Independent Laboratory

Independent Laboratory

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

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

An independent laboratory is a certified laboratory that performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital. All clinical laboratory providers must furnish their Clinical Laboratory Improvement Amendment (CLIA) certification numbers to the Health First Colorado fiscal agent at the time of enrollment.

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

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

Important: All lab tests performed for non-citizens must be emergencies. Claims that are not marked with the "92 - Emergency" code will not be paid.

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. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

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

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

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

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

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP).

The Online Portal contains training, user guides and help that describe claim completion requirements, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

The Health First Colorado OP reviews the claim information for compliance with Health First Colorado billing policy and passes the claim to the Colorado interChange system for adjudication and reporting on the Health First Colorado Provider Remittance Advice (RA).

The OP immediately returns a response to the provider about that single transaction indicating whether the claim will be rejected, suspended or paid.

- If the claim is rejected, the OP sends a rejection response that identifies the rejection reason. The rejected claim can immediately be resubmitted.
- If the claim is suspended then it needs additional manual review by the Fiscal Agent.
- If the claim is accepted, the provider receives a message indicating that the claim is will be paid.

The Online Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Remittance Advice to providers. The Online Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Online Portal. The reports and transactions include:

- Accept/Reject Report
- Remittance Advice
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Online Portal. Access the Online Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Online Portal, please choose the *User Guide* option available for each Online Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's website.

Batch Electronic Claim Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Health First Colorado fiscal agent.

For additional electronic billing information, please refer to the appropriate Companion Guide in the Provider Services Specifications section.

General Prior Authorization Requirements

Prior Authorization Requests (PARs) must be completed for:

- All out-of-state Inpatient non-emergency services
- All transplant procedures, except Cornea and Kidney

*Note: Organ transplants are **not** a covered benefit for Non-Citizens.*

All PARs and revisions processed by the ColoradoPAR Program must be submitted using eQSuite®. Prior Authorization Requests submitted via fax or mail **will not** be processed by the ColoradoPAR Program and subsequently not reviewed for medical necessity. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program.

The electronic PAR format will be required unless an exception is granted by the ColoradoPAR Program. Exceptions may be granted for providers who submit five (5) or less PARs per month.

To request an exception, more information on electronic submission, or any other questions regarding PARs submitted to the ColoradoPAR Program, please contact the ColoradoPAR Program at 888-801-9355 or refer to the Department's ColoradoPAR Program web page.

It is the provider's responsibility to maintain clinical documentation to support services provided in the member's file in the event of an audit or retroactive review. Submitted PARs without minimally required information or with missing or inadequate clinical information will result in a lack of information (LOI) denial.

All accepted PARs are reviewed by the authorizing agency. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR.

Paper PAR forms and completion instructions are located in the Provider Services Forms section of the Department's website. They must be completed and signed by the member's physician and submitted to the authorizing agency for approval.

Do not render services or submit claims for services requiring prior authorization before the PAR is approved. When the authorizing agency has reviewed the service, the PAR status is transmitted to the fiscal agent's prior approval system.

The status of the requested services is available through the Online Portal. In addition, after a PAR has been reviewed, both the provider and the member receive a PAR response letter detailing the status of the requested services. Some services may be approved and others denied. **Check the PAR response carefully as some line items may be approved and others denied.**

Approval of a PAR does **not** guarantee Health First Colorado payment and does **not** serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a benefit of the Health First Colorado.

All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, Primary Care Physician [PCP] information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.

Submitted claim data is checked against the PAR file, therefore, **do not** submit a copy of the PAR with the claim. The fiscal agent identifies the appropriate PAR data using member identification information and the PAR number noted on the claim.

PAR Revisions

All PAR revisions must be completed through eQSuite® on the ColoradoPAR Program's website. If a procedure has been prior authorized but the medical decision was changed, a revision must be sent

immediately to the authorizing agency to have the PAR adjusted. Without a revised PAR the claim will not pay.

If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix D of the Appendices in the Provider Services Billing Manuals section.

Laboratory Prior Authorized Procedure Codes

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

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

Last table update: 08/03/2015

Procedure Code	Short Description	Provider	Max Daily Units	Prior Authorization Required
81162	BRCA 1&2 Sequence and Full Duplication/Deletion	CLIA Certified	1	Yes
81211	BRCA 1&2 FULL SEQUENCE ANALYSIS	CLIA Certified	1	Yes
81212	BRCA 1&2 GENE ANALYSIS	CLIA Certified	1	Yes
81213	BRCA 1&2 GENE ANALYSIS UNCOMMON	CLIA Certified	1	Yes
81214	BRCA 1 FULL SEQUENCE ANALYSIS	CLIA Certified	1	Yes
81215	BRCA 1 GENE KNOWN FAMILIAL VARIANT	CLIA Certified	1	Yes
81216	BRCA 2 FULL SEQUENCE ANALYSIS	CLIA Certified	1	Yes
81217	BRCA 2 GENE KNOWN FAMILIAL VARIANT	CLIA Certified	1	Yes

Laboratory Services

Clinical Laboratory Improvement Amendments (CLIA) Claims

Laboratory providers submitting procedures covered by CLIA must have a CLIA number of the laboratory where the procedure was done on the claim or claim line.

