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Transportation

Benefits

Medical transportation is a Colorado Medical Assistance Program benefit when the member requires transportation. The transportation services must be medically necessary and provided within the scope of the provider’s certification and license. Transportation for Colorado Medical Assistance Program members to and from a medical provider is a benefit when the medical service provided is a benefit of the Colorado Medical Assistance Program.



Medical Transportation includes both emergent and non-emergent services.

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 prior authorized by the Department. Requests may be sent to Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims



Paper claims do not require an NPI, but do require the Colorado Medical Assistance 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 (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal ([Web Portal](#)) or via batch submission through a host system.

For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department’s website (colorado.gov/hcpf/billing-manuals)

Emergency Transportation

Emergency Ambulance and Air Ambulance Transport

All emergency ambulance and air ambulance transportation claims are billed directly to the fiscal agent by the transportation provider. Emergency transportation services require a physician’s statement of medical necessity or trip report that must be retained by the transportation provider and is subject to audit for a period up to six (6) years from the date of service.

Exclusions

The following services are not Colorado Medical Assistance Program emergency transportation benefits:

- Waiting time, cancellations, or additional passengers (e.g., family members) except in the case of approved escorts
- Response calls when, upon arrival at the site of the call, no transportation is needed or provided
- Charges when the member is not in the vehicle
- Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary
- Transportation services when medical treatment is not required or provided upon arrival
- Transportation to services located on military reservations
- Transportation to local treatment programs not enrolled in the Colorado Medical Assistance Program
- Pick up or delivery of prescriptions and/or supplies
- Transportation arranged for the member’ convenience as opposed to medical necessity



Types of Emergency Transportation

Ambulance services

Emergency ambulance service is a Colorado Medical Assistance Program benefit when the member’s condition requires immediate attention.

Air ambulance

Air ambulance benefits are provided when:



- The point of pick up is inaccessible by a land vehicle.
- Great distances or other obstacles prohibit transporting the member by land to the nearest appropriate facility and the member’s condition requires immediate attention.
- The patient is suffering from an illness or injury making other forms of transportation inadvisable.

Submit hospital–based emergency ambulance and air ambulance services as an 837 Institutional (837I) electronic transaction.

Non-Emergent Transportation

Non-emergent medical transportation for Colorado Medical Assistance Program members to and from a medical provider is a benefit only when the member’s medical or physical condition does not allow that member to travel by passenger car, taxi cab or other form of public or private conveyance, as ordered and certified by a qualified healthcare professional. The medical service provided must be to the closest qualified provider, a benefit of the Colorado Medical Assistance Program and must be prior authorized by the State designated entity.

Non-emergent medical transportation benefits are prior authorized and administered by the County Department of Human/Social Services or the County’s contracted broker (State designated entity). This includes obtaining State authorization when necessary. The State designated entity must submit claims to the fiscal agent for processing as well as distribute reimbursed funds to the appropriate providers. The State designated entity must also explore and utilize the least costly, medically appropriate means of transportation for each member and arrange those transportation services. Non-emergent medical transportation includes mobility vehicle, wheelchair van, bus, train, air, and non-emergent ambulance.



Non-emergent medical transportation services must be ordered and certified in writing by a qualified healthcare professional, such as an attending physician, physician assistant, nurse practitioner, therapist or other licensed mental healthcare professional. Written documentation explaining the medical necessity for special transport, including member condition that prohibits the member from seeking his/her own transportation via public or private conveyance and the need for specialized transportation must accompany the written order for transportation.

In rare circumstances, a member who does not qualify for Colorado Medical Assistance transportation services may still receive services in the event the member is a minor child or an at risk adult whose escort has a medical or physical condition that precludes the escort from obtaining his/her own public or private transportation.

Types of Non-Emergent Transportation

General Instructions

The State designated entity must maintain records of all appropriate documentation on file for a period of six (6) years. These records must be available and produced for audit and inspection upon request. Transportation providers should maintain a record of the State designated entity authorization. The authorization must cover the service dates. The State designated entity must also submit a Prior Authorization Request (PAR) to the appropriate State authorizing agency for amounts over the State’s maximum allowable rate (Over-the-Cap).

Transportation services billed by the State designated entity

The State designated entity submits claims for all non-emergent transportation services:



- Mobility vehicle
- Wheelchair van
- Non-emergent ambulance
- Bus
- Train services prior authorized by the State authorizing agency
- Air services prior authorized by the State authorizing agency

- Ancillary services prior authorized by the State authorizing agency
- Out-of-state transportation prior authorized by the State authorizing agency
- Over-the-Cap transportation prior authorized by the State authorizing agency

Exclusions

The following services are not Colorado Medical Assistance Program non-emergent medical transportation benefits:

- Waiting time, cancellations, or additional passengers (e.g., family members) except in the case of approved escorts
- Response calls when, upon arrival at the site of the call, no transportation is needed or provided.
- Charges when the member is not in the vehicle
- Transportation to non-benefit services
- Transportation services not prior approved by the State designated entity
- Transportation to services located on military reservation.
- Pick up or delivery of prescriptions and/or supplies
- Transportation arranged for the member’s convenience as opposed to medical necessity
- Ancillary services when member is receiving in-patient treatment and receives these benefits as part of the in-patient stay



Mobility Vehicle

A mobility vehicle is a passenger carrying vehicle for hire, including those designed, constructed, modified or equipped to meet the needs of passengers with medical, physical or mobility impairments and, when medically necessary, their certified escorts. Mobility vehicles, including mobility van, mini-bus, mountain area transports and other non-profit transportation systems, are defined as vehicles certified as a common or contract carrier and regulated by the Public Utilities Commission (PUC), with a call-and-demand limousine authority, or a specialized intra-governmental agency bus substitute service or specialized mobility service.

