managers will need to enter the data into the web portal maintained by Financial Management Service Provider (FMS) in addition to sending a PAR to the Department.

Case managers may also use the PAR form maintained by FMS to create the entire PAR for a member receiving CDASS as a part of the CCT program. In addition, case managers will need to fax the final PAR approval letter to FMS before attendant timesheets will be paid.

PAR Form Instructional Reference Table

Field Label	Completion Format	Instructions
PA Number being revised		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
Revision	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Client Name	Text	Required Enter the member's last name, first name, and middle initial. Example: Adams, Mary A.
Client ID	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
Sex	Check box ☐ M ☐ F	Required Check the appropriate box.
Birthdate	6 numbers (MM/DD/YY)	Required Enter the member's birth date using MM/DD/YY format. Example: January 1, 2010 = 01/01/10.

Field Label	Completion Format	Instructions
Date of Discharge	6 numbers (MM/DD/YY)	Required Enter the member's date of discharge from qualified facility.
Requesting Physician Provider #	8 numbers	Required Enter the eight-digit Health First Colorado provider number of the requesting provider.
Client's County	Text	Required Enter the member's county of residence.
Case Number (Agency Use)	Text	Optional Enter up to twelve characters, (numbers, letters, and hyphens), which help identify the claim or member.
Dates Covered (From/Through)	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.
Qualified/Demonstration Services Description	Text	N/A List of approved procedure codes for qualified and demonstration services.
Modifier	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
Max # Units	Number	Required Enter the number of units next to the services being requested for reimbursement.
Cost Per Unit	Dollar Amount	Required Enter cost per unit of service.
Total $ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.

Field Label	Completion Format	Instructions
Comments	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here.
Total Authorized CCT Qualified Service Expenditures	Dollar Amount	Required Total automatically populates.
Total Authorized CCT Demonstration Service Expenditures	Dollar Amount	Required Total automatically populates.
Grand Total of CCT Qualified and Demonstration Services	Dollar Amount	Required Total automatically populates.
Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period)	Dollar Amount	Required Enter the total Authorized Home Health expenditures.
Equals Client's Maximum Authorized Cost	Dollar Amount	Required The sum of CCT Expenditures + Home Health Expenditures automatically populates.
Number of Days Covered	Number	Required The number of days covered automatically populates.
Average Cost Per Day	Dollar Amount	Required The member's maximum authorized cost divided by number of days in the care plan period automatically populates.
CDASS Effective Date Monthly Allocation Amt.	 Date (MM/DD/YY) Dollar Amount	Required for MI, EBD 65+ and EBD-PD Enter CDASS information (All CDASS information must be entered in PPL's web portal).

Field Label	Completion Format	Instructions
Immediately prior to CCT enrollment, this client lived in a long-term care facility	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Case Manager Name	Text	Required Enter the name of the Case Manager.
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
Email	Text	Required Enter the email address of the Case Manager.
Date	6 Numbers (MM/DD/YY)	Required Enter the date completed.
Case Manager's Supervisor Name	Text	Required Enter the name of the Case Manager's Supervisor.
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager's Supervisor.
Email	Text	Required Enter the email address of the Case Manager's Supervisor.
Date	6 Numbers (MM/DD/YY)	Required Enter the date of PAR completion.

Claim Submission

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, DXC Technology (DXC), P.O. Box 30, Denver, CO 80201-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires approval)
- Claims that, by policy, require attachments
    - Note: Attachments may be submitted electronically
- Reconsideration claims

For more detailed CMS 1500 billing instructions, please refer to the CMS 1500 General Billing Information manual in the Provider Services Billing Manuals section.

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 EDI SUPPORT SECTION OF THE DEPARTMENT'S WEBSITE (EDI-SUPPORT)
- Online Portal USER GUIDE (VIA WITHIN THE ONLINE PORTAL)

The Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Online Portal (Online Portal) or via batch submission through a host system. Please refer to the Colorado General Provider Information Manual for additional electronic information.

Paper Claim Reference Table

The following paper form reference table gives required fields for the CMS 1500 paper claim form for CCT services.

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: 070115 for July 1, 2015.

CMS Field #	Field Label	Field is?	Instructions
			Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	
10a-c	**Is Patient's Condition Related to?**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Not Required	
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.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Not Required	
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) Colorado Choice Transitions providers may use R69.
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**	Not Required	**HCBS** Leave blank
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.

CMS Field #	Field Label	Field is?	Instructions
			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: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** 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. **Waiver services** Providers should refer to specific billing instructions on the use of span billing.
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. 12 Home
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. **Waiver services**

CMS Field #	Field Label	Field is?	Instructions
			Providers should refer to the Member's approved Prior Authorization (PAR).
24D	**Modifier**	Required	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. **Waiver services** Providers should refer to the Member's approved Prior Authorization (PAR).
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.

CMS Field #	Field Label	Field is?	Instructions
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. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one detail line. Dates of service do not have to be reported separately. Example: If forty units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 01/03/XX and a To Date of 01/31/XX and 40 units.
24H	**EPSDT/ Family Plan**	Not Required	
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	Enter the NPI number of the provider performing the service.
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**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
30	**Reserved 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: 070116 for July 1, 2016. **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.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- 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 Required 33b- Other ID # If the Provider Type is not able to obtain an NPI, enter the eight-digit Health First Colorado provider number of the individual or organization.

CMS Field #	Field Label	Field is?	Instructions
33	**33- Billing Provider Info & Phone #** **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 Required 33b- Other ID # If the Provider Type is not able to obtain an NPI, enter the eight-digit Health First Colorado provider number of the individual or organization.

Procedure/HCPCS Codes Overview

The Department uses procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Health First Colorado members. The procedure codes 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 CPT (Current Procedural Terminology), 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. These include 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. CPT codes are identified using 5 numeric digits.

