

Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

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Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

Providers must be enrolled as a Health First Colorado (Colorado’s Medicaid Program) provider in order to:

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under, who are enrolled in Health First Colorado. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.

Early	Assessing and identifying problems early
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce health problems found

One of the goals of EPSDT is to establish a regular pattern of healthcare through routine health screenings, diagnostic, and treatment services.

All states are required to complete a report to the federal government on April 1 of each year as to the numbers of services received by the EPSDT eligible members. All states have a minimum requirement of 80% of the children and youth receiving at least one screening visit per year.



Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.280), for specific information when providing EPSDT care.

Accountability of services shall be maintained through medical records and documentation used in informing, screening, diagnosis and treatment services. The provider who is performing the screening must maintain medical records specific to EPSDT screening services that:

- Contain the results of all diagnostic tests and reports of all consultations
- Contain the reason for visit, e.g., screening, follow-up, etc.
- Contain the date screening services were performed, and documentation of the specific tests or procedures performed, along with the results of these tests and procedures.
- Contain documentation of any screening service that was due but not completed and the medical contraindication or other reason why it was not completed
- Contain documentation of declination of screening services by parents.
- Contain referrals made for diagnosis, treatment, or other medically necessary health services for conditions as a result of a screening service

- Date next screening is due.
- Documentation of direct referral for age-appropriate dental services



General Billing Information

National Provider Identifier (NPI)

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

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to Affiliated Computer Services (ACS), 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

Paper claims do not require an NPI, but do require the Health First Colorado (Colorado's Medicaid Program) provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (<http://www.wpc-edi.com/>)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's Web site.
- Web Portal User Guide (via within the Web Portal)

Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Web Portal (Web Portal) or via batch submission through a host system. For additional electronic information, please refer to the Health First Colorado Provider Information manual located on the Department's website (Colorado.gov/hcpf) → For Our Providers → Provider Services → [Billing Manuals](#).

General Program Provisions

A comprehensive EPSDT Periodic Screening examination includes the following components:

- Comprehensive health & developmental history
- Comprehensive unclothed physical examination
- Assessment of physical, emotional & developmental growth
- Assessment of mouth, oral cavity and teeth, including referral to a dentist
- Assessment of nutritional status
- Family planning services and adolescent maternity care
- Vision assessment
- Immunizations *appropriate to age & health history*
- Laboratory tests (including lead blood level assessment appropriate to age & risk)
- Assessment of mental/behavioral health
- Hearing assessment
- Health education (including anticipatory guidance)
- Treatment and referrals for any medically necessary further diagnosis and treatment

Types of EPSDT Provider Visits



1) Periodic Screen

The periodic screen includes comprehensive health assessments that are performed soon after birth or as early as possible in a child’s life. It is repeated at prescribed intervals until the age of 20, as described in the AAP Bright Futures Periodicity Schedule.

2) Inter-Periodic Visit

An inter-periodic visit is any other healthcare visit the child may need, such as visits for an ear ache, fever or injury. Additional visits, or “interperiodic” screens, may become necessary if circumstances suggest the need for more screens, or to bring a child who has missed one or more periodic screens into compliance. Medically necessary interperiodic screens must be provided to determine the existence of suspected physical, or mental illnesses or conditions. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the child outside of the formal health care system (e.g., special education programs, Head Start and day care programs, the Special Supplemental Food Program for Women, Infants and Children (WIC) and other nutritional assistance programs).

Outreach and Case Management – Healthy Communities Program

Each family or member is assigned to a Family Health Coordinator in their local area. The Family Health Coordinator's services are a part of the member's Health First Colorado (Colorado's Medicaid Program) benefit and offers support services, including the following:

- Ensures that members are informed of program benefits
- Assists child in accessing health care services within a reasonable time period
- Offers assistance in identifying participating Health First Colorado doctors, dentists, other medical specialists and managed care programs or Accountable Care Programs.
- Assists in making and reminds members of appointments, if requested
- Follows up on appointments that may have been missed, if requested by a provider
- Assists with connecting child with non-medical community resources



Coordinate the following types of health care services wherever possible:

- Newborn or well-baby check-ups
- Day care or Head Start physicals
- Routine well child physical exams
- Dental Screenings
- Behavioral Health screenings
- Developmental screenings

Visit the [Healthy Communities](#) web page on the Department's website to find a [Family Health Coordinator](#) in your area.

