Prenatal Plus Program
Outpatient – Fee-For-Service

Prenatal Plus Program

The Prenatal Plus Program (PN+) is administered by the Colorado Department of Health Care Policy and Financing (the Department). This manual details information regarding the program's programmatic components and billing requirements. The Department periodically modifies the Prenatal Plus Program benefits and services therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

For general information about Colorado's Medical Assistance Program, please refer to the Health First Colorado (Colorado's Medicaid Program) Provider Information found on Billing Manuals web page of the Department's website. The manual provides information about billing the Health First Colorado, reimbursement policies, provider participation, eligibility requirements and other useful information.

Program Overview

The Prenatal Plus Program is a case management program for pregnant women who receive Health First Colorado benefits and who are at risk of negative maternal and infant health outcomes. The program gives women access to a care coordinator, a registered dietician, and a mental health professional who work together to help the woman reduce her risk of having a low birth weight baby. Prenatal Plus Program services are in addition to a woman's regular prenatal care services.

- To be eligible for the program, a woman must meet the following criteria:
- Be eligible for Health First Colorado;
- Be pregnant;
- Be at risk of negative maternal or infant health outcomes due to lifestyle, behavioral, and non-medical parts of the woman's life that could affect her pregnancy (see Eligibility Screening Form).

For more information about the Prenatal Plus Program, please visit the Prenatal Plus Program's web page.

Reimbursable Services

Reimbursable services include nutrition and psychosocial counseling and support; general education and health promotion; and targeted case management services. With the exception of targeted case management, all services can be offered to members in an individual or group setting.

- Nutrition counseling and support provided by the registered dietitian may include nutrition screening, education, and counseling. Counseling includes such activities as nutrition care-planning, goal-setting, monitoring, follow-up, and revision of the care plan.
- Psychosocial counseling and support provided by the mental health professional may include psychosocial health screening, assessment, and counseling. Counseling and support includes such activities as care-planning, goal-planning, monitoring, follow-up, and revision of the care plan.
- General member education, health promotion, and targeted case management are services offered by the care coordinator. Topics may include basic understanding of the prenatal period, concerns related to childbirth and breastfeeding, and the post-partum period and healthy infancy. Targeted case management helps member gain access to needed medical, education, social, and other services.

Rules and Regulations

The Prenatal Plus Program is administered by the Department. Rules governing the program are outlined in the Code of Colorado Regulations, 10 C.C.R. 2505 – 10 §8.748. Providers are required to comply with all of the rules and guidance provided by the Department and are encouraged to contact the Department's policy specialist with any questions.

Required Documentation

Prenatal Plus Program sites utilize three specific forms to implement the program. All of these documents, a more comprehensive program manual, and provider resources and announcements can be found on the Prenatal Plus Program's section of the Department's website at colorado.gov/hcpf. They include:

- Prenatal Plus Eligibility Screening Form
- Initial Assessment Form
- Psychosocial Assessment

While these forms are required, the method and detail of documentation of member's service plans is up to the discretion of the local Prenatal Plus Program staff. Every claim for reimbursement must be supported by clear evidence in the member's record/chart.

Provider Enrollment and Participation

Providers must be enrolled as a Health First Colorado provider in order to treat a Health First Colorado member and to submit claims for payment to the Health First Colorado.

If interested in becoming a Health First Colorado provider, please refer to the Provider Services Enrollment section of the Department's website. Once enrolled in the Health First Colorado, providers who want to provide Prenatal Plus Program services must submit a Prenatal Plus Program Provider Participation Form as an addendum to the Health First Colorado Provider Participation Agreement. This form is found in the Forms section of the Department's website → For Our Providers → Provider Services → Forms

Prenatal Plus Program providers must be enrolled in the Health First Colorado as one of the following Provider Types:

- Clinic
- Federally Qualified Health Center
- Rural Health Center
- Non-Physician Practitioner Group
- Physician
- Nurse Practitioner
- Certified Nurse-Midwife
- Physician's Assistant

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 can 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.

Procedure/Healthcare Common Procedural Coding System (HCPCS) Overview

The codes used for submitting claims for services provided to Health First Colorado members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Health First Colorado provider.

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 Bulletins section. To receive electronic provider bulletin notifications, an email address can be entered into the Provider web portal in the Provider Data Maintenance area. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

Prenatal Plus Program Procedure Codes and Modifiers

The Prenatal Plus Program's services are billed using one procedure code and a combination of modifiers. The code and modifiers are explained in the tables below.

Procedure Code	Description
H1005	Prenatal care, at-risk enhanced service package

Modifier(s)	Description
52	Reduced services
TF	Intermediate level of care
TG	Complex/high tech level of care
TH	Obstetrical treatment/services, prenatal or post partum

Prenatal Plus Billing Packages

The billing options for the Prenatal Plus Program are described in the table below.