CCT Procedure Code Table

Providers may bill the following procedure codes for the CCT program. Below is a breakdown of services by population.

CCT- BI Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Qualified Services			
Adult Day Services	S5102	UC	1 unit = 1 day
Assistive Technology, per purchase	T2029	UC, HB	1 unit = 1 purchase
Behavioral Programming	H0025	UC, TF	1 unit = 30 minutes
CDASS (Cent/Unit)	T2025	UC	1 unit = 1 cent
CDASS Per Member/Per Month	T2040	UC	1 unit = 1 month
Day Treatment	H2018	UC	1 unit = 1 day
Home Modifications	S5165	UC	1 unit = 1 modification
Independent Living Skills Training (ILST)	T2013	UC	1 unit = 1 hour
Mental Health Counseling, Family	H0004	UC, HR	1 unit = 15 minutes
Mental Health Counseling, Group	H0004	UC, HQ	1 unit = 15 minutes
Mental Health Counseling, Individual	H0004	UC	1 unit = 15 minutes
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC, TG	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit = 1 purchase

CCT- BI Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
PERs, Monitoring	S5161	UC	1 unit = 1 month of service
Relative Personal Care	T1019	UC, HR, TG	1 unit = 15 minutes
Respite Care, In Home	S5150	UC	1 unit = 15 minutes
Respite Care, NF	H0045	UC, TF	1 unit = 1 day
Substance Abuse Counseling, Family	T1006	UC, HR, HF	1 unit = 1 hour
Substance Abuse Counseling, Group	H0047	UC, HQ, TF, HF	1 unit = 1 hour
Substance Abuse Counseling, Individual	H0047	UC, TF, HF	1 unit = 1 hour
Supported Living Program	T2033	UC	1 unit = 1 day
Transitional Living, per day	T2016	UC, HB	1 unit = 1 day
Demonstration Services			
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes

CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Qualified Services			
Adult Day Services, Basic	S5105	UC	1 unit = 4-5 hours
Adult Day Services, Specialized	S5105	UC, TF	1 unit = 3-5 hours
Consumer Directed Attendant Support Services (CDASS), (Cent/Unit)	T2025	UC	1 unit = 1 cent
CDASS Per Member/ Per Month (PM/PM)	T2040	UC	1 unit = 1 month
Home Modifications	S5165	UC	1 unit = 1 modification
Homemaker	S5130	UC	1 unit = 15 minutes
IHSS Health Maintenance Activities	H0038	UC	1 unit = 15 minutes
IHSS Homemaker	S5130	UC, KX	1 unit = 15 minutes
IHSS Personal Care	T1019	UC, KX	1 unit = 15 minutes
IHSS Relative Personal Care	T1019	UC, HR, KX	1 unit = 15 minutes

CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Medication Reminder, Install/Purchase	T2029	UC, TF	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UC	1 unit = 1 month
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit =1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month
Relative Personal Care	T1019	UC, HR	1 unit = 15 minutes
Respite Care, ACF	S5151	UC	1 unit = 1 day
Respite Care, In Home	S5150	UC	1 unit = 15 minutes
Respite Care, NF	H0045	UC	1 unit = 1 day
Demonstration Services			
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Independent Living Skills Training (ILST)	H2014	UC	1 unit = 15 minutes

CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Transitional Behavioral Health Supports	H0025	UC	1 unit = 30 minutes

CCT- EBD 18- 64 Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Qualified Services			
Adult Day Services, Basic	S5105	UC	1 unit = 4-5 hours
Adult Day Services, Specialized	S5105	UC, TF	1 unit = 3-5 hours
Consumer Directed Attendant Support Services (CDASS), (Cent/Unit)	T2025	UC	1 unit = 1 cent
CDASS Per Member/ Per Month (PM/PM)	T2040	UC	1 unit = 1 month
Home Modifications	S5165	UC	1 unit = 1 modification
Homemaker	S5130	UC	1 unit = 15 minutes
IHSS Health Maintenance Activities	H0038	UC	1 unit = 15 minutes
IHSS Homemaker	S5130	UC, KX	1 unit = 15 minutes
IHSS Personal Care	T1019	UC, KX	1 unit = 15 minutes
IHSS Relative Personal Care	T1019	UC, HR, KX	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UC, TF	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UC	1 unit = 1 month
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			

CCT- EBD 18- 64 Services Procedure Code Table (Special Program Code 95)

Description	Procedure Code + Modifier(s)		Units
Qualified Services			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit =1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month
Relative Personal Care	T1019	UC, HR	1 unit = 15 minutes
Respite Care, ACF	S5151	UC	1 unit = 1 day
Respite Care, In Home	S5150	UC	1 unit = 15 minutes
Respite Care, NF	H0045	UC	1 unit = 1 day
Demonstration Services			
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Independent Living Skills Training (ILST)	H2014	UC	1 unit = 15 minutes
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Transitional Behavioral Health Supports	H0025	UC	1 unit = 30 minutes

CCT- CMHS Services Procedure Code Table (Special Program Code 95)

Description	Procedure Code + Modifier(s)		Units
Qualified Services			
Adult Day Services, Basic	S5105	UC	1 unit = 4-5 hours
Adult Day Services, Specialized	S5105	UC, TF	1 unit = 3-5 hours

CCT- CMHS Services Procedure Code Table (Special Program Code 95)			
Description		**Procedure Code + Modifier(s)**	**Units**
Consumer Directed Attendant Support Services (CDASS), (Cent/Unit)	T2025	UC	1 unit = 1 cent
CDASS Per Member/ Per Month (PM/PM)	T2040	UC	1 unit = 1 month
Home Modifications	S5165	UC	1 unit = 1 modification
Homemaker	S5130	UC	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UC, TF	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UC	1 unit = 1 month
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit =1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month
Relative Personal Care	T1019	UC, HR	1 unit = 15 minutes
Respite Care, ACF	S5151	UC	1 unit = 1 day
Respite Care, NF	H0045	UC	1 unit = 1 day
Demonstration Services			
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase

