Colorado Choice Transitions (CCT) Program Reference Manual

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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 Medicaid 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.

Medicaid members participating in CCT must meet long-term care Medicaid 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 Medicaid State Plan services. When a member chooses to receive services under a waiver and the CCT program, the services must be provided by certified Medicaid 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 Medicaid nursing facilities; adults aged 18-64 with physical disabilities residing in Medicaid nursing facilities; adults aged 18 and older with developmental disabilities residing in Intermediate Care Facilities (ICFs) and Medicaid 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 Colorado Medical Assistance program and assigned a provider number.

Prior Authorization Requests (PARs) for CCT

All CCT services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case management agencies 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 Colorado Medical Assistance Program 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 Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, provider information completed appropriately, required attachments included, etc.) before payment can be made.

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 fillable electronically and are located in the Provider Services Forms section of the Department's Website. The use of the forms is strongly encouraged due to the complexity of the calculations.

Send all New, Continued Stay Review (CSR), and Revised PARs for CCT to Xerox State Healthcare:

Xerox State Healthcare
PARs
P.O. Box 30
Denver, CO80201-0030

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 Public Partnerships, Limited (PPL) in addition to sending a PAR to the Department.

Case managers may also use the PAR form maintained by PPL 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 PPL 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.

Field Label	Completion Format	Instructions
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.
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 Colorado Medical Assistance Program 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.

Field Label	Completion Format	Instructions
Total $ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.
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.

Field Label	Completion Format	Instructions
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).
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.

Field Label	Completion Format	Instructions
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, 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 5 claims or fewer per month (requires approval)
- Claims that, by policy, require attachments
- 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 837 Professional (837P) Web Portal User guide via the Web Portal found on the Provider Services web page and also on the Department's Colorado Medical Assistance Program Web Portal page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for CCT are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent.

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 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**	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**		

CMS Field #	Field Label	Field is?	Instructions
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	
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	

CMS Field #	Field Label	Field is?	Instructions
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	
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**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
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
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**	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. **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

CMS Field #	Field Label	Field is?	Instructions
			From To **01 01 15 01 01 15** Span dates of service From To **01 01 15 01 31 15** Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: Permissible if the same service (same procedure code) is provided on consecutive dates. **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 Colorado Medical Assistance Program 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** 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.

CMS Field #	Field Label	Field is?	Instructions
			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-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.
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. **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.

CMS Field #	Field Label	Field is?	Instructions
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).
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	
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: 070114 for July 1, 2014.

CMS Field #	Field Label	Field is?	Instructions
			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 Informatio n** **32a- NPI Number** **32b- Other ID #**	Not Required	
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 Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program 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 Colorado Medical Assistance Program members. The procedure codes represent services that may be provided by enrolled certified Colorado Medical Assistance Program 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

CCT- BI Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Personal Care	T1019	UC, TG	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 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
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Vision	V2799	UC	1 unit = 1 procedure

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

CCT- EBD 65+ 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
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			
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

CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
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
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
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
Vision	V2799	UC	1 unit = 1 procedure

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

CCT- EBD 18- 64 Services Procedure Code Table (Special Program Code 95)			
Description	**Procedure Code + Modifier(s)**		**Units**
Qualified Services			
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			
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
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
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
Vision	V2799	UC	1 unit = 1 procedure

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
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			

CCT- CMHS Services Procedure Code Table (Special Program Code 95)			
Description		**Procedure Code + Modifier(s)**	**Units**
Mileage Band 1 (0-10 miles) Mileage Band 2 (11-20 miles) Mileage Band 3 (over 20 miles)	A0120 A0120 A0120	UC, HB UC, TT, HB UC, TN, HB	1 unit = 1 way trip 1 unit = 1 way trip 1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles) Mileage Band 2 (11-20 miles) Mileage Band 3 (over 20 miles)	A0130 A0130 A0130	UC UC, TT UC, TN	1 unit = 1 way trip 1 unit = 1 way trip 1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles) Mileage Band 2 (11-20 miles) Mileage Band 3 (over 20 miles)	A0130 A0130 A0130	UC, HB UC, TT, HB UC, TN, HB	1 unit = 1 way trip 1 unit = 1 way trip 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
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
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**
Vision	V2799	UC	1 unit = 1 procedure

