

# Colorado Choice Transitions (CCT) Program Reference Manual

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# Colorado Choice Transitions Program (CCT)

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## Program Overview

Colorado Choice Transitions (CCT), part of the federal Money Follows the Person Rebalancing Demonstration, is a five year grant program. The primary goal is facilitating the transition of Medicaid clients from nursing and other long-term care (LTC) facilities to the community using home and community based (HCBS) services and supports. Services are intended to promote independence, improve the transition process, and support individuals in the community. Participants of the CCT program will have access to qualified waiver services as well as demonstration services. They will be enrolled in the program for up to 365 days after which time they will enroll into one of five HCBS waivers so long as they remain Medicaid eligible. Days in a hospital or LTC facility for a period of less than 30 days during the enrollment period will not count towards the 365 days. Qualified services are HCBS waiver services that will continue once the CCT program has ended if the client continues to be eligible for HCBS. Demonstration services are enhanced services provided during an individual's enrollment in the demonstration program post-transition and end on the last day of CCT enrollment. The grant funding will also be used to streamline and improve the HCBS systems in Colorado.



Medicaid clients participating in CCT must meet long-term care Medicaid eligibility requirements (which include functional and financial eligibility); must reside in a long-term care facility for a period of no less than ninety days (90) not counting days for rehabilitation; have been Medicaid eligible for one day; and must be willing to move to qualified housing as defined in federal statute. To participate, clients must meet financial, medical, and program criteria to access services through the CCT program, and be willing to receive services in their homes or communities. A client who receives services through the CCT program is also eligible for all Medicaid State Plan services. When a client chooses to receive services under a waiver and the CCT program, the services must be provided by certified Medicaid providers.

The CCT program will compliment the Elderly, Blind and Disabled Waiver, the Persons with Brain Injury Waiver, the Community Mental Health Supports Waiver, the Persons with Developmental Disabilities Wavier, and the Supported Living Services Waiver. The populations that will be transitioned through the program include: elderly adults aged 65 years or older residing in Medicaid nursing facilities; adults aged 18-64 with physical disabilities residing in Medicaid nursing facilities; adults aged 18 and older with developmental disabilities residing in Intermediate Care Facilities (ICFs) and Medicaid nursing facilities; and adults 65 years and older and individuals under 22 residing in institutions for mental disease (IMDs).

**Note:** The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

## Policy Guidance for Services

The [Services and Supports Desk Reference](#) offers essential information on CCT demonstration services to providers, clients and stakeholders. The information includes service definitions, minimum provider qualifications, service rates, and other pertinent information. The Department may periodically modify policy guidance.

Providers are notified of change in policy guidance in the monthly HCBS Provider Bulletin and other Department communications.

## Provider Participation

Before claims can be accepted for payment of goods and services provided to eligible clients, the provider of goods and services shall be enrolled in the Colorado Medical Assistance program and assigned a provider number.

## Prior Authorization Requests (PARs) for CCT

All CCT services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case management agencies complete the Prior Authorization Request for CCT according to instructions provided by the Department.

The case management agencies responsibilities include, but are not limited to:

1. Assessing needs;
2. Determining CCT program eligibility;
3. Service planning and authorization;
4. Care coordination;
5. Risk mitigation;
6. Service monitoring;
7. Monitoring the health, welfare and safety of the client;
8. Promotion of client's self-advocacy; and
9. Coordination of the client's transition from the CCT program to one of the existing HCBS waivers at the end of the client's participation on the CCT program, as long as the client remains eligible.



### **Approval of prior authorization does not guarantee Colorado Medical Assistance Program**

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



**Prior approvals must be completed thoroughly and accurately.** If an error is noted on an approved request, it should be brought to the attention of the client's case manager and the Department for corrections. Procedure codes, quantities, etc., may be changed or entered by the client's case manager.

The authorizing agent or case management agency is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

## PAR Submission

All [CCT PAR](#) forms are fillable electronically and are located in the Provider Services [Forms](#) section of the [Department's Web site](#). The use of the forms is strongly encouraged due to the complexity of the calculations.

Send all New, Continued Stay Review (CSR), and Revised PARs for CCT to the Department using any of the three ways listed below:

**Encrypted Email:** [CCTPars@state.co.us](mailto:CCTPars@state.co.us)      **Fax:** 1-303-866-2786      **Mail:** The Colorado Department of Health Care Policy and Financing  
 Attn: Long Term Services and Supports Division  
 1570 Grant St.  
 Denver, CO 80203-1818

For questions regarding the PAR submission process to the CCT program, please call the Long Term Services and Supports Division at 303-866-2858 or 303-866-3566.