As a provider under a Regional Accountable Care Organization (RCCO) you also have the ability to access medical case management through those organizations. Please visit <https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations> for more information.

Services

EPSDT is made up of the following screening, diagnostic, and treatment services:

Screening Services

Comprehensive health and developmental history

At the initial screen, the provider should obtain a comprehensive health, developmental, behavioral, mental health and nutritional history from the child's parents or guardians. The comprehensive initial history should include the following information:

- Family medical history
- Patient medical history, including prenatal problems, neonatal problems, developmental milestones, surgeries, current medication and current health problems
- Immunization history
- Nutritional history
- Social history
- Living conditions
- Family and patient history of behavioral problems

This information should be updated at every well child check.

Comprehensive unclothed physical exam

Unclothed Physical Inspection - Check the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including orthopedic disorders, hernia, skin disease, and genital abnormalities. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal. Please visit the AAP Bright Futures Periodicity Schedule for more information at <https://brightfutures.aap.org/clinical-practice/Pages/default.aspx>.

Appropriate immunizations (according to the Advisory Committee on Immunization Practices) The National Vaccines for Children Program (VFC) supplies most vaccines at no cost to physicians enrolled in the VFC program. All PCPs participating in Health First Colorado (including those in MCOs) are eligible to enroll and participate in the VFC program.

Oral Health Screening Services

Dental screening services, such as oral health assessments, can be provided during a well-child visit by the pediatric primary care provider.

Laboratory tests (including lead toxicity testing)

Identify the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups. Physicians providing screening/assessment services under the EPSDT benefit use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed.

Federal regulations require that all Health First Colorado-enrolled children have a blood lead test at 12 and 24 months of age. CMS requires the use of the blood lead test when screening children for lead poisoning.

If a child between the ages of 24 months and 72 months has not received a screening blood lead test, the child must receive it immediately.

If a child is found to have blood lead levels equal to or greater than 10 ug/dl, providers are to use their professional judgment, with reference to CDC guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated. Determining the source of lead may be completed by your local public health agency. For more information please visit the Colorado Department of Public Health and Environment's site at www.colorado.gov/pacific/cdphe/lead-exposure.

Vision and Hearing Screening Services

Subjective vision and hearing screens should be performed at every well-child visit, or based on an assessment of risk. If medically indicated, the subjective screens can lead to inter-periodic screens or a referral to a specialist if a problem is identified.

Developmental Surveillance and Screening Services

According to the American Academy of Pediatrics, developmental surveillance is a flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. Developmental surveillance should include the following:

- Eliciting and attending to the parents' concerns about their child's development
- Documenting and maintaining a developmental history
- Making accurate observations of the child

- Identifying the risk and protective factors
- Maintaining an accurate record and documenting the process and findings

A developmental screening is a brief assessment using a validated tool designed to identify children who should receive further assessment. A developmental screen is designed to evaluate whether an individual's development processes fall within a normal range of achievement according to age group. A developmental screening tool may be administered by appropriate office staff; however the tool should be scored by the billing provider. If a developmental screening uncovers a potential developmental delay, the provider must make the appropriate referral to the appropriate provider for further evaluation. If a developmental delay is identified in a child ages 0-3 years old, the provider should refer to Colorado's Early Intervention Program. More information available at <http://www.eicolorado.org/>

Developmental screens should be completed according to the Bright Futures periodicity schedule, at 9 months, 18 months, and 30 months of age. The assessment should consist of developmental history, observations, physical and developmental evaluation and assessment of developmental status.

Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Other Necessary Health Care Services

Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis (see medical necessity below for more information) and providers are to make requests for services that may not be covered by the state plan or by private insurance.

Diagnosis

A presumptive diagnosis may be made at the time of screening, but it is usually necessary to advise the member of the need for further diagnosis and treatment. Necessary treatments may be rendered by the PCP or MCO practitioner or by referral to an authorized Health First Colorado specialist.

Providers should make requests for services or items they feel best meets the child/youth needs even if they are not listed in the state plan as a benefit or the code is not showing as a benefit in the provider fee schedule.

Treatment

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Under EPSDT, Health First Colorado beneficiaries are entitled to a broader scope of services than adults. Providers must make available or refer the patient for the health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by EPSDT screening services.

Providers should make requests for services or items they feel best meets the child/youth needs even if they are not listed in the state plan as a benefit or the code is not showing as a benefit in the provider fee schedule.

Medical Necessity

All Health First Colorado coverable, medically necessary services must be provided even if the service is not available under the State plan to other Health First Colorado members. No arbitrary limitations on services are allowed, e.g., one pair of eyeglasses or 10 physical therapy visits per year.

Providers should consult the fee schedule at www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule to determine if the procedure code requires prior authorization. Medical necessity or a medically necessary service is defined as a good or service that will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. See Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.076.1.8), for the complete Medical Necessity Definition. For EPSDT, medical necessity includes a good or service that will or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living, and meets the criteria, Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.280.4.E.2)

To request services that a provider feels are medically necessary but are not currently covered, [Billing Manuals](#) section of the Department's website.

Health First Colorado makes the final determination of medical necessity and it is determined on a case-by-case basis. Provider recommendations will be taken in to consideration, but are not the sole determining factor in coverage. Colorado determines which treatment it will cover among equally effective, available alternative among equally effective treatments.

ColoradoPAR Prior Authorization Requests (PARs)

If the non-covered services or supplies being requested contain codes normally prior authorized by the Departments Utilization Management (UM) vendor the provider must submit a PAR through the ColoradoPAR Program. The ColoradoPAR Program is Colorado Medicaid's Utilization Management (UM) Program. This third-party vendor reviews Prior Authorization Requests (PARs) to ensure services requested meet medical necessity guidelines and are within Colorado Medicaid's policies.

The ColoradoPAR Program's third-party vendor processes electronic PARs through an online PAR portal. The online PAR portal is a web-based HIPAA-compliant PAR system that offers providers 24/7 access to the information and functions providers need. Clinical documentation will be accepted in the following formats: doc, docx, xls, xlsx, ppt, pdf, jpg, gif, bmp, tiff, tif, and jpeg.

See ColordaoPAR.com for information and instructions on how to submit PARs electronically through the online PAR portal. For additional assistance or support, contact the ColoradoPAR provider helpline at 888-801-9355. PAR status may be verified in the online PAR portal or by contacting the ColoradoPAR provider helpline. The approved PAR identification number must be submitted with the claim to receive payment.

Claims for prior authorized services must be submitted within 120 days of the date of service. Services rendered prior to the authorized date will be denied reimbursement.

Approval of the PAR does not guarantee payment by Medicaid. The member and the EPSDT provider shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations. Medicaid is the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to bill Medicare or other third party insurance prior to billing Medicaid.

PAR Requirements

Any provider submitting a PAR must be enrolled in the Colorado Medicaid Program for. Providers must

also verify eligibility at the time service is rendered and include the necessary information with the PAR. All services require prior authorization by Colorado Medicaid's third-party vendor using the approved prior authorization request online portal. It is the EPSDT provider's responsibility to provide sufficient documentation to support the medical necessity for the requested services. PARs must be submitted to Colorado Medicaid's third-party vendor in accordance with 10 CCR 2505-10 § 8.058.