Based upon this PUC regulation, a mobility vehicle may transport “mixed parties” without the consent of the other passengers and therefore may transport several members at the same time. A mobility vehicle does not calculate charges based upon a meter. Taxi service is not a mobility vehicle; however, a taxi company may also have call-and-demand limousine authority from the PUC and may operate its vehicles under that authority as mobility vehicles.



In this case, the taxi company agrees to the Colorado Medical Assistance Program reimbursement for mobility vehicles. Mobility vehicle services are transportation services provided to individuals who are not wheelchair confined.

Mobility vehicle transportation is a Colorado Medical Assistance Program benefit when the member’s physician-certified medical or physical condition precludes the use of member-purchased public or private transportation, or other less costly means of Colorado Medical Assistance transportation. The State designated entity must prior authorize mobility vehicle transportation.

A mobility vehicle may bill using wheelchair van codes only when the member is a physician-certified wheelchair user and the vehicle has been modified with appropriate wheelchair equipment. If these requirements are not met, the mobility vehicle may not bill using wheelchair van codes.

Mobility vehicles may bill over-the-cap transportation when the trip is beyond the local community of the point of pickup. This is generally about 12 miles. When a mobility vehicle transport is outside the local community (about 12 miles), it should be billed as over-the-cap.

When a mobility vehicle provides over-the-cap transportation to more than one member, special multiple rider exceptions apply. (See Over-the-Cap)

Wheelchair Van

A wheelchair van is a vehicle for hire that has been specifically designed, constructed, modified, or equipped to accommodate the needs of wheelchair users. Wheelchair van services are a Colorado Medical Assistance Program benefit when ordered by a physician and the member’s, physician-certified, medical or physical condition precludes the utilization of member-purchased public or private transportation, or a less costly means of Colorado Medical Assistance Program transportation. Wheelchair van transportation is only for wheelchair-confined members, as certified by a physician, within a vehicle that has been modified to accommodate the wheelchair and must be prior authorized by the State designated entity.



Wheelchair van service is not regulated by the PUC. Any company with a vehicle for hire that has been modified to accommodate a wheelchair may transport wheelchair members without regard to any other authority the company may have from the PUC. When operating as a wheelchair van, the provider agrees to wheelchair van reimbursement.

Oxygen administration is allowed when medically necessary. Wheelchair vans must bill using mobility vehicle codes if the member is not a physician-certified wheelchair user, in which case, the mobility vehicle must also meet PUC requirements for mobility vehicle services. (See Mobility Vehicle)

Wheelchair vans may bill over-the-cap services when appropriate. Over-the cap special multiple rider exceptions apply when billing multiple over-the-cap riders. (See Over-the-Cap)

Non-Emergent Ambulance Services

Non-emergent, pre-planned ambulance service is a Colorado Medical Assistance Program benefit when the member’s condition is such that he or she requires an ambulance in order to be transported safely. Non-emergent ambulance must be certified by a physician and prior authorized by the State designated entity.

Air Ambulance

Air ambulance benefits are provided when:



- Non-emergency, pre-planned services are prior authorized by the State authorizing agency.
- Great distances or other obstacles prohibit transporting the member by land to the nearest appropriate facility and the member’s condition requires immediate attention.
- The patient is suffering from an illness or injury making other forms of transportation inadvisable.

Submit hospital-based ambulance and air ambulance services as an 837I-Institutional electronic transaction.

Over-the-Cap

Over-the-cap transportation services require State approval which is obtained by the State designated entity. Documentation requirements for over-the-cap authorization must include information demonstrating the mode of transportation is the most appropriate and least costly for the member’s condition and that the trip is medically necessary. The State designated entity must document that the care required by the member is not available in the member’s local community and that the member is seeing the closest, qualified provider for a Colorado Medical Assistance Program service. The State designated entity must also document that the member qualifies for Colorado Medical Assistance Program transportation as ordered and certified by a qualified healthcare professional.

When over-the-cap transportation services are provided to more than one member, special multiple rider exceptions apply. The member traveling the greatest distance is reimbursed at the full rate of the trip. The rider traveling the second greatest distance is reimbursed at one half the rate for the distance traveled by this member. The reimbursement for the third and any other additional riders is one quarter the rate of the distance traveled by those members.



Air/Train

Air and train transport are benefits of the Colorado Medical Assistance Program only when a member’s, physician-certified, medical or physical condition precludes the use of member-purchased public or private transportation, or when other less costly, medically appropriate means of Colorado Medical Assistance Program transportation are not available. Air and train transport are permissible for out-of-state travel. In extreme circumstances air transport may be available for in state travel when it is the most cost effective, medically appropriate means of transportation for the member’s condition. All air and train transportation must be prior authorized by the State-authorizing agency. The State designated entity obtains prior authorization from the State.



Bus

Bus transportation may be a benefit when the member’s condition does not allow the member to purchase public or private transportation and when other less costly, medically appropriate means of Colorado Medical Assistance Program transportation are not available.