Package Type	Procedure Code	Required Modifier(s)	Condition(s) Under Which Code Can Be Billed
Partial	H1005	TH and 52	Member enrolls at 28 or more weeks gestation and receives 1-4 contacts, at least one of which must be a face-to-face contact; **OR** Member enrolls in the first or second trimester (prior to 28 weeks) and receives 1-4 contacts, at least one of which must be a face-to-face contact, but withdraws from the program before delivery **OR** does not meet the criteria for the other package categories.
Partial Plus	H1005	TH and TF	Member enrolls at 28 or more weeks gestation and receives 5-9 contacts; **OR** Member enrolls in the first or second trimester (prior to 28 weeks) and receives 5-9 contacts, but withdraws from the program before delivery **OR** does not meet the criteria for the Full package categories. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a member cannot be considered a contact.

Package Type	Procedure Code	Required Modifier(s)	Condition(s) Under Which Code Can Be Billed
Full	H1005	TH	Member enrolls at 27 or fewer weeks gestation; A minimum of one case conference is held; **AND** Member receives a total of ten (10) contacts over the course of the pregnancy and through the end of the second month following the month in which the member delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a member cannot be considered a contact.
Full Plus	H1005	TH and TG	Member enrolls at 27 or fewer weeks gestation; A minimum of one case conference is held; **AND** Member receives a minimum of eleven (11) contacts over the course of the pregnancy and through the end of the second month following the month in which the member delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a member cannot be considered a contact.

Claims Submission and Timely Filing

Prenatal Plus Program claims must be submitted directly to the Health First Colorado for processing within 120 days after the last date of service. The last date of service is either the delivery date or the last date of contact for those who withdraw from the program. Providers should bill completed packages as soon as possible after the delivery date, even if the member may be seen for additional visits. Please see the Timely Filing section of this manual for more information.

Other Insurance Coverage

Occasionally, Prenatal Plus Program members have primary insurance coverage in addition to being eligible for Health First Colorado coverage. In these cases, claims for services must first be submitted to the primary insurance company. If the primary insurance company denies the claim, the claim can be submitted to the Health First Colorado for processing, along with a copy/date of the denial.

If the member is covered by one of the Health First Colorado's managed care organizations, a denial is not necessary before billing for Prenatal Plus services covered by Health First Colorado.

Please refer to the Health First Colorado Provider Information found on Billing Manuals web page of the Department's website for more information on the payer of last resort.

Billing more than once in a nine-month period

The Colorado interChange System allows for one billing per member in a nine-month period using Prenatal Plus billing codes. However, the following exceptions may be made:

- A member is seen for an initial pregnancy, subsequently has either a miscarriage or an abortion, and becomes pregnant again within a nine-month period. In this case, the provider may bill for the second pregnancy within the nine-month period.
- A member receives a Partial or Partial Plus package from one provider, then moves from the area and re-enrolls with a new provider. In this case, the first provider may bill a Partial or Partial Plus package, and the second provider may bill either a Partial, Partial Plus, Full or Full Plus package depending on the level of services provided (i.e., if all requirements for a Full package have been met, the provider can bill a Full package).

If a member leaves the program, and then re-enrolls with the same provider during the same pregnancy, the provider must request that the claim for the previously billed service package be voided out of the interChange. Billing for the new service package can be done once criteria for the new package are met. An agency cannot bill the Health First Colorado for two separate packages for the same member during the same pregnancy.

Deactivate Participation in the Prenatal Plus Program

Prenatal Plus Program sites can end participation in the program at any time. Instructions can be found on the Prenatal Plus Program's web page.

Other Covered Maternity Services Not Part of the Prenatal Plus Program

The following services are available to pregnant women but must be billed in addition to Prenatal Plus Program claims:

- Clinical prenatal and postpartum care, labor, and delivery
- Depression screenings
- Non-emergent medical transportation (transportation to and from Health First Colorado services)
- Prenatal vitamins
- Substance use counseling and SBIRT services
- Tobacco cessation counseling and medications
- Family Planning Counseling

Contact Information

Please contact the Department's fiscal agent, DXC Technology (DXC) at 844-235-2387 (toll free) with billing inquiries.

The Department's Prenatal Plus Program policy specialist at 303-866-2844 can be contacted for all other inquiries.

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.
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**		

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.

CMS Field #	Field Label	Field is?	Instructions
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	
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: 070116 for July 1, 2016. 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	

CMS Field #	Field Label	Field is?	Instructions
18	**Hospitalization Dates Related to Current Service**	Not Required	
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.
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 condition. Most commonly appropriate ICD 10 Code: O09: Supervision of high risk pregnancy. 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** Not Required

CMS Field #	Field Label	Field is?	Instructions
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 For Prenatal Plus, the Date of Service is the date of final service. From To **01 01 16** | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information.