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
Dental				
Dental, Basic/ Preventive	D2999	UC, HI		1 unit = 1 dollar

CCT- DD Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
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				

CCT- DD Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Assistive Technology, Extended	T2029	UC		1 unit = 1 purchase
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
Enhanced Nursing, RN	T1002	UC		1 unit = 15 minutes
Home Accessibility Adaptations, Extended	S5165	UC, KG		I unit = 1 modification
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				
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

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
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
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				

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
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				
Specialized Medical Equipment and Supplies, Disposable	T2028	UC		1 unit = 1 dollar

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
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
Enhanced Nursing, RN	T1002	UC		1 unit = 15 minutes

CCT- SLS Services Procedure Code Table (Special Program Code 95)				
Description	**Procedure Code**	**Modifier(s)**	**Level**	**Units**
Home Accessibility Adaptations, Extended *	S5165	UC, KG		I unit = 1 modification
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)**				

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.

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.

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.

Billing Instruction Detail	Instructions
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. 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 Certification & Request for Timely Filing Extension in the Provider Services Forms 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 Delayed Notification of Eligibility	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.)

Billing Instruction Detail	Instructions
	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. 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 Certification & Request for Timely Filing Extension in the Provider Services Forms 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.
Medicare Denied Services Electronic Medicare Crossover Claims	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare 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. 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.

Billing Instruction Detail	Instructions
	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 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.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance.

Billing Instruction Detail	Instructions
	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 Commercial Insurance Processing	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. 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.
Member Changes Providers during Obstetrical Care Correspondence LBOD Authorization	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. 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.

Billing Instruction Detail	Instructions
	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.

CCT PAR and Claim Examples

CCT-BI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO CHOICE TRANSITIONS YOUR PATH TO INDEPENDENCE

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT - Persons with Brain Injury Demonstration

☑ CCT-UC

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE	5. DATE OF DISCHARGE
		☐ M ☐ F		

6. REQUESTING PROVIDER #	7. CLIENT'S COUNTY	8. CASE NUMBER (AGENCY USE)	9. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

10. Qualified Services Description		11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5102 Adult Day Services (UC)						
T2029 Assistive Technology, per purchase (UC)						
H0025 Behavioral Programming (UC)						
T2025 CDASS, (Cent/Unit) (UC)						
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)	Fiscal Employer Agent (FEA)					
H2018 Day Treatment (UC)						
S5165 Home Modifications (UC)						
T2013 Independent Living Skills Training (ILST) (UC)						
H0004 Mental Health Counseling, Family (UC)		HR				
H0004 Mental Health Counseling, Group (UC)		HQ				
H0004 Mental Health Counseling, Individual (UC)						
A0100 Non Medical Transportation (NMT), Taxi (UC)						
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 mi) (UC)					
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 mi) (UC)					
T1019 Personal Care (UC)		TG				
S5160 Personal Emergency Response System (PERs), Install/Purchase (UC)						
S5161 PERs, Monitoring (UC)						
T1019 Relative Personal Care (UC)		HR, TG				
H0045 Respite Care, NF (UC)						
S5150 Respite Care, In Home (UC)						
T1006 Substance Abuse Counseling, Family (UC)		HR, HF				
H0047 Substance Abuse Counseling, Group (UC)		HQ, HF				
H0047 Substance Abuse Counseling, Individual (UC)		HF				
T2033 Supported Living Program (UC)						
T2016 Transitional Living, per day (UC)						
Demonstration Services Description						
T2029 Assistive Technology, Extended (UC)						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC)						
A9900 Community Transition Services, Items Purchased (UC)						
D2999 Dental (UC)						
T1002 Enhanced Nursing, RN (UC)						
S5170 Home Delivered Meals (UC)						
S5165 Home Modifications, Extended (UC)		KG				
T1016 Intensive Case Management (UC)						
H2015 Peer Mentorship (UC)						
V2799 Vision (UC)						