Out-of-State Transportation

Benefits are provided when:

- Routine medical services for members in Colorado border communities are performed across the state line because of closer proximity to the closest qualified provider. All rules and practices for in state travel apply.
- Out-of-state specialized medical treatment that requires non-emergency transportation must be prior authorized by the state and the member must meet medical necessity requirements as certified by the member’s physician.
- Documentation must include information as to why the member cannot obtain treatment in state. Treatment must not be available in the State of Colorado. Out of state travel requests must also include anticipated period of travel as well as the need for meals, lodging and an escort when indicated. The State designated entity must obtain the prior authorization from the State.
- The State designated entity must also verify that any out-of-state treatment has been prior authorized as required.



- A member temporarily residing out of state requires emergency transportation services.

Ancillary Services

All ancillary services (meals, lodging, escort) require State authorization.

- An escort is a Colorado Medical Assistance Program benefit when the member’s medical or physical condition necessitates an escort, as certified by the member’s physician, and the member qualifies for Colorado Medical Assistance Program transportation services.
- Meals and lodging are a benefit for the member only when the member qualifies for Colorado Medical Assistance Program transportation and travel cannot be completed in one calendar day for in-state treatment.
- Both member and escort are eligible for meals and lodging when the qualifying member is traveling out of state for treatment and does not receive these services as part of an in-patient stay. Meals, lodging and round trip transportation expenses for the escort are covered only during transit to and from the destination of medical treatment, unless the escort’s continued stay is authorized for a minor child or an at risk adult, unable to make medical determinations or provide necessary self care.



Prior Authorization Requests (PARs) for Transportation

The Colorado Medical Assistance Program requires prior authorization for all non-emergent medical transportation services. The State designated entity must authorize the transportation or obtain prior authorization from the State for all services requiring State authorization. Services requiring State authorization include:

- Air/Train
- Out-of-state Travel
- Ancillary Services
- Over-the-cap Services

All transportation services require a physician’s statement of medical necessity that must be retained by the provider or State designated entity, as described above, as part of the transportation records. Submit completed non-emergency transportation PARs to the State authorizing agency.

When the State designated entity receives a PAR letter approving transportation, the claim may be submitted to the fiscal agent. Occasionally, the provider is requested to submit a copy of the approved PAR with the claim.

General Requirements

The State designated entity must submit the paper PAR. A copy of the paper Prior Authorization Request form and accompanying instructions follow. Complete paper PAR forms thoroughly and accurately. Mail paper PARs to the address listed in [Appendix C](#). Paper-submitted PARs lacking the minimally required information are refused and require resubmission.



All complete 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. The results of the PAR review are posted online and included in PAR letters sent to both the State designated entity and the member. Read the results carefully as some line items may be approved and others denied. Requests for prior authorization must be submitted and approved before services are rendered.

The services rendered must match the approved transportation services exactly.

All PARs and revisions processed by the ColoradoPAR Program must be submitted using CareWebQI ([CWQI](#)). 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 1-888-454-7686 or refer to the Department’s [ColoradoPAR Program](#) web page.

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

Paper PAR forms must be completed accurately. If an error is noted on an approved request, it should be brought to the attention of the authorizing agency and corrected. Procedure codes, quantities, etc., may be changed or entered by the authorizing agency.

Mail Colorado Medical Assistance Program PARs to the address listed in [Appendix C](#).

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for fiscal agent use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) which help identify the claim or member.
1. Client Name	Text	Required Enter the member’s last name, first name and middle initial. Example: Adams, Mary A.
2. Client Identification Number	7 characters, a letter prefix followed by six numbers	Required Enter the member’s state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.

Field Label	Completion Format	Instructions
3. Sex	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 digits (MMDDYY)	Required Enter the member's birth date using MMDDYY format. Example: January 1, 1978 = 010178.
5. Client Address	Characters: numbers and letters	Required Enter the member's full address: Street, city, state, and zip code.
6. Client Telephone Number	Text	Optional Enter the member's telephone number.
7. Prior Authorization Number Preprinted	None	Not used.
8. Dates Covered by This Request	6 digits for from date and 6 digits for through date (MMDDYY)	Required Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates.
9. Does Client Reside in a Nursing Facility?	Check Box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
10. Group Home Name	Text	Conditional Enter the name of the group home if the member resides in a group home.
11. Diagnosis	Text	Required Enter the diagnosis and/or sufficient relevant information to justify the request. If diagnosis codes are used, the written description of the diagnosis is also required. Document that certificate of medical necessity is on file. Approval of the PAR is based on documented medical necessity. Attach documents as required. (For Over-The-Cap requests - include beginning location and destination address. Justify medical necessity of the trip and why member is unable to receive treatment closer to home. Specify type of transportation and that less costly means are unavailable. Provide

Field Label	Completion Format	Instructions
		mileage per unit and dollar amount requested per unit. OTC approval is based on documented medical necessity, mode of transportation, unit cost and certificate of medical necessity on file. OTC PARs do not require diagnosis, but sufficient information must be provided to justify the trip.)
12. Requesting Authorization for Repairs	None	Not Required Not applicable to transportation PAR
13. Indicate Length of Necessity	None	Not Required Not applicable to transportation PAR
14. Estimated Cost of Equipment	None	Not Required Not applicable to transportation PAR
15. Services To Be Authorized Preprinted	None	Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service to be provided. Example: Over-The-Cap Wheelchair van Example: Over-The-Cap Mobility van
17. Procedure, Supply or Drug Code	Digits	Required Enter the HCPCS code for each service that will be billed on the claim form. The authorizing agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Number of Services	Digits	Required Enter the number of units for services requested. The authorizing agency will complete this field if it is left blank. (Over-The-Cap: 1 unit = 1 way trip)
19. Authorized No. of Services	None	Leave Blank The authorizing agency indicates the number of services authorized. This number may or may not equal number requested in Field 18 (Number Of Services).