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

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

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

Handling, Collection and Conveyance Charges

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

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

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

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

Papanicolaou (Pap) Smears

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

General Requirements

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

Procedure/HCPCS Codes Overview

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

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

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

Procedure Codes

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

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

CMS 1500 Paper Claim Reference Table

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

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.

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

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

CMS Field #	Field Label	Field is?	Instructions
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Conditional	Complete if <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.

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

CMS Field #	Field Label	Field is?	Instructions
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To **01 01 15** | | | | | | Or From To **01 01 15 01 01 15** Span dates of service From To **01 01 15 01 31 15** Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 81 Independent Lab

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

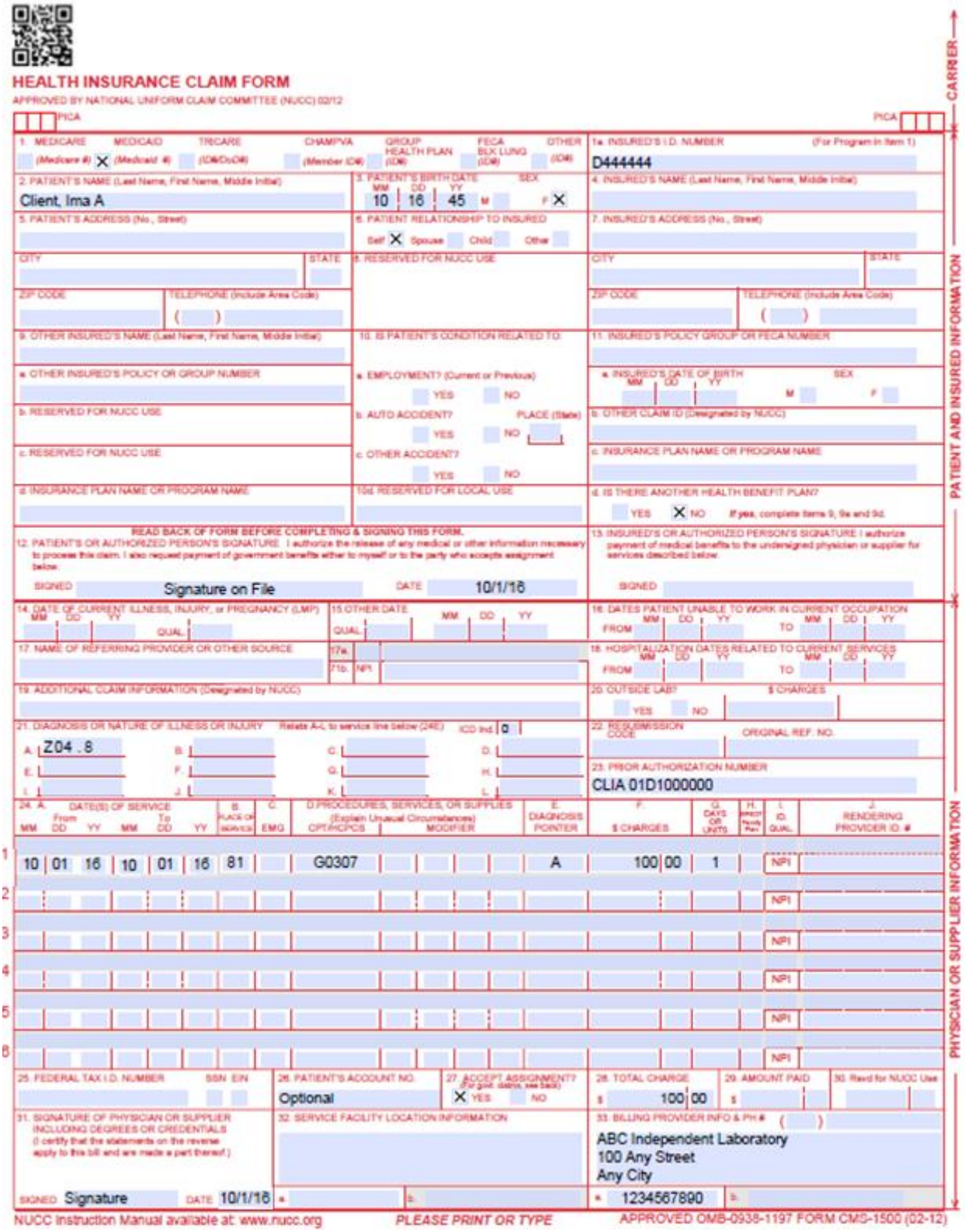
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **Mod** **Description** 26 **Professional component** Use with diagnostic codes to report professional component services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