CCT- CMHS Services Procedure Code Table (Special Program Code 95)			
Description		**Procedure Code + Modifier(s)**	**Units**
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Independent Living Skills Training (ILST)	H2014	UC	1 unit = 15 minutes
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Transitional Behavioral Health Supports	H0025	UC	1 unit = 30 minutes

CCT- DD Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Qualified Services				
Behavioral Services				
Line Service	H2019	UC		1 unit = 15 minutes
Behavioral Consultation	H2019	UC, HI, TG		1 unit = 15 minutes
Behavioral Counseling, Individual	H2019	UC, TF, TG		1 unit = 15 minutes
Behavioral Counseling, Group	H2019	UC, TF, HQ		1 unit = 15 minutes
Behavioral Plan Assessment	T2024	UC, HI		1 unit = 15 minutes
Day Habilitation				
Specialized Day Habilitation	T2021 T2021 T2021 T2021 T2021 T2021 T2021	UC, HQ UC. HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ UC, SC, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Supported Community Connections	T2021 T2021 T2021 T2021 T2021 T2021 T2021	UC UC, HI UC, TF UC, TF, HI UC, TG UC, TG, HI UC, SC	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes

CCT- DD Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Dental				
Dental, Basic/ Preventive	D2999	UC, HI		1 unit = 1 dollar
Dental, Major	D2999	UC, TF		1 unit = 1 dollar
Non- Medical Transportation				
To/From Day Program, Mileage Range	T2003 T2003 T2003	UC UC, HI UC, TF	0-10 Miles 11-20 Miles 21- up Miles	1 unit = 2 trips per day 1 unit = 2 trips per day 1 unit = 2 trips per day
Other (Public Conveyance)	T2004	UC		1 unit = 1 dollar
Pre-Vocational Services				
Pre-Vocational Services	T2015 T2015 T2015 T2015 T2015 T2015	UC, HQ UC, HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Residential Services				
Group Home	T2016 T2016 T2016 T2016 T2016 T2016 T2016	UC, HQ UC, HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ UC, SC, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Personal Care Alternative	T2016 T2016 T2016 T2016 T2016 T2016 T2016	UC UC, HI UC, TF UC, TF, HI UC, TG UC, TG, HI UC, SC	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day

CCT- DD Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Host Home	T2016 T2016 T2016 T2016 T2016 T2016 T2016	UC, TT UC, HI, TT UC, TF, TT UC, TF, HI, TT UC, TG, TT UC, TG, HI, TT UC, SC, TT	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = 1 day 1 unit = individual approved rate
Supported Employment				
Supported Employment, Individual, All Levels (1-6)	T2019	UC, SC	All Levels (1-6)	1 unit = 15 minutes
Supported Employment, Group	T2019 T2019 T2019 T2019 T2019 T2019	UC, HQ UC, HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Job Development, Individual, Level 1-2	H2023	UC	Level 1-2	1 unit = 15 minutes
Job Development, Individual, Level 3-4	H2023	UC, HI	Level 3-4	1 unit = 15 minutes
Job Development, Individual, Level 5-6	H2023	UC, TF	Level 5-6	1 unit = 15 minutes
Job Development, Group, All Levels	H2023	UC, HQ	All Levels (1-6)	1 unit = 15 minutes
Job Placement, Individual, All Levels (1-6)	H2024	UC	All Levels (1-6)	1 unit = 1 dollar
Job Placement, Group, All Levels (1-6)	H2024	UC, HQ	All Levels (1-6)	1 unit = 1 dollar
Specialized Medical Equipment				
Specialized Medical Equipment and Supplies, Disposable	T2028	UC		1 unit = 1 dollar
Specialized Medical Equipment	T2029	UC, TF		1 unit = 1 dollar
Vision	V2799	UC, HI		1 unit = 1 dollar
Demonstration Services				
Assistive Technology, Extended	T2029	UC		1 unit = 1 purchase

CCT- DD Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Caregiver Education	S5110	UC		1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC		1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC		1 unit = 1 purchase
Intensive Case Management	T1016	UC		1 unit = 15 minutes
Peer Mentorship	H2015	UC		1 unit = 15 minutes

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Qualified Services				
Assistive Technology *	T2035	UC		1 unit = 1 dollar
Mentorship	H2021	UC		1 unit = 15 minutes
Personal Care	T1019	UC, TF		1 unit = 15 minutes
Personal Emergency Response (PERs)	S5161	UC		1 unit = 1 dollar
Vehicle Modifications *	T2039	UC		1 unit = 1 dollar
Vision *	V2799	UC, HI		1 unit = 1 dollar
Behavioral Services				
Line Services	H2019	UC		1 unit = 15 minutes
Behavioral Consultation	H2019	UC, HI, TG		1 unit = 15 minutes
Behavioral Counseling, Group	H2019	UC, TF, HQ		1 unit = 15 minutes
Behavioral Counseling, Individual	H2019	UC, TF, TG		1 unit = 15 minutes
Behavioral Plan Assessment	T2024	UC, HI		1 unit = 15 minutes
Day Habilitation				

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Specialized Day Habilitation	T2021 T2021 T2021 T2021 T2021 T2021	UC, HQ UC. HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Supported Community Connections	T2021 T2021 T2021 T2021 T2021 T2021	UC UC, HI UC, TF UC, TF, HI UC, TG UC, TG, HI	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Dental				
Dental, Basic/ Preventive Services *	D2999	UC, HI		1 unit = 1 dollar
Dental, Major Services *	D2999	UC, TF		1 unit = 1 dollar
Homemaker				
Homemaker, Basic	S5130	UC, HI		1 unit = 15 minutes
Qualified Services				
Homemaker, Enhanced	S5130	UC, TF		1 unit = 15 minutes
Home Accessibility Adaptations *	S5165	UC		1 unit = 1 dollar
Non- Medical Transportation				
To/From Day Program, Mileage Range *	T2003 T2003 T2003	UC UC, HI UC, TF	0-10 Miles 11-20 Miles 21- up Miles	1 unit = 2 trips per day 1 unit = 2 trips per day 1 unit = 2 trips per day