Field Label	Completion Format	Instructions
20. A=Approved D=Denied	None	Leave Blank Providers should check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	Text	Not Required
Telephone Number	Text	Not Required
22. Primary Care Physician Address	Text	Not Required
23. PCP Provider Number	8 Digits	Not Required
24. Name and Address of Provider Requesting Prior Authorization	Text	Required Enter the complete name and address of the State designated entity requesting prior authorization.
25. Name and Address of Provider Who will Render Service Telephone Number	Text	Required Enter the name and address of the State designated entity that will receive reimbursement from the State and properly disperse funds to the appropriate transportation provider. Enter the telephone number of rendering State designated entity.
26. Signature Telephone Number	Text	Required The State designated entity representative must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR. Enter the telephone number of the requesting State designated entity.
27. Date Signed	6 Digits	Required Enter the date the PAR form is signed by the requesting State designated entity.
28. Provider Number	8 Digits	Required

Field Label	Completion Format	Instructions
		Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
29. Service Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the State designated entity. The rendering provider must be enrolled in the Colorado Medical Assistance Program.
30. Comments or Reasons For Denial of Benefits	None	Leave Blank Providers should check the PAR on-line or refer to the PAR letter.
31. PA Number Being Revised	Text	Conditional Complete if revising the original PAR. Enter the prior authorization number of the original PAR that is being revised.

After the PAR is reviewed, the approved or denied PAR is available through the File and Report Service (FRS) via the Colorado Medical Assistance Program Web Portal ([Web Portal](#)). The claim must contain the PAR number for payment.

If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix C.

Do not combine services from different PARs on the same claim form. Also, do not combine PAR and non-PAR services on one claim form.

Procedure Coding

Transportation HCPCS codes

The Colorado Medical Assistance Program uses the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS). 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.



HCPCS are used to identify and reimburse transportation services.

The Department updates and revises HCPCS codes through Colorado Medical Assistance Program the appropriate billing manuals.

The series of local procedure codes used to bill for mobility van services (X6022-X6030) are no longer available. Providers should use HCPCS A0120 plus modifier TK (Extra patient or passenger) to bill for mobility van services. Use the appropriate number of units to identify the actual number of riders.

The XU-Split unit modifier is no longer valid.

Transportation Codes and PAR Requirements

Code	Description	PAR Requirements
A0021	Ambulance service, outside state per mile, transport- Emergency	No PAR
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	No PAR
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	No PAR
A0100	Nonemergency transportation; taxi	No PAR
A0110	Nonemergency transportation and bus, intra- or interstate carrier	No PAR
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	No PAR
A0130	Nonemergency transportation: wheelchair van	No PAR
A0140	Nonemergency transportation and air travel (private or commercial), intra- or interstate	ColoradoPAR Always
A0180	Nonemergency transportation: ancillary: lodging - recipient	ColoradoPAR Sometimes
A0190	Nonemergency transportation: ancillary: meals - recipient	ColoradoPAR Sometimes
A0200	Nonemergency transportation: ancillary: lodging - escort	ColoradoPAR Sometimes
A0210	Nonemergency transportation: ancillary: meals - escort	ColoradoPAR Sometimes
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way	No PAR
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	No PAR
A0425	Ground mileage, per statute mile	No PAR
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	No PAR
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)	No PAR
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	No PAR
A0429	Ambulance service, basic life support, emergency transport (BLS - emergency)	No PAR
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	ColoradoPAR Always
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	ColoradoPAR Always

Code	Description	PAR Requirements
A0433	Advanced life support, level 2 (ALS 2)	No PAR
A0434	Specialty care transport (SCT)	No PAR
A0999	Unlisted ambulance service	No PAR
S0209	Wheelchair van, mileage, per mile	No PAR
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	ColoradoPAR Always
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	ColoradoPAR Always
T2001	Nonemergency transportation; patient attendant/escort	No PAR
T2003	Nonemergency transportation; encounter/trip	No PAR
T2005	Nonemergency transportation; stretcher van	No PAR
T2049	Nonemergency transportation; stretcher van, mileage; per mile	No PAR

Transportation Billing Instructions

The 837 Professional (837P) transaction should be utilized for electronic billing.

Diagnosis Codes

A diagnosis is required on all claims. Enter code 780 for all claims. Do not fill unused spaces with zeroes. The diagnosis must be referenced to each detail line by placing a "1" in the diagnosis indicator field.

Dates of Services

Each detail line includes space to enter two dates of service: a 'From' Date Of Service (FDOS) and a 'To' Date Of Service (TDOS). Both dates must be completed on the electronic record. For services rendered on a single date, complete the FDOS and the TDOS with the same date.

Span Billing

Span billing is not allowed for transportation services.

Place of Service Codes

Use CMS place of service codes. Use place of service code 41-land transportation and code 42-air transportation.

Procedure Codes

Each detail line must include a valid procedure code.