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

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

CMS Field #	Field Label	Field is?	Instructions
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 Independent Laboratory Claim Example with CLIA Number



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 10/1/16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 01D1000000

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	81		G0307		A	100 00	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

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

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

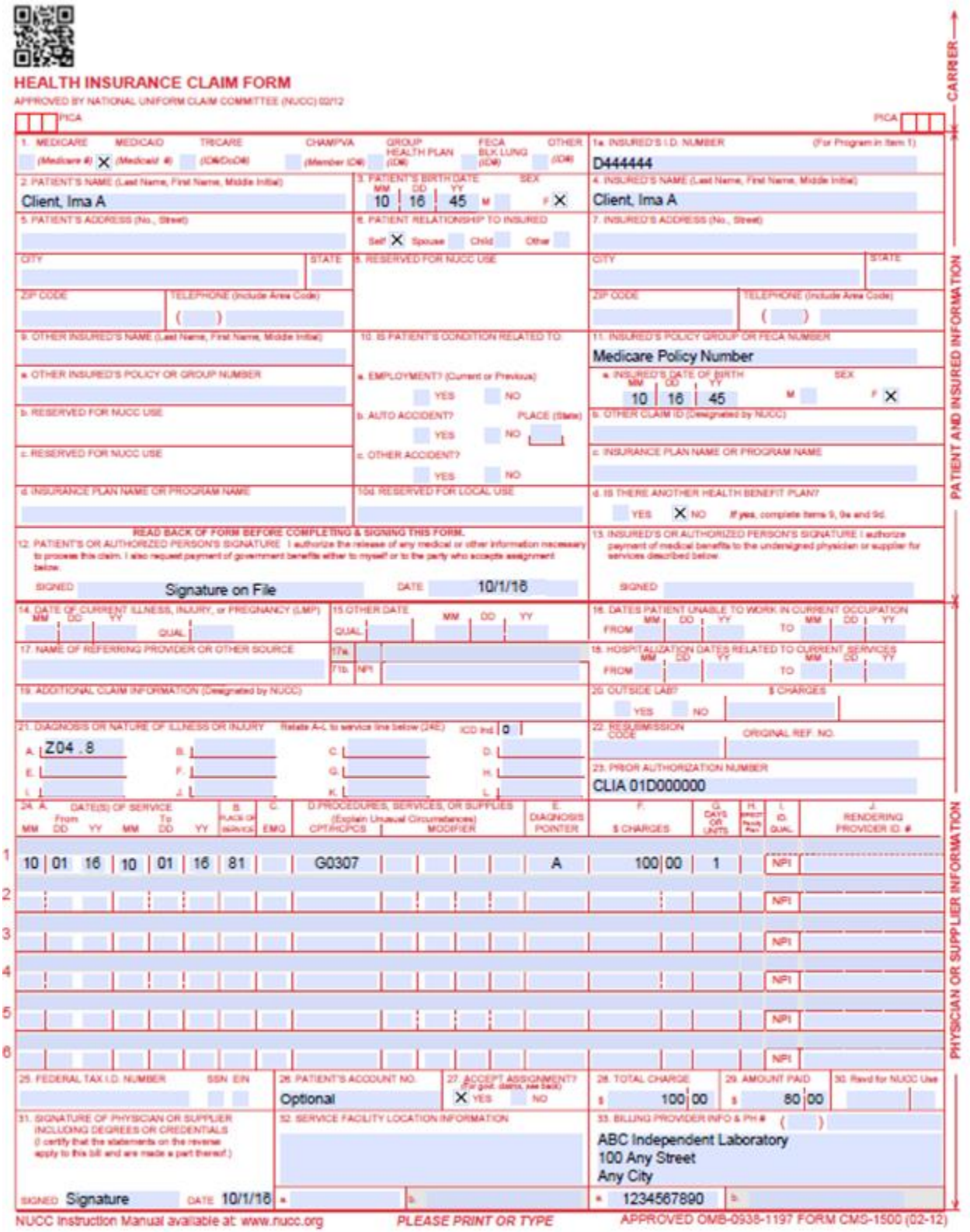
ABC Independent Laboratory
100 Any Street
Any City

a. 1234567890 b.

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

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500 Independent Laboratory Crossover Claim Example with CLIA Number



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY: STATE:

8. RESERVED FOR NUCC USE

CITY: STATE:

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES | NO

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

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES | NO PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 10/1/16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL:

15. OTHER DATE: QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES | NO $ CHARGES

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

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

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 01D000000

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	81		G0307		A	100 00	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

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

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $ 80 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: Signature DATE: 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION: a. b.

33. BILLING PROVIDER INFO & PH #: ( )

ABC Independent Laboratory
100 Any Street
Any City

a. 1234567890 b.

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)

Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section.

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

Independent Laboratory Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manuals Comment Log v0_2.xlsx*	*5, 10*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1, 6*	*DXC*

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.*