- A PAR will be pended by Colorado Medicaid's third-party vendor if all of the required information is not provided in the PAR, or additional information is required by the third-party vendor to complete the review. If the third-party vendor does not receive the required documentation within **four (4)** business days, the PAR will be denied for lack of information.
- All other information determined necessary by Colorado Medicaid's third-party vendor to make a decision on the medical necessity and appropriateness of the proposed treatment plan must be included.
- The PAR will be reviewed by medical experts in children's health who work for the Colorado Medicaid program's third-party vendor. Nurses and doctors will decide if the request for services or supplies meets the rules for medical necessity and for the Personal Care Benefit.

ColoradoPAR Peer-to-Peer and Reconsideration Process

If an EPSDT requested service or supply is denied or partially denied by the UM vendor the MD, DO, or APN who requested the PAR has the option to discuss the PAR over the phone in a process called a Peer-To-Peer review. If the Peer-To-Peer review still results in a denied or partially denied PAR, the EPSDT provider can work with the UM vendor two (2) options:

- PAR Reconsideration: A PAR Reconsideration is similar to a second opinion and must be requested by the EPSDT provider. A MD, DO, or APN who is different from the one who made the initial PAR denial will re-review the PAR along with the new information and make a final PAR decision. Additional documents not submitted with the original request may be submitted during the Reconsideration process.
- PAR Resubmission: Submit a new PAR that includes additional medical information needed for the PAR review.

The provider will be notified of the final PAR determination for all PARs reviewed by the UM vendor via the online PAR portal. The provider and member will receive the final PAR determination letter from the Department's fiscal agent. If the PAR is denied, the provider will also receive a detailed explanation of why the PAR was denied. A member who receives a denial notification letter has the option to submit a written request for an appeal to the Office of Administrative Courts.

EPSDT Medical Necessity Does NOT include:

- Experimental or investigational treatments,
- Services or items not in accordance with professionally recognized standards for health care in the United States, or
- Services primarily for caregiver or providers convenience

Services for which Colorado has a waiver are also not considered to be state plan benefits, and therefore are not a benefit under EPSDT. Items such as respite, in-home support services, and home modifications are examples of waiver services.

To request services that a provider feels are medically necessary but are not currently covered by the state plan, a prior authorization request must be completed as well as a letter of medical necessity. Both

should be sent to the authorizing agent listed in Appendix D located in the [Billing Manuals](#) section of the Department's website.

Benefits

Developmental, Depression, and Autism Screenings

Developmental

Health First Colorado (Colorado's Medicaid Program) enrolled children aged 0 – 4 (up to 59 months) following the 3 by 3 framework from the AAP. Three (3) screens per year for children aged 0 – 24 months.

Health First Colorado covers developmental screening for children ages 0 – 4 (up to 59 months), using a standardized, validated developmental screening tool (i.e., PEDS, Ages and Stages, etc.) at the child's periodic visits. In the absence of established risk factors or parental or provider concerns, the AAP recommends developmental screens at the 9-, 18-, and 30-months and not at every visit.

Depression

Health First Colorado covers depression screening for individuals aged 11 and older, using a standardized, validated depression screening tool (i.e., PHQ-9 (Department recommended), Edinburgh Postnatal Depression Scale, Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale, etc.) at the client's periodic visits. The exact frequency of validated, standardized screening depends on both the concerns of the child's parents or adult client and also the provider as to whether routine surveillance suggests the client may be at risk for depression.

Autism

Health First Colorado covers autism screening for children aged 18- and 24-months, using a standardized, validated autism screening tool (i.e., M-CHAT, etc.) at the child's periodic visits. When an autism screen identifies a child as being at risk for an Autism Spectrum Disorder, an ASD Diagnostic Evaluation should follow.

Dental Benefits

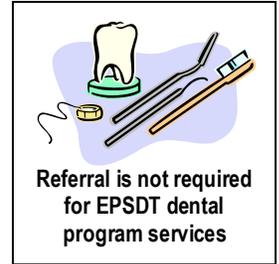
A non-emergency oral examination, dental prophylaxis, and fluoride topical application once every six months are benefits of the EPSDT program. Health First Colorado recommends regular periodic examinations by a dentist with eruption of the first tooth or at age one, and continuing every six (6) months or as recommended by a dentist. Referral from the PCP is **not** required for EPSDT dental services.