Units of Service

Units represent the number of services provided.

Transportation by Bus, Train, or Air and Special Transportation Services

Units represent the number of one-way trips taken. Do not bill for mileage.

Meals and Lodging

Report units as the number of days of lodging and/or meals provided. Do not complete units to represent the number of meals provided; total number of meals cannot exceed 1 unit per day.

Required Attachments

Claims that require attachments must be billed on paper.

Air and Train Transportation

A copy of the air or train ticket or invoice and a copy of the approved PAR letter must be attached.

Timely Filing

The Colorado Medical Assistance Program timely filing period is 120 days from the date of service.



If the original timely filing (120 day) period expires, claims must be submitted within 60 days of the last remittance statement or adverse action. Refer to the General Claim Requirements section for complete information on timely filing.

CMS 1500 Paper Claim Reference Table

The following paper claim form reference table shows required, optional, and conditional fields and detailed field completion instructions for transportation claims on 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 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	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.
11b	Other Claim ID	Not Required	

CMS Field #	Field Label	Field is?	Instructions
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	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	<p>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.</p> <p>Enter the applicable qualifier to identify which date is being reported</p> <p>431 Onset of Current Symptoms or Illness 484 Last Menstrual Period</p>
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	<p>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</p>

CMS Field #	Field Label	Field is?	Instructions
			date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	<p>LBOD Use to document the Late Bill Override Date for timely filing.</p> <p>TRANSPORTATION When applicable, enter the word "TRANSPORT CERT" to certify that you have a transportation certificate or trip sheet on file for this service.</p>
20	Outside Lab? \$ Charges	Conditional	<p>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.</p> <p>Practitioners may not request payment for services performed by an independent or hospital laboratory.</p>
21	Diagnosis or Nature of Illness or Injury	Required	<p>Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition.</p> <p>Enter applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Transportation Enter diagnosis code 780.</p>
22	Medicaid Resubmission Code	Conditional	<p>List the original reference number for resubmitted claims.</p> <p>When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field.</p> <p>7 Replacement of prior claim 8 Void/Cancel of prior claim</p> <p>This field is not intended for use for original claim submissions.</p>
23	Prior Authorization	Conditional	<p>Enter the six character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one</p>

CMS Field #	Field Label	Field is?	Instructions																		
			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	<p>The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p>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.</p> <p>Each claim form must be fully completed (totaled).</p> <p>Do not file continuation claims (e.g., Page 1 of 2).</p>																		
24A	Dates of Service	Required	<p>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.</p> <p>Example: 010114 for January 1, 2014</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">14</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> <p style="text-align: center;">Or</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">14</td> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">14</td> </tr> </table> <p>Span dates of service</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">14</td> <td style="width: 20px;">01</td> <td style="width: 20px;">31</td> <td style="width: 20px;">14</td> </tr> </table> <p><u>Single Date of Service:</u> 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.</p> <p><u>Span billing:</u> permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>County transportation and Waiver services</p> <p>Providers should refer to specific billing instructions on the use of span billing.</p>	01	01	14				01	01	14	01	01	14	01	01	14	01	31	14
01	01	14																			
01	01	14	01	01	14																
01	01	14	01	31	14																

CMS Field #	Field Label	Field is?	Instructions
			<p>Supplemental Qualifier To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <p>ZZ Narrative description of unspecified code</p> <p>N4 National Drug Codes</p> <p>VP Vendor Product Number</p> <p>OZ Product Number</p> <p>CTR Contract Rate</p> <p>JP Universal/National Tooth Designation</p> <p>JO Dentistry Designation System for Tooth & Areas of Oral Cavity</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> <p>41 Transportation – Land</p> <p>42 Transportation – Air or Water</p>
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>

CMS Field #	Field Label	Field is?	Instructions
24D	Modifier	Not Required	
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>

CMS Field #	Field Label	Field is?	Instructions
24G	Days or Units	General Instructions	<p>A unit represents the number of times the described procedure or service was rendered.</p> <p>Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.</p> <p>Transportation Units represent the number of one-way trips taken. Do not bill for mileage.</p> <p>Meals and Lodging Report units as the number of days of lodging and days of meals provided. Do not complete units to represent the number of meals provided.</p> <p>When the HCPCS code narrative indicates a round trip, bill one unit.</p>
24H	EPSDT/Family Plan	Not Required	
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Not Required	
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	<p>Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).</p>
27	Accept Assignment?	Required	<p>The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.</p>
28	Total Charge	Required	<p>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.</p>

CMS Field #	Field Label	Field is?	Instructions
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	<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 #	Conditional	<p>Complete for services provided in a hospital or nursing facility 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>32a- NPI Number</p> <p>Enter the NPI of the service facility (if known).</p> <p>32b- Other ID #</p>

CMS Field #	Field Label	Field is?	Instructions
			Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
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: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