16a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)	**$0.00**	16c. Grand Total
16b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	**$0.00**	**$0.00**
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)		**$0.00**
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT SERVICES EXPENDENITURES + HOME HEALTH EXPENDITURES)		**$0.00**
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)		
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	**authorizedcms@business.com**	**$0.00**
A. Monthly State Cost Containment Amount		**$0.00**
B. Divided by 30.42 days = Daily Cost Containment Ceiling	**authorizedcms@business.com**	**$0.00**

21. Immediately prior to CCT Services enrollment, this client lived in a: ☐ Long-Tern Care Facility ☐ No ☐ Hospital ☐ No

22. CASE MANAGER NAME	23. AGENCY	24. PHONE #	25. EMAIL	26. DATE
27. CASE MANAGER'S SUPERVISOR NAME	**28. AGENCY**	**29. PHONE #**	**30. EMAIL**	**31. DATE**

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

REGULATION(S) upon which Denial or Return is based:

DEPARTMENT APPROVAL SIGNATURE: DATE:

☐ CCT-BI-CE ☐ CCT-BI-300

CCT-CMHS (formerly MI) PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT - Community Mental Health Supports Demonstration

☑ CCT-UC

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE	5. DATE OF DISCHARGE
		☐ M ☐ F		

6. REQUESTING PROVIDER #	7. CLIENT'S COUNTY	8. CASE NUMBER (AGENCY USE)	9. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

10. Qualified Services Description			11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (UC)							
S5105 Adult Day Services, Specialized (UC)			**TF**				
T2025 CDASS, (Cent/Unit) (UC)							
T2040 CDASS Per Member/ Per Month (PM/PM)		Fiscal Employer Agent (FEA)					
S5165 Home Modifications (UC)							
S5130 Homemaker (UC)							
T2029 Medication Reminder, Install/Purchase (UC)							
S5185 Medication Reminder, Monitoring (UC)							
A0100 NMT, Taxi (UC)							
A0120	NMT, Mobility Van	Mileage Band 1 (0-10 mi) (UC)					
A0130	NMT, Wheelchair Van	Mileage Band 1 (0-10 mi) (UC)					
T1019 Personal Care (UC)							
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)							
S5161 PERs, Monitoring (UC)							
T1019 Relative Personal Care (UC)			**HR**				
S5151 Respite Care, ACF (UC)							
H0045 Respite Care, NF (UC)							
Demonstration Services Description							
S5110 Caregiver Education (UC)							
T2038 Community Transition Services, Coordinator (UC)							
A9900 Community Transition Services, Items Purchased (UC)							
D2999 Dental (UC)							
T1002 Enhanced Nursing, RN (UC)							
S5170 Home Delivered Meals (UC)							
S5165 Home Modifications, Extended (UC)			**KG**				
H2014 Independent Living Skills Training (ILST) (UC)							
T1016 Intensive Case Management (UC)							
H2015 Peer Mentorship (UC)							
H0025 Transitional Behavioral Health Supports (UC)							
V2799 Vision (UC)							

16a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)	**$0.00**	16c. Grand Total
16b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	**$0.00**	**$0.00**
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts		**$0.00**
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDENITURES + HOME HEALTH EXPENDITURES)		**$0.00**
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)		
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)		**$0.00**
A. Monthly State Cost Containment Amount		**$5,361.22**
B. Divided by 30.42 days = Daily Cost Containment Ceiling		**$176.24**

21. CDASS (amounts must match client's allocation worksheet)	Effective Date:		Monthly Allocation Amt:	**$0.00**

22. Immediately prior to CCT enrollment, this client lived in a long term care facility? ☐ Yes ☐ No

23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL	27. DATE
28. CASE MANAGER'S **SUPERVISOR** NAME	29. AGENCY	30. PHONE #	31. EMAIL	32. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

REGULATION(S) upon which Denial or Return is based:

DEPARTMENT APPROVAL SIGNATURE: DATE:

☐ CCT-MI-CE ☐ CCT-MI-300

CCT-DD PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT - Persons with Developmental Disabilities Demonstration