Orthodontia is available for children who have been diagnosed with a severely handicapping malocclusion. More information can be found at: DentaQuest's website

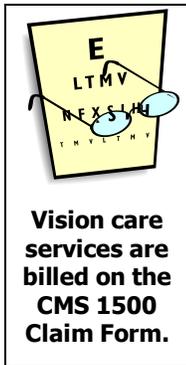
Dentally necessary radiographs, restorations, endodontics, periodontics, prosthodontics and oral surgery are also benefits. Dental services are billed on the 2006 American Dental Association (ADA) claim form or the 837 D. Complete billing instructions for dental services are included in DentaQuest Provider Office Reference Manual (ORM) found under DentaQuest Resources section of DentaQuest's [website](#). Health First Colorado dental providers can also call DentaQuest's Provider Relations/Services at 1-855-225-1731 (for TTY assistance, please call AT&T's TTY line at 711).

Hearing Assisted Device Benefits

Audiological benefits include identification, diagnostic evaluation, and treatment for children with hearing impairments. Benefits include hearing aids and other assisted devices, auditory training in the use of hearing aids, therapy for children with hearing impairments, and family-focused home based early language intervention for children, (birth to three years of age), with hearing loss through the Colorado Home Intervention Program (CHIP).



Vision Care Benefits



Vision diagnostic and treatment services may be performed by an ophthalmologist or optometrist. Referral is **not** required for vision care. Single and multifocal vision lenses and frames, as well as repair or replacement of broken lenses or frames, are benefits of EPSDT and may be provided by an ophthalmologist, optometrist, or optician. Contact lenses are available in some medically necessary situations and require prior authorization.

Vision care services are billed on the CMS 1500 Health Insurance claim form or the 837 P. Complete billing instructions for vision services are included in the vision billing manual.

Billing Guidelines

EPSDT Billing

Providers submitting claims electronically must use the 837P.
Providers submitting claims on paper must use the EPSDT paper claim form.

The EPSDT claim form is used by primary care providers who bill fee-for-service for EPSDT periodic screens.

The Department tracks the EPSDT periodic screens by procedure and diagnosis codes appropriate for the screen. Other children’s health care services are billed on the CMS 1500, using national standard codes.

Providers must identify if a visit is a result of a referral from an EPSDT Screen

If a provider is seeing a child as a result of a referral from the EPSDT periodic screen for further diagnosis or treatment, the provider should enter a **“Yes” in Box # L** on the CMS 1500.

If the visit is a referral from an EPSDT periodic screen for further diagnosis and treatment, enter a **“Yes” in the service line** (Loop 2400, Segment SV1, Element SV111). It is important to identify these services as they are reported on the Annual EPSDT Participation Report (416) to the Centers for Medicare and Medicaid Services (CMS) along with the number of EPSDT periodic screens.

- Dental benefits are billed on the ADA claim form or the 837 D.
- Vision benefits are billed on the CMS 1500 claim form or 837 P.
- If the child is ill, services related to the illness should be billed on the CMS 1500 claim form. An appointment for an EPSDT screening should be made at a later date.

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) complete the UB-04 claim form for EPSDT-rendered services. Refer to the FQHC/RHC Billing Manual for specific UB-04 billing instructions. FQHCs and RHCs use V72.0 to bill for the EPSDT Periodic Screen.

EPSDT benefits may include medically necessary covered benefits available for children enrolled in the Medical Assistance Program.

Procedure/HCPCS Codes Overview

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program members and 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 Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by completing and submitting a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure. Always remember that any code or service can be requested, even if the code is not open in the fee schedule or listed in this or other billing manuals.