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Mileage Not Day Program *	T2003	UC, HB		1 unit = 4 trips per week
Other (Public Conveyance) *	T2004	UC		1 unit = 1 dollar
Pre-Vocational Services				
Pre-Vocational Services	T2015 T2015 T2015 T2015 T2015 T2015	UC, HQ UC, HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Professional Services				
Massage Therapy	97124	UC		1 unit = 15 minutes
Movement Therapy, Bachelor's Degree	G0176	UC, HN		1 unit = 15 minutes
Movement Therapy, Master's Degree	G0176	UC		1 unit = 15 minutes
Hippotherapy, Group	S8940	UC, HQ		1 unit = 15 minutes
Hippotherapy, Individual	S8940	UC		1 unit = 15 minutes
Rec Pass, Access Fee	S5199	UC		1 unit = 1 dollar
Respite Care				
Respite Care, Camp	T2036	UC		1 unit = 1 dollar
Respite Care, Group	S5151	UC, HQ, TG		1 unit = 1 dollar
Respite Care, Individual, 15 Minutes	S5150	UC, TG		1 unit = 15 minutes
Respite Care, Individual, Day	S5151	UC, TG		1 unit = 1 dollar
Qualified Services				
Specialized Medical Equipment and Supplies				

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Specialized Medical Equipment and Supplies, Disposable	T2028	UC		1 unit = 1 dollar
Specialized Medical Equipment	T2029	UC, TF		1 unit = 1 dollar
Supported Employment				
Supported Employment, Individual, All Levels (1-6)	T2019	UC, HI	All Levels (1-6)	1 unit = 15 minutes
Supported Employment, Group	T2019 T2019 T2019 T2019 T2019 T2019	UC, HQ UC, HI, HQ UC, TF, HQ UC, TF, HI, HQ UC, TG, HQ UC, TG, HI, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes 1 unit = 15 minutes
Job Development, Individual, Level 1-2	H2023	UC	Level 1-2	1 unit = 15 minutes
Job Development, Individual, Level 3-4	H2023	UC, HI	Level 3-4	1 unit = 15 minutes
Job Development, Individual, Level 5-6	H2023	UC, TF	Level 5-6	1 unit = 15 minutes
Job Development, Group, All Levels	H2023	UC, HQ	All Levels (1-6)	1 unit = 15 minutes
Job Placement, Individual, All Levels (1-6)	H2024	UC	All Levels (1-6)	1 unit = 1 dollar
Job Placement, Group, All Levels (1-6)	H2024	UC, HQ	All Levels (1-6)	1 unit = 1 dollar
Demonstration Services				
Caregiver Education	S5110	UC		1 unit = 15 minutes
Community Transition Services, Coordinator *	T2038	UC		1 unit = 1 transition
Community Transition Services, Items Purchased *	A9900	UC		1 unit = 1 purchase

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Demonstration Services				
Independent Living Skills Training (ILST)	H2014	UC		1 unit = 15 minutes
Intensive Case Management *	T1016	UC		1 unit = 15 minutes
*** Outside of Service Plan Authorization Limit (SPAL)**				

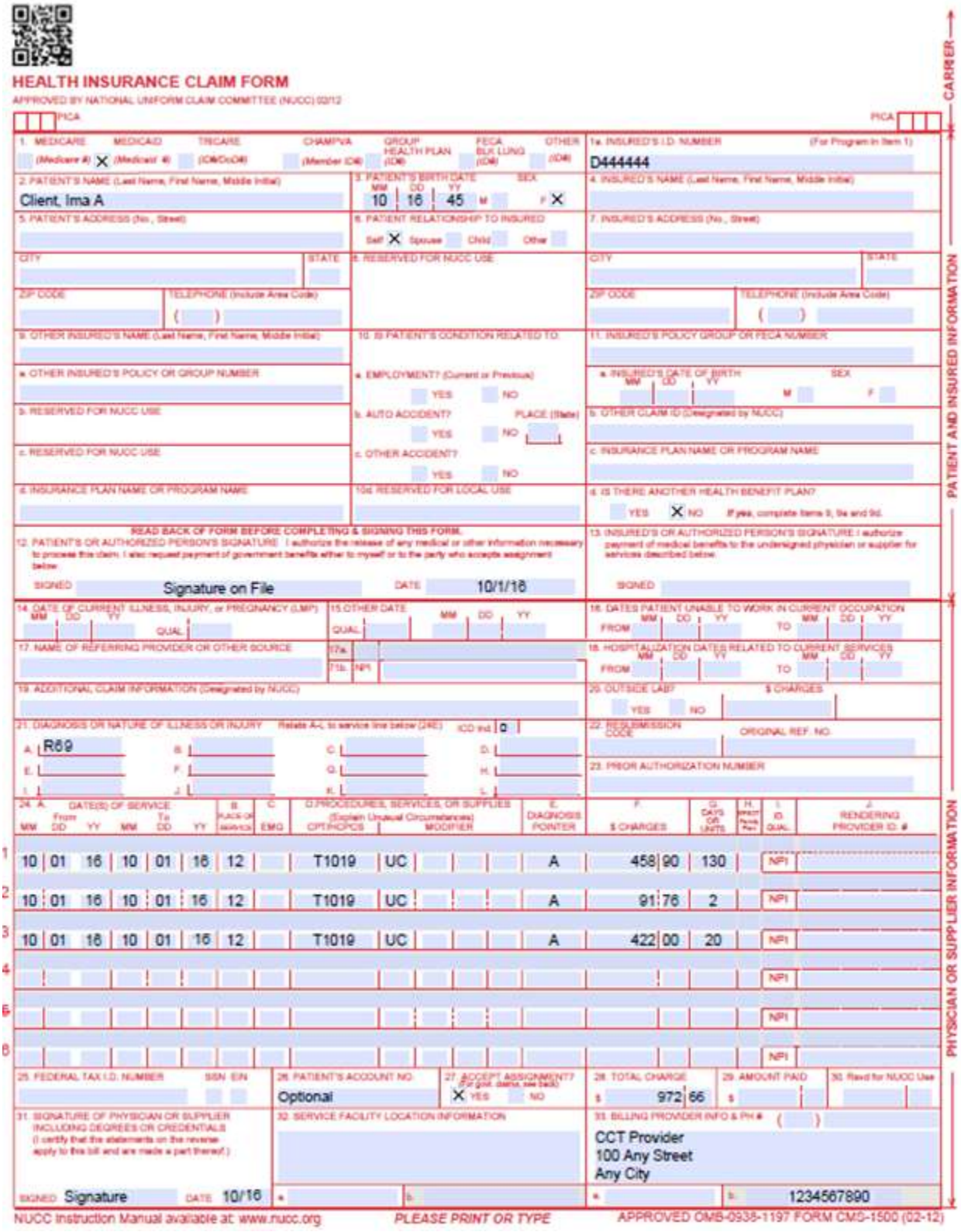
Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado 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.