CMS 1500 Transportation 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"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A		3. PATIENT'S BIRTH DATE MM DD YY 10 16 45 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)	
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)	
8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____		15. OTHER DATE MM DD YY QUAL. _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) TRANS CERT		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9		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. EFFECT PERIOD (Per 1500) I. ID. QUAL. J. RENDERING PROVIDER ID. #		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. EFFECT PERIOD (Per 1500) I. ID. QUAL. J. RENDERING PROVIDER ID. #		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. EFFECT PERIOD (Per 1500) I. ID. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. Optional	
25. FEDERAL TAX I.D. NUMBER SSN EIN		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. FEDERAL TAX I.D. NUMBER SSN EIN		28. TOTAL CHARGE \$ 150.00	
25. FEDERAL TAX I.D. NUMBER SSN EIN		29. AMOUNT PAID \$ _____	
25. FEDERAL TAX I.D. NUMBER SSN EIN		30. Revid 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.)		32. SERVICE FACILITY LOCATION INFORMATION	
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.)		33. BILLING PROVIDER INFO & PH # () ABC Transportation 100 Any Street Any City	
SIGNED Signature DATE 1/1/15		a. 1234567890 b. 04567890	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Transportation Third Party Claim - No Mileage 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 (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										3. PATIENT'S BIRTH DATE MM DD YY 10 16 45					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
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) Client, Ima A										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE														
a. OTHER INSURED'S POLICY OR GROUP NUMBER 010101010										11. INSURED'S POLICY GROUP OR FECA NUMBER					* INSURED'S DATE OF BIRTH MM DD YY M SEX F									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME									
c. RESERVED FOR NUCC USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d.</i>					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 _____ DATE 1/1/15									
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. SIGNED Signature on File DATE 1/1/15										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____					15. OTHER DATE MM DD YY QUAL: _____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) TRANS CERT										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24c) ICD Ind. 9					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. FROM THIS DATE I. ID. QUAL. J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER														
1 01 01 15 01 01 15 41 Y A0429 A 20 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) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 20 00				
29. AMOUNT PAID \$ 10 00										30. Revid for NUCC Use					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH# () ABC Transportation 100 Any Street Any City					* 1234567890 b. 04567890									

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PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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PLEASE PRINT OR TYPE

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

Transportation Crossover Claim Example



HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (DoD/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										3. PATIENT'S BIRTH DATE MM DD YY 10 16 45 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																													
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										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)																													
8. RESERVED FOR NUCC USE										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? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER Medicare Policy Number a. INSURED'S DATE OF BIRTH MM DD YY 10 16 45 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a and 9d.																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____										15. OTHER DATE MM DD YY QUAL _____																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) TRANS CERT																				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9 A. 780 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. I.D. QUAL. I. ID. QUAL. J. RENDERING PROVIDER ID. #																				25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. Optional 27. ACCEPT ASSIGNMENT? (For govt. 340A, 144 2402) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 20 00 29. AMOUNT PAID \$ 10 00 30. Rwd for NUCC Use																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15										32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____																													
33. BILLING PROVIDER INFO & PH # () ABC Transportation 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)

UB-04 Paper Claim Instructional Reference Table

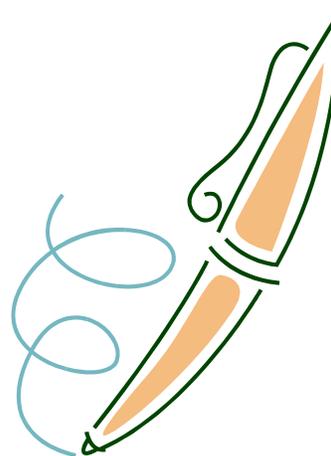
The paper claim reference table below lists required and conditional fields for the paper UB-04 claim form for Hospital based transportation claims. For complete UB-04 paper claim instructions, see the Paper Claim Instructional Reference in the IP/OP Hospital [Billing manual](#).

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837I (wpc-edi.com), 837I Companion Guide (in the Provider Services [Specifications](#) section of the Department’s Web site), and in the Web Portal User Guide (via within the portal).

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Inpatient/ Outpatient – Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Inpatient/Outpatient - Optional Enter information that identifies the member or claim in the provider’s billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Inpatient/Outpatient - Optional Enter the number assigned to the patient to assist in retrieval of medical records.

Form Locator and Label	Completion Format	Instructions
<p>4. Type of Bill</p>	<p>3 digits</p>	<p>Required. Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p><u>Digit 1</u> <u>Type of Facility</u> 1 Hospital</p> <p><u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities):</u> 3 Outpatient</p> <p><u>Digit 3</u> <u>Frequency:</u> 1 Admit through discharge claim</p> <p>Enter 131.</p>
<p>5. Federal Tax Number</p>	<p>N/A</p>	<p>Submitted information is not entered into the claim processing system.</p>
<p>6. Statement Covers Period – From/Through</p>	<p>From: 6 digits MMDDYY Through: 6 digits MMDDYY</p>	<p>Required. Enter the From (beginning) date and Through (ending) date of service covered by this bill using MMDDYY format. <i>For Example:</i> January 1, 2014 = 0101014 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.</p>
<p>8a. Patient Identifier</p>	<p>None</p>	<p>Submitted information is not entered into the claim processing system.</p>
<p>8b. Patient Name</p>	<p>Up to 25 characters: Letters & spaces</p>	<p>Required. Enter the member's last name, first name and middle initial.</p>
<p>9a. Patient Address - Street</p>	<p>Characters Letters & numbers</p>	<p>Required. Enter the member's street/post office box as determined at the time of admission.</p>
<p>9b. Patient Address – City</p>	<p>Text</p>	<p>Inpatient/ Outpatient - Required Enter the member's city as determined at the time of admission.</p>