EPSDT Procedure Coding

Procedure Code(s)	Description
Periodic Screening: Preventive Medicine Codes*	
99381 – 99385	New Patient (age specific)
99391 – 99395	Established Patient (age specific)
99431	History and examination
99432	Normal newborn care
Periodic Screening: Evaluation and Management Codes	
99203 – 99205	New Patient
99214 – 99215	Established Patient

Note: These CPT-4 codes must be used in conjunction with the following Z codes:

Procedure Code(s)	Description
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Z76.2, Z00.121, Z00.129, Z00.110, Z00.111, Z00.00-01, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.81, Z02.82, Z02.83, Z02.89, Z00.8, Z00.6, Z00.5, Z00.70, Z00.71.

These codes must be used in conjunction with diagnosis codes for a well-child exam including 99202-99205, 99213-99215

Inter-periodic Visit Codes

Range 99201 – 99350

Note: Used in conjunction with the appropriate diagnosis codes *excluding* the well-child diagnosis codes: Z76.2, Z00.121, Z00.129, Z00.110, Z00.111, Z00.00-01, Z02.0 –Z02.6, Z02.81-Z02.83, Z02.89, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8

CMS 1500 Paper Claim Instructions

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

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

CMS Field #	Field Label	Field is?	Instructions
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	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	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.

CMS Field #	Field Label	Field is?	Instructions
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	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	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 0701146 for July 1, 2016. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	LBOD Use to document the Late Bill Override Date for timely filing.
20	Outside Lab? \$ Charges	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported.

CMS Field #	Field Label	Field is?	Instructions
			0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	Medicaid Resubmission Code	Conditional	List the original reference number for 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	
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: 010116 for January 1, 2016 From To 01 01 16 Or From To 01 01 16 01 01 16 Span dates of service From To 01 01 16 01 31 16

CMS Field #	Field Label	Field is?	Instructions
			<p>EPSDT All dates of service must be the same date as screening.</p>
24B	Place of Service	Required	<p>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.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 32 Nursing Facility 99 Other Unlisted
24C	EMG	Conditional	<p>Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.</p> <p>If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.</p>
24D	Procedures, Services, or Supplies	Required	<p>Enter the HCPCS procedure code that specifically describes the service for which payment is requested.</p> <p>All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually.</p> <p>HCPCS Level II Codes</p> <p>The current Medicare coding publication (for Medicare crossover claims only).</p> <p>Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
24D	Modifier	Conditional	<p>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.</p> <ul style="list-style-type: none"> 24 Evaluation/Management (E/M) service during the postoperative period

CMS Field #	Field Label	Field is?	Instructions
			<p>Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p>26 Professional component Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services <u>only</u> if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.</p> <p>47 Anesthesia by surgeon Use with surgical procedure codes to report general or regional anesthesia by the surgeon. Local anesthesia is included in the surgical reimbursement.</p> <p>50 Bilateral procedures Use to identify the bilateral (second) surgical procedure performed at the same operative session. Read CPT descriptions carefully. Do not use modifier -50 if the procedure descriptor states "Unilateral or bilateral" services.</p> <p>51 Multiple Procedures Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate "add-on" codes.</p> <p>59 Multiple Procedures Use to indicate a service that is distinct or independent from other services that are performed on the</p>