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 fine and imprisonment under state and/or federal law.

CCT Claim Examples

CMS 1500 CCT-BI 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 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. R69 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	10 01 16	10 01 16	12		T1019	UC	A	458 90	130		NPI
2	10 01 16	10 01 16	12		T1019	UC	A	91 76	2		NPI
3	10 01 16	10 01 16	12		T1019	UC	A	422 00	20		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 $ 972 66

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 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

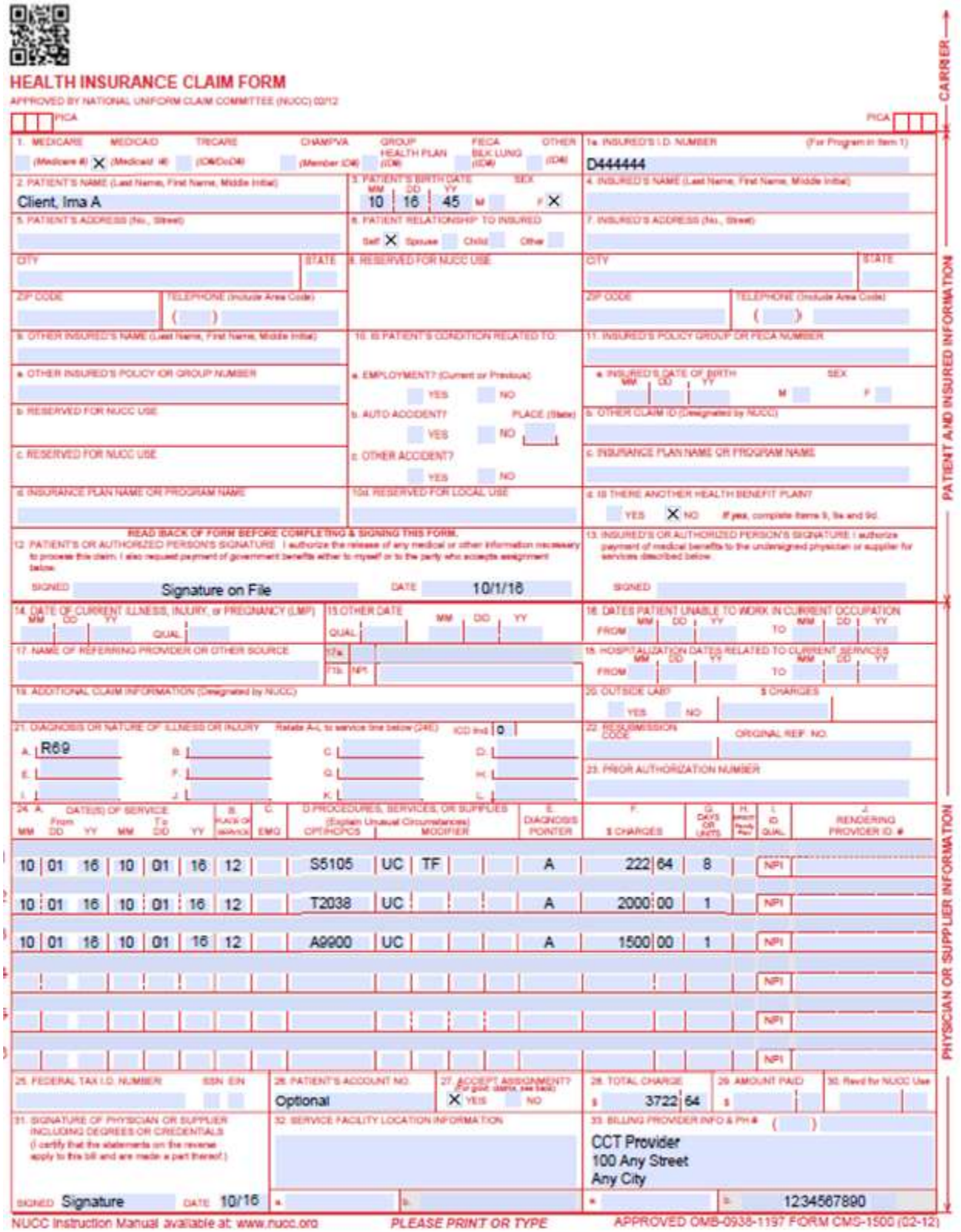
a. b. 1234567890

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)