☑ CCT-UC

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. DATE OF DISCHARGE	4. SEX ☐ F ☐ M	5. BIRTHDATE:
			6. SUPPORT LEVEL (1-7)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
7. REQUESTING PROVIDER # / 8. CLIENT'S COUNTY	9. CASE NUMBER (AGENCY USE)		10. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

11. Qualified Services Description	12. Support Level	13. Modifier	14. Max # Units	15. Cost Per Unit	16. Total $ Authorized	17. Comments:
Behavioral Services						
H2019 Line Services (UC)						
H2019 Behavioral Consultation (UC)		**HI, TG**				
H2019 Behavioral Counseling, Individual (UC)		**TF, TG**				
H2019 Behavioral Counseling, Group (UC)		**TF, HQ**				
T2024 Behavioral Plan Assessment (UC)		**HI**				
Day Habilitation						
T2021 Specialized Day Habilitation (UC)	------					
T2021 Supported Community Connections (UC)	------					
Dental						
D2999 Dental, Basic/ Preventive (UC)						
D2999 Dental, Major (UC)		**TF**				
Non-Medical Transportation						
T2003 To/From Day Program, Mileage Range (UC)	------					
T2004 Other (Public Conveyance) (UC)						
Pre-Vocational Services						
T2015 Pre-Vocational Services (UC)	------					
Residential Services						
T2016 Group Home (UC)	------					
T2016 Personal Care Alternative (UC)	------					
T2016 Host Home (UC)	------					
Supported Employment						
T2019 Supported Employment, Individual, All Levels (1-6) (UC)		**HI**				
T2019 Supported Employment, Group (UC)	------					
H2023 Job Development, Individual (UC)	**Level 1-2**					
H2023 Job Development, Individual (UC)	**Level 3-4**	**HI**				
H2023 Job Development, Individual (UC)	**Level 5-6**	**TF**				
H2023 Job Development, Group, All Levels (1-6) (UC)		**HQ**				
H2024 Job Placement, Individual, All Levels (1-6) (UC)						
H2024 Job Placement, Group, All Levels (1-6) (UC)		**HQ**				
Specialized Medical Equipment						
T2028 Specialized Medical Equipment, Disposable (UC)						
T2029 Specialized Medical Equipment (UC)						
V2799 Vision (UC)						
Demonstration Services Description						
T2029 Assistive Technology, Extended (UC)						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC)						
A9900 Community Transition Services, Items Purchased (UC)						
T1002 Enhanced Nursing, RN (UC)						
S5165 Home Accessibility Adaptations, Extended (UC)		**KG**				
T1016 Intensive Case Management (UC)						
H2015 Peer Mentorship (UC)						

18a. TOTAL AUTHORIZED CCT QUALIFIED SERVICES EXPENDITURES (SUM OF QUALIFIED SERVICES)	**$0.00**	18c.Grand Total
18b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICES EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	**$0.00**	**$0.00**
19. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)		**$0.00**
20. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDENITURES + HOME HEALTH EXPENDITURES)		**$0.00**
21. NUMBER OF DAYS COVERED (FROM FIELD 9 ABOVE)		
22. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)		**$0.00**

23. Immediately prior to CCT enrollment, this client lived in a long term care facility? ☐ Yes ☐ No

24. CASE MANAGER NAME	25. AGENCY	26. PHONE #	27. EMAIL	28. DATE
29. CASE MANAGER'S **SUPERVISOR** NAME	30. AGENCY	31. PHONE #	32. EMAIL	33. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

REGULATION(S) upon which Denial or Return is based:

DEPARTMENT APPROVAL SIGNATURE: DATE:

☐ CCT-DD-CE ☐ CCT-DD-300

CCT-EBD (18-64) PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT- Persons who are Elderly, Blind, and Disabled Demonstration, 18-64

☑ CCT-UC

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE	5. DATE OF DISCHARGE
		☐ M ☐ F		

6. REQUESTING PROVIDER #	7. CLIENT'S COUNTY	8. CASE NUMBER (AGENCY USE)	9. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