			<p>same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system or separate lesion or injury.</p> <p>76 Repeat procedure by <u>same</u> physician/provider Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes.</p> <p>77 Repeat procedure by <u>another</u> physician/provider Use to identify subsequent occurrences of the same service on the same day by different rendering providers.</p> <p>79 Unrelated procedure or service by surgeon Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p>80 Assistant surgeon Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable.</p> <p>GY Item or services statutorily excluded or does not meet the Medicare benefit. Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier -GY takes the place of the required provider certification that the services are not covered by</p>
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CMS Field #	Field Label	Field is?	Instructions
			<p>Medicare. The Medicare non-covered services field on the claim record must also be completed.</p> <p>KX Specific required documentation on file</p> <p>Use with laboratory codes to certify that the laboratory’s equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider’s certification, “I certify that the necessary laboratory equipment was not functioning to perform the requested test ”, or “I certify that this laboratory is not certified to perform the requested test.”</p> <p>UK Inpatient newborn care billed using mother’s State ID and birth date</p> <p>Use to identify inpatient physician services rendered to newborn infants while the mother remains in the hospital. Services provided to a hospitalized newborn after the mother’s discharge must be submitted using the Colorado Medical Assistance Program ID number assigned to the child. Modifier -UK takes the place of the required certification, “Newborn care billed using Mother’s State ID”.</p> <p>55 Postoperative Management only</p> <p>Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for members over age 20 must be related to surgery. Modifier -55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery.</p>

CMS Field #	Field Label	Field is?	Instructions
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>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.</p> <p>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.</p> <p>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.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area)</p> <p>For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p>

CMS Field #	Field Label	Field is?	Instructions
			AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used Family Planning (unshaded area) Not Required
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
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	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		

CMS Field #	Field Label	Field is?	Instructions
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>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.</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
32	32- Service Facility Location Information 32a- NPI Number 32b- Other ID #	Not Required	
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name</p> <p>2nd Line Address</p> <p>3rd Line City, State and ZIP Code</p> <p>33a- NPI Number</p> <p>Enter the NPI of the billing provider</p> <p>33b- Other ID #</p>

CMS Field #	Field Label	Field is?	Instructions
			Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



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.

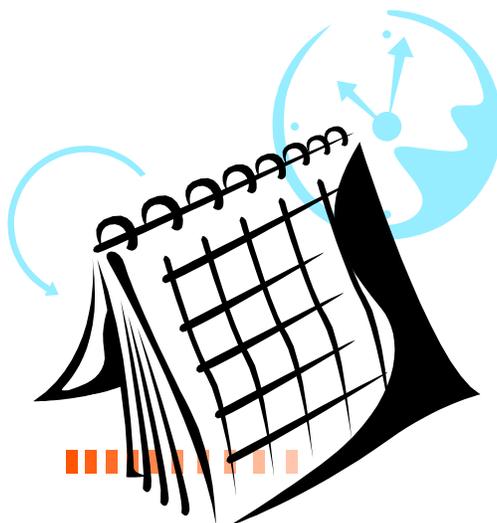
Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>CMS 1500</i>: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➤ <i>2006 ADA Dental</i>: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	<p>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.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p>

Billing Instruction Detail	Instructions
	<p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
Denied Paper Claims	<p>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.</p> <p>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.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
Returned Paper Claims	<p>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.</p> <p>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.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
Rejected Electronic Claims	<p>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.</p> <p>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.</p> <p>LBOD = the date shown on the claim rejection report.</p>
Denied/Rejected Due to Member Eligibility	<p>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.</p> <p>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.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
Retroactive Member Eligibility	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>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:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive

Billing Instruction Detail	Instructions
	<ul style="list-style-type: none"> Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>
Delayed Notification of Eligibility	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>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.</p> <ul style="list-style-type: none"> 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. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
Electronic Medicare Crossover Claims	<p>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.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
Medicare Denied Services	<p>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.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>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.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>

Billing Instruction Detail	Instructions
Commercial Insurance Processing	<p>The claim has been paid or denied by commercial insurance.</p> <p>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.</p> <p>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.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
Correspondence LBOD Authorization	<p>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.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
Member Changes Providers during Obstetrical Care	<p>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.</p> <p>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.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