Form Locator and Label	Completion Format	Instructions
9c. Patient Address – State	Text	Inpatient/ Outpatient - Required Enter the member’s state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Inpatient/ Outpatient - Required Enter the member’s zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Inpatient/ Outpatient - Optional
10. Birthdate	8 digits (MMDDCCYY)	Required. Enter the member’s birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Required. Enter an M (male) or F (female) to indicate the member’s sex.
12. Admission Date	N/A	N/A
13. Admission Hour	N/A	N/A
14. Admission Type	N/A	N/A
15. Source of Admission	N/A	N/A
16. Discharge Hour	N/A	N/A
17. Patient Discharge Status	N/A	N/A



Form Locator and Label	Completion Format	Instructions
<p>18-28.Condition Codes</p>	<p>2 Digits</p>	<p>Conditional. Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing.</p> <p><u>Condition Codes</u></p> <ul style="list-style-type: none"> 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 APR-DRG (Day outlier) <p><u>Renal dialysis settings</u></p> <ul style="list-style-type: none"> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility <p><u>Special Program Indicator Codes</u></p> <ul style="list-style-type: none"> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge

Form Locator and Label	Completion Format	Instructions
18-28. Condition Codes (continued)	2 Digits	<p><u>PRO Approval Codes</u></p> <p>C1 Approved as billed</p> <p>C2 Automatic approval as billed - Based on focused review</p> <p>C3 Partial approval</p> <p>C4 Admission/Services denied</p> <p>C5 Post payment review applicable</p> <p>C6 Admission preauthorization</p> <p>C7 Extended authorization</p> <p><u>Claim Change Reason Codes</u></p> <p>D3 Second/Subsequent interim PPS bill</p>
29. Accident State	2 digits	Optional State's abbreviation where accident occurred
31-34. Occurrence Code/Date	2 digits and 6 digits	<p>Conditional</p> <p>Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.</p> <p><u>Occurrence Codes:</u></p> <p>01 Accident/Medical Coverage</p> <p>02 Auto Accident - No Fault Liability</p> <p>03 Accident/Tort Liability</p> <p>04 Accident/Employment Related</p> <p>05 Other Accident/No Medical Coverage or Liability Coverage</p> <p>06 Crime Victim</p> <p>20 Date Guarantee of Payment Began</p> <p>24* Date Insurance Denied</p> <p>25* Date Benefits Terminated by Primary Payer</p> <p>26 Date Skilled Nursing Facility Bed Available</p> <p>27 Date of Hospice Certification or Re-certification</p> <p>30 Preadmission testing</p> <p>40 Scheduled Date of Admission (RTD)</p> <p>50 Medicare Pay Date</p> <p>51 Medicare Denial Date</p> <p>53 Late Bill Override Date</p> <p>55 Insurance Pay Date</p>

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date (continued)	2 digits and 6 digits	<p><u>Occurrence Codes:</u></p> <p>A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50</p> <p>B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50</p> <p>C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50</p> <p><i>*Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information</i></p>
35-36. Occurrence Span Code From/ Through	N/A	N/A
38. Responsible Party Name/ Address	None	Submitted information is not entered into the claim processing system.
39-41. Value Code- Code Value Code- Amount	N/A	N/A
42. Revenue Code	4 digits	Required Complete for hospital based transportation. Use revenue code range 540-549.
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/Hi PPS Rate Codes	5 digits	Conditional. Use only State assigned transportation codes. Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Do not use revenue codes. HCPCS codes must be identified for the following revenue codes: <ul style="list-style-type: none"> ▪ 054X Ambulance
27. Service Date	6 digits	Required. Not required for single date of service claims.

Form Locator and Label	Completion Format	Instructions
28. Service Units	3 digits	Required. The number of units cannot exceed 9,999,999 on a single detail line.
29. Total Charges	9 digits	Required. Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
30. Non-Covered Charges	N/A	N/A Non-covered charges cannot be billed for hospital based transportation services.
50. Payer Name	1 letter and text	Required. Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider . Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID	N/A	Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Colorado Medical Assistance Program line. Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.

Form Locator and Label	Completion Format	Instructions
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number	N/A	Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeroes to the diagnosis code. The Present on Admission (POA) indicator is required for inpatient claims. Document the POA in the gray area to the right side of the principal diagnosis code. Allowed responses are limited to: <ul style="list-style-type: none"> ✓ Y = Yes – present at the time of inpatient admission ✓ N = No – not present at the time of inpatient admission ✓ U = Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission ✓ W = Clinically Undetermined – the provider is unable to clinically determined whether the condition was present at the time of inpatient admission or not ✓ “1” on UB-04 (“Blank” on the 837I) = Unreported/Not used – diagnosis is exempt from POA reporting Outpatient Hospital Laboratory May use diagnosis code V71(may require 4 th or 5 th digit) Hospital Based Transportation May use diagnosis code 780 (may require 4 th or 5 th digit)

Form Locator and Label	Completion Format	Instructions
67. Principal Diagnosis Code	Up to 6 digits	Required. Hospital based transportation claims enter diagnosis code. Provider may use code 780.
67A- Other 67Q. Diagnosis	N/A	N/A
69. Admitting Diagnosis Code	N/A	N/A
70. Patient Reason Diagnosis	N/A	N/A
71. PPS Code	N/A	Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
75. Unlabeled Field	N/A	N/A