10. Qualified Services Description		11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (UC)						
S5105 Adult Day Services, Specialized (UC)		**TF**				
T2025 CDASS, (Cent/Unit) (UC)						
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)	Fiscal Employer Agent (FEA)					
S5165 Home Modifications (UC)						
S5130 Homemaker (UC)						
H0038 IHSS Health Maintenance Activities (UC)						
S5130 IHSS Homemaker (UC)		**KX**				
T1019 IHSS Personal Care (UC)		**KX**				
T1019 IHSS Relative Personal Care (UC)		**HR, KX**				
S5185 Medication Reminder, Monitoring (UC)						
T2029 Medication Reminder, Install/Purchase (UC)						
A0100 NMT, Taxi (UC)						
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 mi) (UC)					
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 mi) (UC)					
T1019 Personal Care (UC)						
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)						
S5161 PERs, Monitoring (UC)						
T1019 Relative Personal Care (UC)		**HR**				
S5151 Respite Care, ACF (UC)						
S5150 Respite Care, In Home (UC)						
H0045 Respite Care, NF (UC)						
Demonstration Services Description						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC)						
A9900 Community Transition Services, Items Purchased (UC)						
D2999 Dental (UC)						
T1002 Enhanced Nursing, RN (UC)						
S5170 Home Delivered Meals (UC)						
S5165 Home Modifications, Extended (UC)		**KG**				
H2014 Independent Living Skills Training (ILST) (UC)						
T1016 Intensive Case Management (UC)						
H2015 Peer Mentorship (UC)						
H0025 Transitional Behavioral Health Supports (UC)						
V2799 Vision (UC)						

16a. TOTAL AUTHORIZED CCT QUALIFIED SERVICES EXPENDITURES (SUM OF QUALIFIED SERVICES)	**$0.00**	16c. Grand Total
16b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICES EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	**$0.00**	**$0.00**
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts		**$0.00**
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDENITURES + HOME HEALTH EXPENDITURES)		**$0.00**
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)		
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)		**$0.00**
A. Monthly State Cost Containment Amount		**$5,082.88**
B. Divided by 30.42 days = Daily Cost Containment Ceiling		**$167.09**

21. CDASS (amounts must match client's allocation worksheet)	Effective Date:		Monthly Allocation Amt:	**$0.00**

22. Immediately prior to CCT enrollment, this client lived in a long term care facility? ☐ Yes ☐ No

23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL	27. DATE
28. CASE MANAGER'S SUPERVISOR NAME	**29. AGENCY**	**30. PHONE #**	**31. EMAIL**	**32. DATE**

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

REGULATION(S) upon which Denial or Return is based:

DEPARTMENT APPROVAL SIGNATURE: DATE:

☐ CCT-PD-CE ☐ CCT-PD-300

CCT-EBD (65+) PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT- Persons who are Elderly, Blind, and Disabled Demonstration, 65+

☑ CCT-UC

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE	5. DATE OF DISCHARGE
		☐ M ☐ F		

6. REQUESTING PROVIDER #	7. CLIENT'S COUNTY	8. CASE NUMBER (AGENCY USE)	9. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

10. Qualified Services Description		11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (UC)						
S5105 Adult Day Services, Specialized (UC)		**TF**				
T2025 CDASS, (Cent/Unit) (UC)						
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)	Fiscal Employer Agent (FEA)					
S5165 Home Modifications (UC)						
S5130 Homemaker (UC)						
H0038 IHSS Health Maintenance Activities (UC)						
S5130 IHSS Homemaker (UC)		**KX**				
T1019 IHSS Personal Care (UC)		**KX**				
T1019 IHSS Relative Personal Care (UC)		**HR, KX**				
T2029 Medication Reminder, Install/Purchase (UC)						
S5185 Medication Reminder, Monitoring (UC)						
A0100 NMT, Taxi (UC)						
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 mi) (UC)					
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 mi) (UC)					
T1019 Personal Care (UC)						
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)						
S5161 PERs, Monitoring (UC)						
T1019 Relative Personal Care (UC)		**HR**				
S5151 Respite Care, ACF (UC)						
S5150 Respite Care, In Home (UC)						
H0045 Respite Care, NF (UC)						
Demonstration Services Description						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC)						
A9900 Community Transition Services, Items Purchased (UC)						
D2999 Dental (UC)						
T1002 Enhanced Nursing, RN (UC)						
S5170 Home Delivered Meals (UC)						
S5165 Home Modifications, Extended (UC)		**KG**				
H2014 Independent Living Skills Training (ILST) (UC)						
T1016 Intensive Case Management (UC)						
H2015 Peer Mentorship (UC)						
H0025 Transitional Behavioral Health Supports (UC)						
V2799 Vision (UC)						