CMS 1500 EPSDT Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>												PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (IDMCoD#) (Member ID#) (ID#)</small>				1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A				3. PATIENT'S BIRTH DATE MM DD YY SEX 10 16 11 M F <input checked="" type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) CITY STATE 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 <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 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					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 10/1/15												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. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. R32 B. C. D. E. F. G. H. I. J. K. L.				ICD Ind. 0				22. RESUBMISSION CODE ORIGINAL REF. NO.					
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. ICD-9-CM ICD-10-CM J. RENDERING PROVIDER ID. #													
1 10 01 15 10 01 15 11 99393 A 30 00 1 S2 12345678 NPI 0123456789													
2 10 01 15 10 01 15 11 90705 A 25 00 1 S2 12345678 NPI 0123456789													
3 10 01 15 10 01 15 11 89210 A 10 00 1 S2 12345678 NPI 0123456789													
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) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 65 00		29. AMOUNT PAID \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 10/15				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ABC EPSDT Center 100 Any Street Any City a. 1234567890 b. 04567890					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

EPSDT Revisions Log

Revision Date	Additions/Changes	Pages	Made by
04/21/2009	Drafted Manual	All	jg
07/06/2009	Accepted changes and verified TOC	Throughout	jg
10/19/2009	LBOD	23	jg
01/12/2010	Updated Web site links	Throughout	jg
02/10/2010	Changed EOMB to SPR	25	jg
03/04/2010	Added link to Program Rules	2	jg
12/05/2011	Replaced 997 with 999 Replaced http://www.wpc-edi.com/hipaa with http://www.wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)	4 2 2	ss
05/08/2013	Deleted duplicate GY modifier information	19	jg
09/27/2013	Removed electronic billing and referenced the CO-1500 General billing manual Removed MED-178 instructions and example. Referenced location of form and instructions on p.30	3 30-35	cc
10/03/2013	Formatted Updated TOC	Throughout i	jg
02/03/2014	Updated abortion information	29 & 30	jg
05/14/2014	Updated Billing Manual for removal of the Primary Care Physical Program	Throughout	Mm
8/8/14	Replaced all CO 1500 references with CMS 1500	Throughout	ZS
8/8/14	Updated Professional Claim Billing Instructions section with CMS 1500 information.		ZS
8/8/14	Updated all references of Client to Member	Throughout	ZS
8/8/14	Updated all claims examples to CMS1500		ZS
8/11/14	Updated all web links to reflect Department's new site	Throughout	Mm
8/20/2014	Revised General Program Provisions per benefit manager	3-4	GR, MM
8/20/2014	Added Cavity Free at Three information	4	GR, MM
8/20/2014	Added all references to DentaQuest, new Dental ASO	6, Throughout	GR, MM
8/20/2014	Revised Outreach and Case Management to include Healthy Living Program	5	GR, MM
8/20/2014	Removed immunization references	8-10, throughout	GR, MM

<i>10/27/2014</i>	<i>Added frequencies and benefits for developmental, depression, and autism screenings under Services and Benefits.</i>	<i>6-8</i>	<i>MC, RM</i>
<i>10/27/14</i>	<i>Updated Table of Contents</i>	<i>1</i>	<i>MC</i>
<i>11/21/14</i>	<i>Removed Appendix H information, added Timely Filing document information</i>	<i>24</i>	<i>rm</i>
<i>04/28/2015</i>	<i>Changed the word unshaded to shaded</i>	<i>24J</i>	<i>BI</i>
<i>8/19/2015</i>	<i>Added Allowed Procedure Codes table template</i>	<i>11</i>	<i>CF</i>
<i>8/21/15</i>	<i>Added the ICD-10 diagnosis codes swapped out ICD 9 references with ICD-10. Changed font to Tahoma, updated table of contents. There are no references to CareWebQI</i>	<i>10, 32, 36 Throughout Throughout Throughout</i>	<i>JH</i>
<i>09/08/2015</i>	<i>Accepted changes and updated TOC</i>	<i>Throughout</i>	<i>BI</i>
<i>07/19/2016</i>	<i>Changed Medicaid to Health First Colorado where applicable.</i>	<i>Throughout</i>	<i>JH</i>
<i>7/25/2016</i>	<i>Checked links and added new ones where applicable. Cleaned up language and added UM vendor process</i>	<i>Throughout</i>	<i>GR</i>

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