**Note:** Any CCT PAR sent directly to the Department’s Fiscal Agent will be returned to the case manager.

## **Consumer Directed Attendant Support Services (CDASS)**

For clients authorized to receive CDASS, case managers will need to enter the data into the web portal maintained by [Public Partnerships, Limited \(PPL\)](#) in addition to sending a PAR to the Department.

Case managers may also use the PAR form maintained by PPL to create the entire PAR for a client receiving CDASS as a part of the CCT program. In addition, case managers will need to fax the final PAR approval letter to PPL before attendant timesheets will be paid.

### **PAR Form Instructional Reference Table**

Field Label	Completion Format	Instructions
<b>PA Number being revised</b>		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
<b>Revision</b>	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
<b>Client Name</b>	Text	Required Enter the client's last name, first name and middle initial. Example: Adams, Mary A.
<b>Client ID</b>	7 characters, a letter prefix followed by six numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
<b>Sex</b>	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Check the appropriate box.

Field Label	Completion Format	Instructions
<b>Birthdate</b>	6 numbers (MM/DD/YY)	Required Enter the client's birth date using MM/DD/YY format. Example: January 1, 2010 = 01/01/10.
<b>Date of Discharge</b>	6 numbers (MM/DD/YY)	Required Enter the client's date of discharge from qualified facility.
<b>Requesting Physician Provider #</b>	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
<b>Client's County</b>	Text	Required Enter the client's county of residence
<b>Case Number (Agency Use)</b>	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or client.
<b>Dates Covered (From/Through)</b>	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.
<b>Qualified/Demonstration Services Description</b>	Text	N/A List of approved procedure codes for qualified and demonstration services.
<b>Modifier</b>	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
<b>Max # Units</b>	Number	Required Enter the number of units next to the services being requested for reimbursement.
<b>Cost Per Unit</b>	Dollar Amount	Required Enter cost per unit of service.

Field Label	Completion Format	Instructions
<b>Total \$ Authorized</b>	Dollar Amount	Required The dollar amount authorized for this service automatically populates.
<b>Comments</b>	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in “Dates Covered” field, please include the HCPCS procedure code and date span here.
<b>Total Authorized CCT Qualified Service Expenditures</b>	Dollar Amount	Required Total automatically populates.
<b>Total Authorized CCT Demonstration Service Expenditures</b>	Dollar Amount	Required Total automatically populates.
<b>Grand Total of CCT Qualified and Demonstration Services</b>	Dollar Amount	Required Total automatically populates.
<b>Plus Total Authorized Home Health Expenditures</b> (Sum of Authorized Home Health Services during the HCBS Care Plan Period)	Dollar Amount	Required Enter the total Authorized Home Health expenditures.
<b>Equals Client’s Maximum Authorized Cost</b>	Dollar Amount	Required The sum of CCT Expenditures + Home Health Expenditures automatically populates.
<b>Number of Days Covered</b>	Number	Required The number of days covered automatically populates.
<b>Average Cost Per Day</b>	Dollar Amount	Required The client’s maximum authorized cost divided by number of days in the care plan period automatically populates.

Field Label	Completion Format	Instructions
<b>CDASS</b> Effective Date Monthly Allocation Amt.	Date (MM/DD/YY) Dollar Amount	Required for MI, EBD 65+ and EBD-PD Enter CDASS information (All CDASS information must be entered in PPL’s web portal).
<b>Immediately prior to CCT enrollment, this client lived in a long-term care facility</b>	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
<b>Case Manager Name</b>	Text	Required Enter the name of the Case Manager.
<b>Agency</b>	Text	Required Enter the name of the agency.
<b>Phone #</b>	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
<b>Email</b>	Text	Required Enter the email address of the Case Manager.
<b>Date</b>	6 Numbers (MM/DD/YY)	Required Enter the date completed.
<b>Case Manager’s Supervisor Name</b>	Text	Required Enter the name of the Case Manager’s Supervisor.
<b>Agency</b>	Text	Required Enter the name of the agency.
<b>Phone #</b>	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager’s Supervisor.
<b>Email</b>	Text	Required Enter the email address of the Case Manager’s Supervisor.
<b>Date</b>	6 Numbers (MM/DD/YY)	Required Enter the date of PAR completion.