16a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)	**$0.00**	16c. Grand Total
16b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	**$0.00**	**$0.00**
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support		**$0.00**
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDENITURES + HOME HEALTH EXPENDITURES)		**$0.00**
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)		
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)		**$0.00**
A. Monthly State Cost Containment Amount		**$5,082.88**
B. Divided by 30.42 days = Daily Cost Containment Ceiling		**$167.09**

21. CDASS (amounts must match client's allocation worksheet) Effective Date: Monthly Allocation Amt: **$0.00**

22. Immediately prior to CCT enrollment, this client lived in a long term care facility? ☐ Yes ☐ No

23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL	27. DATE

28. CASE MANAGER'S **SUPERVISOR** NAME	29. AGENCY	30. PHONE #	31. EMAIL	32. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

ASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

REGULATION(S) upon which Denial or Return is based:

DEPARTMENT APPROVAL SIGNATURE: DATE:

☐ CCT-ELD-CE ☐ CCT-ELD300

CCT-SLS PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT - Supported Living Services Demonstration

☑ CCT-UC
PA Number being revised:
Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. DATE OF DISCHARGE	4. SEX ☐ M ☐ F	5. BIRTHDATE:
			6. SUPPORT LEVEL (1-6)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
7. REQUESTING PROVIDER # / 8. CLIENT'S COUNTY	9. CASE NUMBER (AGENCY USE)		10. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

11. Qualified Services Description	12. Support Level	13. Modifier	14. Total # Units Authorized	15. Cost Per Unit	16. Total $ Authorized	17. Comments:
T2035 Assistive Technology (UC) *						
H2021 Mentorship (UC)						
T1019 Personal Care (UC)		TF				
S5161 Personal Emergency Response (PERs) (UC)						
T2039 Vehicle Modifications (UC) *						
V2799 Vision (UC) *						
Behavioral Services						
H2019 Line Services (UC)						
H2019 Behavioral Consultation (UC)		HI, TG				
H2019 Behavioral Counseling, Group (UC)		TF, HQ				
H2019 Behavioral Counseling, Individual (UC)		TF, TG				
T2024 Behavioral Plan Assessment (UC)		HI				
Day Habilitation						
T2021 Specialized Day Habilitation (UC)	------					
T2021 Supported Community Connections (UC)	------					
Dental						
D2999 Dental, Basic/ Preventive Services (UC) *						
D2999 Dental, Major Services (UC) *		TF				
Homemaker						
S5130 Homemaker, Basic (UC)		TF				
S5130 Homemaker, Enhanced (UC)		HI				
S5165 Home Accessibility Adaptations (UC) *						
Non-Medical Transportation						
T2003 To/From Day Program, Mileage Range (UC) *	------					
T2003 Mileage Not Day Program (UC) *		HB				
T2004 Other (Public Conveyance) (UC) *						
Pre-Vocational Services						
T2015 Pre-Vocational Services (UC)	------					
Professional Services						
97124 Massage Therapy (UC)						
G0176 Movement Therapy, Bachelors Degree (UC)		HN				
G0176 Movement Therapy, Masters Degree (UC)						
S8940 Hippotherapy, Group (UC)		HQ				
S8940 Hippotherapy, Individual (UC)						
S5199 Rec Pass, Access Fee (UC)						
Respite Care						
T2036 Respite Camp (UC)						
S5151 Respite Care, Group (UC)		HQ				
S5150 Respite Care, Individual, 15 Minutes (UC)						
S5151 Respite Care, Individual, Day (UC)						
Specialized Medical Equipment and Supplies						
T2028 Specialized Medical Equipment and Supplies, Disposable (UC)						
T2029 Specialized Medical Equipment (UC)						
Supported Employment						
T2019 Supported Employment, Individual, All Levels (1-6) (UC)		HI				
T2019 Supported Employment, Group (UC)	------					
H2023 Job Development, Individual (UC)	**Level 1-2**					
H2023 Job Development, Individual (UC)	**Level 3-4**	HI				
H2023 Job Development, Individual (UC)	**Level 5-6**	TF				
H2023 Job Development, Group, All Levels (UC)		HQ				
H2024 Job Placement, Individual, All Levels (1-6) (UC)						
H2024 Job Placement, Group, All Levels (1-6) (UC)		HQ				
Demonstration Services Description						
T2029 Assistive Technology, Extended (UC)						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC) *						
A9900 Community Transition Services, Items Purchased (UC) *						
T1002 Enhanced Nursing, RN (UC)						
S5165 Home Accessibility Adaptations, Extended (UC) *		KG				
H2014 Independent Living Skills Training (ILST) (UC)						
T1016 Intensive Case Management (UC) *						