CMS 1500 CCT-CMHS 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: D444444

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

3. PATIENT'S BIRTH DATE: 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. R69 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. #
10	01	16	10	01	16	12		S5105	UC TF	A	222 64	8		NPI	
10	01	16	10	01	16	12		T2038	UC	A	2000 00	1		NPI	
10	01	16	10	01	16	12		A9900	UC	A	1500 00	1		NPI	
														NPI	
														NPI	
														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 $ 3722 64

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 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. b. 1234567890

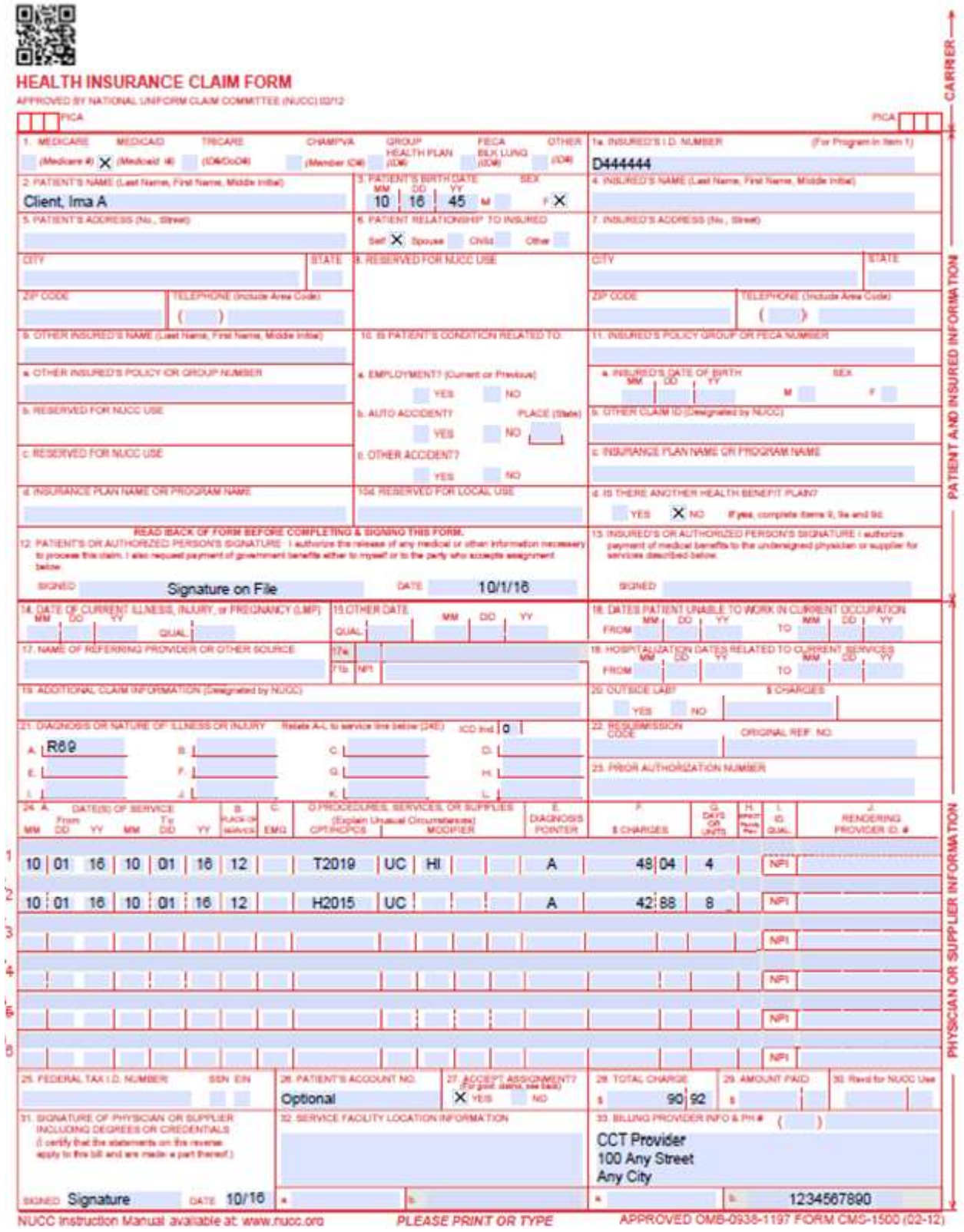
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500 CCT-DD 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 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 MM DD YY | QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. R69 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	10 01 16	10 01 16	12		T2019	UC HI	A	48 04	4		NPI
2	10 01 16	10 01 16	12		H2015	UC	A	42 88	8		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 $ 90 92

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 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. b. 1234567890