CMS Field #	Field Label	Field is?	Instructions
			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. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted

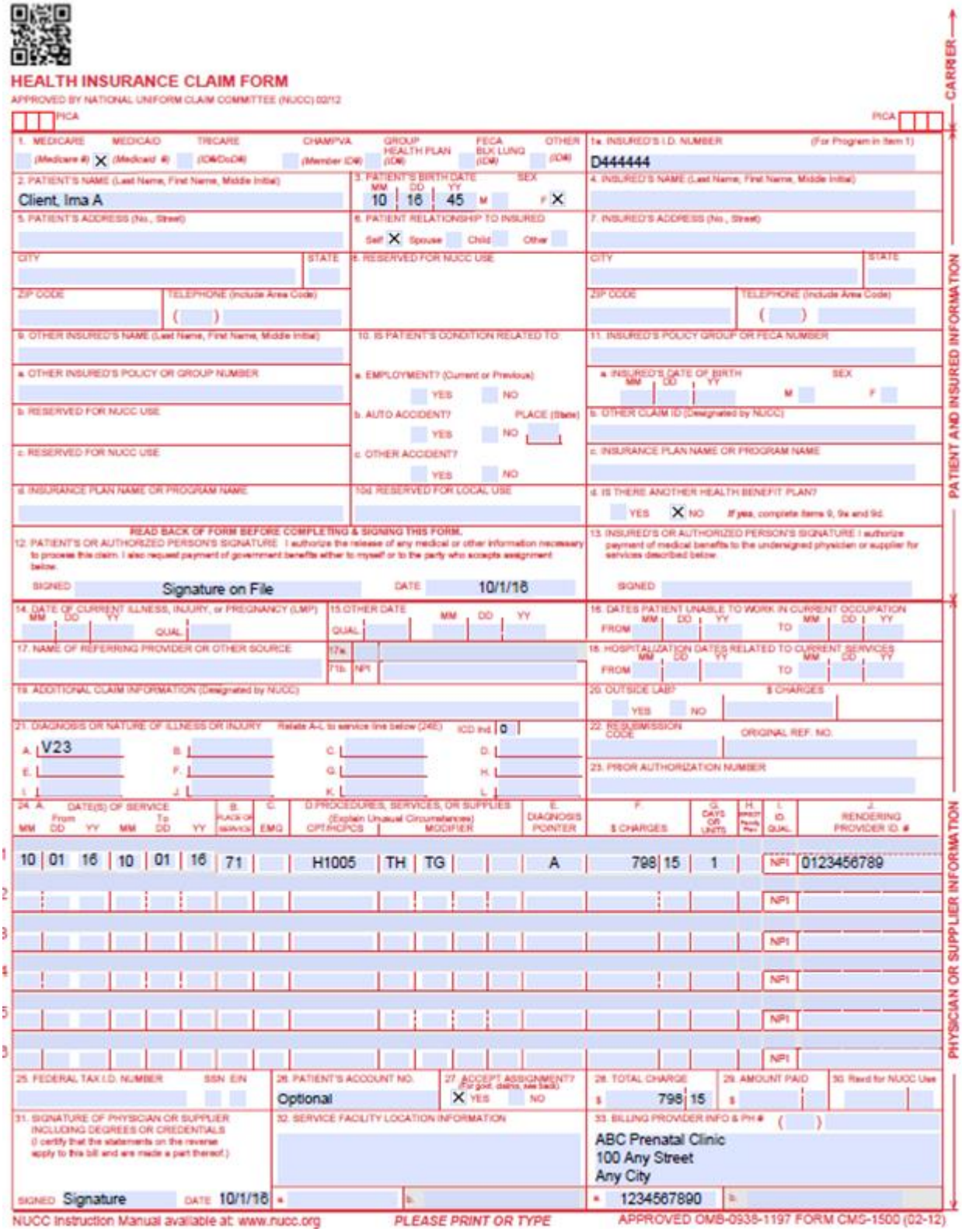
CMS Field #	Field Label	Field is?	Instructions
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians 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. **Prenatal Plus Program** H1005 for prenatal care, at-risk enhanced service package
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. 52 **Reduced services** TF **Intermediate level of care** TG **Complex/high tech level of care** TH **Obstetrical treatment/services, prenatal or post partum**
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.

CMS Field #	Field Label	Field is?	Instructions
			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.
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) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field**.**

CMS Field #	Field Label	Field is?	Instructions
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**		
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

CMS Field #	Field Label	Field is?	Instructions
			name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	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 Prenatal Plus Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. V23 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	71		H1005	TH TG	A	798 15	1		NPI 0123456789
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 $ 798 15

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 Prenatal Clinic
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.

Prenatal Plus Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*1, 2, 7, 10, 11*	*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*	*3, 7*	*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.