18a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)	**$0.00**	18c. Grand Total
18b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	**$0.00**	**$0.00**
19. TOTAL WITHIN SPAL EXPENDITURES (SUM OF ALL SPAL SERVICES IN COLUMN 15 ABOVE)		**$0.00**
20. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)		**$0.00**
21. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDENITURES + HOME HEALTH EXPENDITURES)		**$0.00**
22. NUMBER OF DAYS COVERED (FROM FIELD 9 ABOVE)		
23. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)		**$0.00**
24. Immediately prior to CCT Services enrollment, this client lived in a long term care facility?	☐ Yes ☐ No	

25. CASE MANAGER NAME	26. AGENCY	27. PHONE #	28. EMAIL	29. DATE
30. CASE MANAGER'S **SUPERVISOR** NAME	31. AGENCY	32. PHONE #	33. EMAIL	34. DATE

* **Outside of Service Plan Authorization Limit (SPAL)**

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

REGULATION(S) upon which Denial or Return is based:

DEPARTMENT APPROVAL SIGNATURE: DATE:

☐ CCT-SLS-CE ☐ CCT-SLS300

CMS 1500 CCT-BI Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#): X

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 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)

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. 854 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	12		T1019	UC			1	458 90	130		NPI
2	01	01	15	01	01	15	12		T1019	UC			1	91 76	2		NPI
3	01	01	15	01	01	15	12		T1019	UC			1	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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. 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)

CMS 1500 CCT-CMHS 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 [ ] NO [X] If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 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)

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. 295.3 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	11		S5105	UC	TF		1	222 64	8		NPI	
2	01	01	15	01	01	15	12		T2038	UC			1	2000 00	1		NPI	
3	01	01	15	01	01	15	11		A9900	UC			1	1500 00	1		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 $ 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: 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. 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)

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 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 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)

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. 317 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	12		T2019	UC	HI		1	48 04	4		NPI	
2	01	01	15	01	01	15	12		H2015	UC			1	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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. 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)

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 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)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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)

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. 428 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	12		S5130	UC	I		1	27 76	8		NPI	
2 01	01	15	01	01	15	12		T1016	UC			1	84 40	4		NPI	
3 01	01	15	01	01	15	11		S5170	UC			1	32 40	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 $ 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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. 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)

CMS 1500 CCT-EBD (65+) Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

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

3. PATIENT'S BIRTH DATE MM 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)

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. 250 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	12		S5130	UC			1	27 76	8		NPI	
2	01 01 15	01 01 15	12		S5165	UC			1	8500 00	1		NPI	
3	01 01 15	01 01 15	12		T1016	UC			1	84 40	4		NPI	
4	01 01 15	01 01 15	11		H0047	UC	HF		1	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 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CCT Provider
100 Any Street
Any City

a. 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)

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 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)

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. 299 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	12		T2019	UC				1	54 84	12		NPI	
2	01	01	15	01	01	15	12		T2021	UC	TF			1	13 04	1		NPI	
3	01	01	15	01	01	15	12		T1016	UC				1	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 $