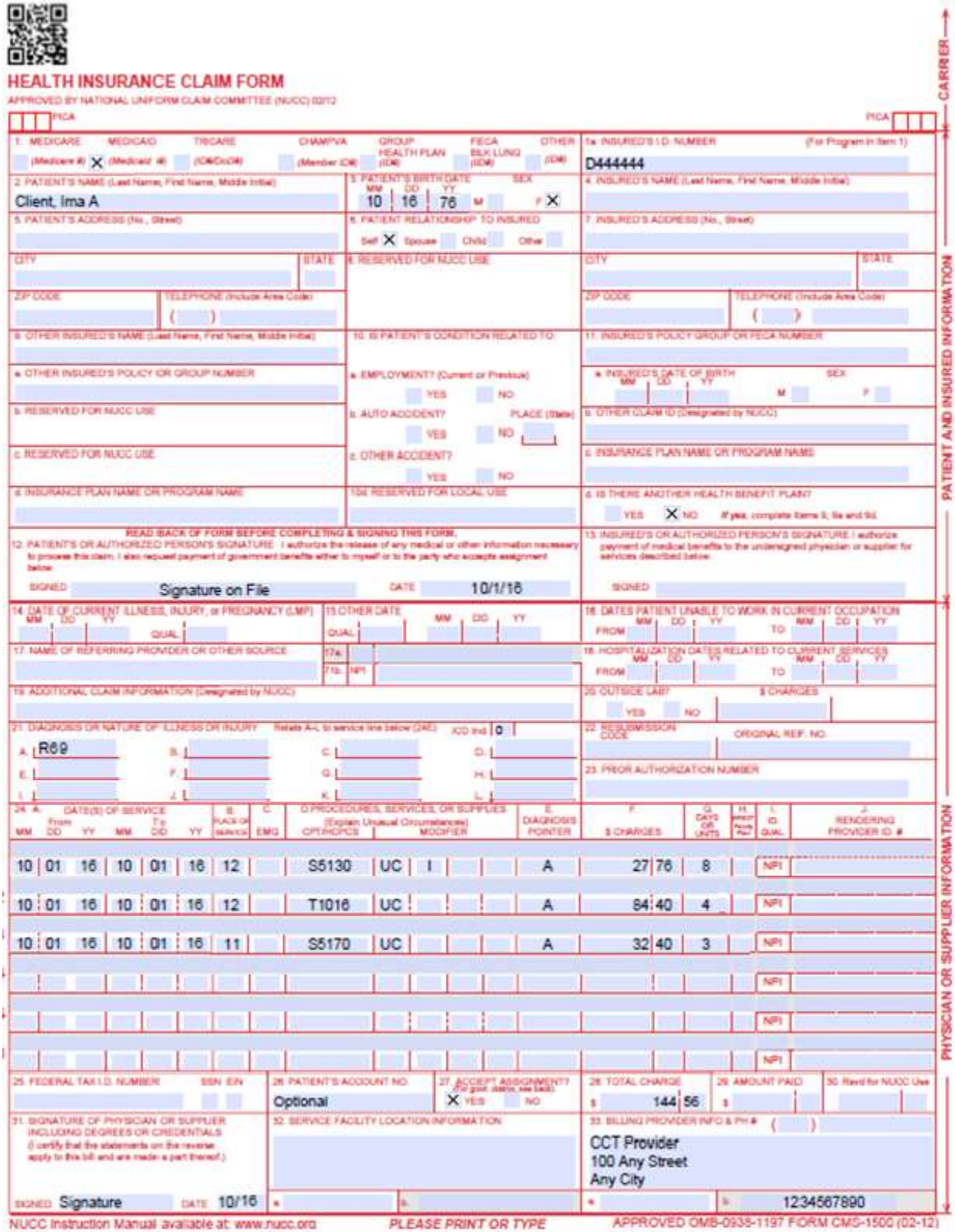
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500 CCT-EBD (18-64) 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 76 | 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 MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

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

A. R69 | 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. #
10 01 16	10 01 16	12		S5130	UC I	A	27 76	8		NPI	
10 01 16	10 01 16	12		T1016	UC	A	84 40	4		NPI	
10 01 16	10 01 16	11		S5170	UC	A	32 40	3		NPI	
										NPI	
										NPI	
										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 $ 144 56

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 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. | b. 1234567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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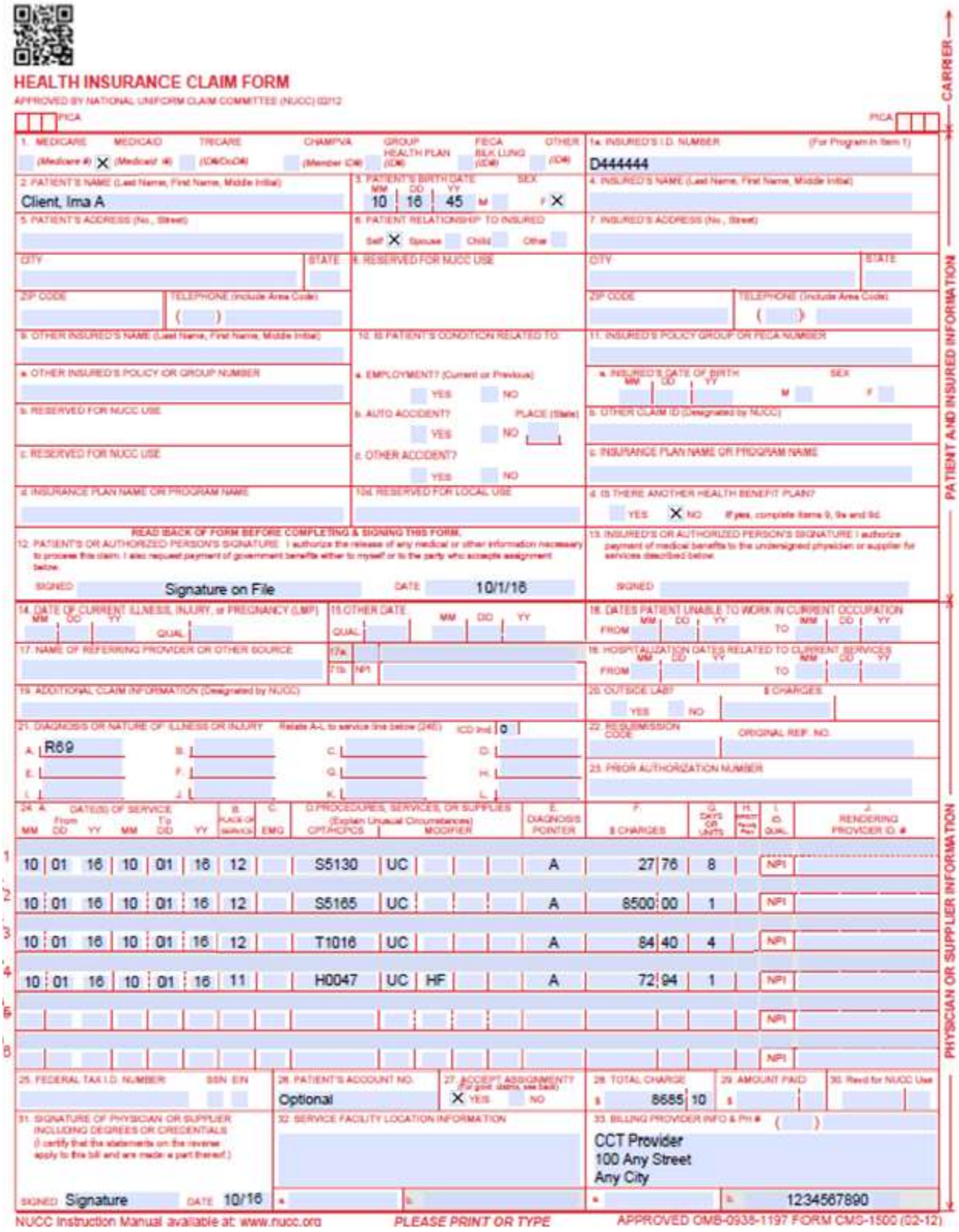
CMS 1500 CCT-EBD (65+) Claim Example