Form Locator and Label	Completion Format	Instructions
<p>76. Attending NPI – Conditional QUAL - Conditional</p> <p>ID - (Colorado Medical Assistance Provider #) – Required</p> <p>Attending - Last/First Name</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Required.</p> <p>NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and <u>cannot</u> be a clinic or group number.</p> <p>(If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)</p> <p>Hospitals may enter the member's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program.</p> <p>QUAL – Enter "1D " for Medicaid</p> <p>Enter the attending physician's last and first name.</p> <p>This form locator must be completed for all services.</p>
<p>77. Operating-NPI/QUAL/ID</p>	<p>N/A</p>	<p>Submitted information is not entered into the claim processing system.</p>
<p>78-79. Other ID</p> <p>NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Conditional (see below)</p> <p>Complete when attending physician is not the PCP or to identify additional physicians.</p> <p>NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the Colorado Medical Assistance Program member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted.</p> <p>The attending physician's last and first name are optional.</p>
<p>80. Remarks</p>	<p>Text</p>	<p>Enter specific additional information necessary to process the claim or fulfill reporting requirements.</p>

Form Locator and Label	Completion Format	Instructions
81. Code-Code QUAL/CODE/VALUE (a-d)	N/A	Submitted information is not entered into the claim processing system



UB-04 Transportation Claim Example

1 City Hospital 100 Saginaw St. Anytown, CO 80000 333-333-3333										2										3a PAT. CNTL.# b. MED. REC.#					4 TYPE OF BILL 131																													
8 PATIENT NAME a Client, Ian										9 PATIENT ADDRESS a 123 Main Street										5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM 01/10/14 THROUGH 01/10/14					7																								
10 BIRTHDATE 11/11/1955										11 SEX M					12 DATE					ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR					17 STAT					18 19 20 21					CONDITION CODES 22 23 24 25 26 27 28					29 ACCT STATE					30									
31 OCCURRENCE DATE										32 OCCURRENCE CODE					33 OCCURRENCE DATE					34 OCCURRENCE CODE					35 OCCURRENCE DATE					36 OCCURRENCE CODE					37																			
38										39 CODE					VALUE CODES AMOUNT					40 CODE					VALUE CODES AMOUNT					41 CODE					VALUE CODES AMOUNT																			
42 REV. CD.										43 DESCRIPTION					44 HCPCS / RATE / HIPPS CODE					45 SERV. DATE					46 SERV. UNITS					47 TOTAL CHARGES					48 NON-COVERED CHARGES					49														
1 540										Ambulance					A0428					01/20/14					1					97:35																								
2 549										Mileage					A0425					01/20/14					15					24:00																								
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50 PAYER NAME A D - Medicaid										51 HEALTH PLAN ID 12345678					52 REL. INFO					53 ASG. BEN.					54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NP1					57 OTHER					58									
58 INSURED'S NAME A Client, Ian										59 P. REL.					60 INSURED'S UNIQUE ID A123456					61 GROUP NAME					62 INSURANCE GROUP NO.																													
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER					65 EMPLOYER NAME																																							
66 DX 780										A					B					C					D					E					F					G					H					I				
69 ADMIT DX										70 PATIENT REASON DX					71 PPS CODE					72 ECI					73																													
74 PRINCIPAL PROCEDURE CODE										a OTHER PROCEDURE CODE					b OTHER PROCEDURE CODE					c OTHER PROCEDURE CODE					75					76 ATTENDING NP1					QUAL																			
77 OPERATING NP1										d OTHER PROCEDURE CODE					e OTHER PROCEDURE CODE					76					LAST					FIRST																								
80 REMARKS										b1 CC					77					78 OTHER NP1					QUAL																													
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UB-04 CMS-1450

APPROVED OMB NO. 0908-0597

NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 of the Department’s website.

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 a 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> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
<p>Denied Paper Claims</p>	<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>
<p>Returned Paper Claims</p>	<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>
<p>Rejected Electronic Claims</p>	<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>
<p>Denied/Rejected Due to Member Eligibility</p>	<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>
<p>Retroactive Member Eligibility</p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system.

Billing Instruction Detail	Instructions
	<p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>
<p>Delayed Notification of Eligibility</p>	<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>
<p>Electronic Medicare Crossover Claims</p>	<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>
<p>Medicare Denied Services</p>	<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
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance. File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. LBOD = the date commercial insurance paid or denied.</p>
<p>Correspondence LBOD Authorization</p>	<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. File the claim within 60 days of the date on the authorization letter. Retain the authorization letter. LBOD = the date on the authorization letter.</p>
<p>Member Changes Providers during Obstetrical Care</p>	<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. File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. LBOD = the last date of OB care by the billing provider.</p>





Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ **Date:** _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a) (1-2) to be attached to paper claims submitted on the UB-04.

Transportation Billing Manual Revisions Log

Revision Date	Section/Action	Pages	Made by
01/17/2014	<i>Created</i>	<i>All</i>	<i>jg</i>
01/21/2014	<i>Added 2 new HCPCS: S9960 and S9961</i>	<i>13</i>	<i>cc</i>
01/22/2014	<i>Reformatted Updated claim examples Added PAR Requirements for S9960 and S9961 Updated TOC</i>	<i>Throughout 25, 26, 27 & 40 13 i & ii</i>	<i>Jg</i>
08/29/2014	<i>Updated web links for the Department's new website</i>	<i>Throughout</i>	<i>MM</i>
12/08/2014	<i>Removed Appendix H information, added Timely Filing document information</i>	<i>44</i>	<i>mc</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.