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CCT Revisions Log

Revision Date	Additions/ Changes	Pages	Made by
09/2012	*Creation of reference manual*		*cc*
09/27/2012	*Formatted manual* *Added PAR and claim examples* *Created TOC*	*All* *24-35*	*jg*
10/05/2012	*Revised PAR form modifier instructions to include HB, TT, TN* *Removed A0125 from BI, EBDs, & MI.* *Added mileage bands to BI, EBDs, & MI*	*4* *9-16* *9-16*	*cc*
01/24/2013	*Revised IHHS to IHSS* *Added CDASS* *Added TG modifier to SLS, Respite Care*	*11-15* *11-15* *22*	*cc*
03/19/2013	*Removed Alternative Care Facility from all procedure code tables* *Revised PAR table instructions to match PAR table.*	*11-16* *5-6*	*cc*
08/22/2013	*Added Date of Discharge requirement to PAR Reference Table*	*5*	*cc*
09/26/2013	*Revised modifiers for BI, CMHS, EBD, DD and SLS*	*10-23*	*cc*
03/06/2014	*Formatted* *Updated TOC* *Updated the BI PAR example* *Fixed signatures on claim examples*	*Throughout* *I* *28* *35-40*	*Jg*
7/11/14	*Changed CO 1500 claim examples to CMS 1500 claim examples*	*Throughout*	*ZS*
7/11/14	*Changed CO 1500 claim examples to CMS 1500 claim examples*		*ZS*
7/11/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
7/14/2014	*Updated web links to reflect new website links*	*Throughout*	*mm*
7/14/2014	*Updated references from Member to Member per new standards*	*Throughout*	*Mm*
7/18/14	*Added CDASS Cent/Unit and Member/Month codes per Benefit Manager*	*17*	*mm*
11/25/14	*Corrected grammatical errors*	*11, 29*	*rm*
11/25/14	*Spelled out Reserved and Phone*	*14*	*rm*
11/25/14	*Removed duplicative rows for Qualified Services*	*17-26*	*rm*
11/25/14	*Removed Appendix H information, added Timely Filing document information*	*34, 35*	*rm*
12/05/2014	*Formatting and TOC changes*	*Throughout*	*Bl*

07/20/15	*Clarified PAR Form Instructional Reference Table*	*5*	*NS*
07/20/15	*Removed Transitional Specialized Day Rehabilitation Services from CCT-BI Demonstration Services grid.*	*17*	*NS*
07/20/15	*Removed Assistive Technology, Extended; Substance Abuse Counseling Transitional, Group; Substance Abuse counseling Transitional, Individual; Transitional Specialized Day Rehabilitation Services from CCT-EBD 65+ Demonstration Services grid*	*18*	*NS*
07/20/15	*Removed Assistive Technology, Extended; Substance Abuse Counseling Transitional, Group; Substance Abuse Counseling Transitional, Individual; Transitional Specialized Day Rehabilitation Services from CCT-EBD 18-64 Procedure Code Table*	*20*	*NS*
07/20/15	*Removed Assistive Technology, Extended; Substance Abuse Counseling transitional, Group; Substance Abuse Counseling Transitional, Individual; Transitional Specialized Day rehabilitation Services from CCT-CMHS Procedure Code Table*	*23*	*NS*
07/20/15	*Removed Substance Abuse Counseling Transitional, Group; Substance Abuse Counseling transitional, individual from CCT-DD Services Procedure Code Table*	*26*	*NS*
07/20/15	*Removed Substance Abuse Counseling transitional, group and individual from CCT-SLS Procedure Code Table*	*30*	
07/21/2015	*Minor formatting, TOC update, and spacing changes. Updated screenshots of the CCT PAR forms.*	*Throughout*	*Bl*
9/2/15	*Removed reference to ICD-9* *Reviewed for ICD codes but none used/No mention of CWQI or ColoradoPAR*	*11* *Throughout*	*JH, NS*
09/08/2015	*Accepted changes, updated TOC, removed blank spaces*	*Throughout*	*bl*