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 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. R69 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	10 01 16	10 01 16	12		S5130	UC			A	27 76	8		NPI	
2	10 01 16	10 01 16	12		S5165	UC			A	8500 00	1		NPI	
3	10 01 16	10 01 16	12		T1016	UC			A	84 40	4		NPI	
4	10 01 16	10 01 16	11		H0047	UC	HF		A	72 94	1		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 $ 8685 10

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 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. b. 1234567890

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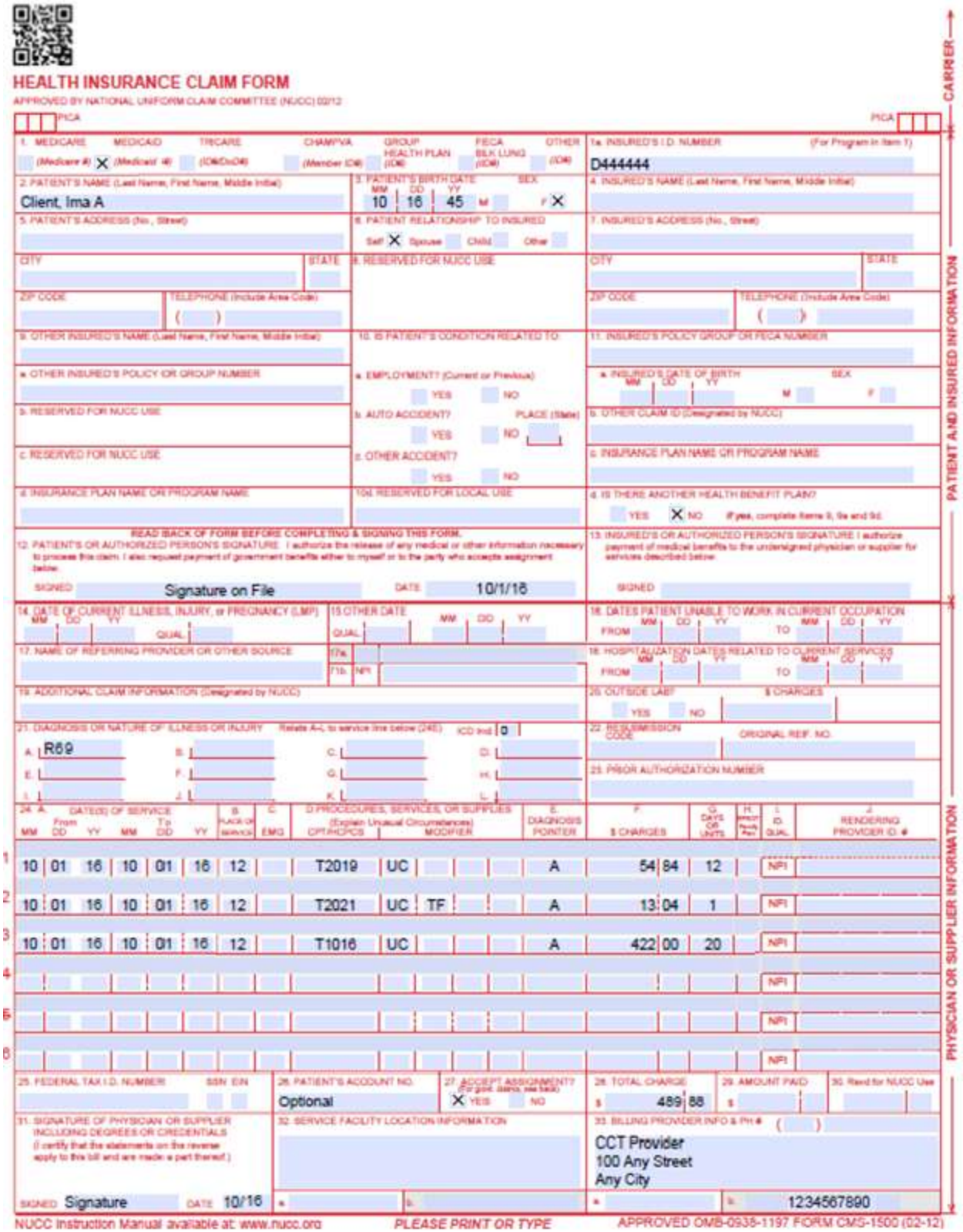
PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

CMS 1500 CCT-SLS 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: 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. R69 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	10 01 16	10 01 16	12		T2019	UC			A	54 84	12		NPI	
2	10 01 16	10 01 16	12		T2021	UC	TF		A	13 04	1		NPI	
3	10 01 16	10 01 16	12		T1016	UC			A	422 00	20		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 $ 489 88

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: 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. b. 1234567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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CCT 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 Manual Comment Log v0_2.xlsx*	*Multiple*	*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*	*11*	*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*	*8*	*DXC*

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.*