## Claim Submission

### Paper Claims



Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department’s fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

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

For more detailed Colorado 1500 billing instructions, please refer to the Colorado1500 General Billing Information manual in the Provider Services [Billing Manuals](#) section.

### Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal Userguide via the Web Portal and also on the [Department’s Colorado Medical Assistance Program Web Portal](#) page.

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

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

## Paper Claim Reference Table

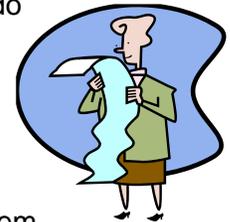
The following paper form reference table gives required fields for the Colorado 1500 paper claim form for CCT services.

Field Label	Special Instructions
<b>Special Program Code 95</b>	Required
<b>1. Client Name</b>	Required
<b>2. Client Date of Birth</b>	Required
<b>3. Colorado Medical Assistance Program ID Number (Client ID Number)</b>	Required
<b>5. Client Sex</b>	Required
<b>18. ICD-9-CM</b>	Required
<b>19A. Date of Service</b>	Required

Field Label	Special Instructions
<b>19B. Place of Service</b>	Required Enter place of service code <b>11</b> -Office or <b>12</b> -Patient's residence.
<b>19C. Procedure Code (HCPCS code) MOD</b>	Required Refer to the CCT procedure code table.
<b>19F. Diagnosis</b>	Required
<b>19G. Charges</b>	Required
<b>19H. Days or Units</b>	Required
<b>20. Total Charges</b>	Required
<b>23 Net Charge</b>	Required
<b>27. Signature</b>	Required
<b>28. Billing Provider Name</b>	Required
<b>29. Billing Provider Number</b>	Required

### **Procedure/HCPCS Codes Overview**

The Department uses procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Colorado Medical Assistance Program clients. The procedure codes represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.



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

## CCT Procedure Code Table

Providers may bill the following procedure codes for the CCT program. Below is a breakdown of services by population.

<b>CCT- BI Services Procedure Code Table (Special Program Code 95)</b>			
Description	Procedure Code + Modifier(s)		Units
<b>Qualified Services</b>			
Adult Day Services	S5102	UC	1 unit = 1 day
Assistive Technology, per purchase	T2029	UC, HB	1 unit = 1 purchase
Behavioral Programming	H0025	UC, TF	1 unit = 30 minutes
Day Treatment	H2018	UC	1 unit = 1 day
Home Modifications	S5165	UC	1 unit = 1 modification
Independent Living Skills Training (ILST)	T2013	UC	1 unit = 1 hour
Mental Health Counseling, Family	H0004	UC, HR	1 unit = 15 minutes
Mental Health Counseling, Group	H0004	UC, HQ	1 unit = 15 minutes
Mental Health Counseling, Individual	H0004	UC	1 unit = 15 minutes
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC, TG	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit = 1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month of service

<b>CCT- BI Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Relative Personal Care	T1019	UC, HR, TG	1 unit = 15 minutes
Respite Care, In Home	S5150	UC	1 unit = 15 minutes
Respite Care, NF	H0045	UC, TF	1 unit = 1 day
Substance Abuse Counseling, Family	T1006	UC, HR, HF	1 unit = 1 hour
Substance Abuse Counseling, Group	H0047	UC, HQ, TF, HF	1 unit = 1 hour
Substance Abuse Counseling, Individual	H0047	UC, TF, HF	1 unit = 1 hour
Supported Living Program	T2033	UC	1 unit = 1 day
Transitional Living, per day	T2016	UC, HB	1 unit = 1 day
<b>Demonstration Services</b>			
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Transitional Specialized Day Rehabilitation Services	S5101	UC	1 unit = 4-5 hours
Vision	V2799	UC	1 unit = 1 procedure

<b>CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Adult Day Services, Basic	S5105	UC	1 unit = 4-5 hours
Adult Day Services, Specialized	S5105	UC, TF	1 unit = 3-5 hours
Consumer Directed Attendant Support Services (CDASS), (Cent/Unit)	T2025	UC	1 unit = 1 cent

<b>CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)</b>			
Description	Procedure Code + Modifier(s)		Units
<b>Qualified Services</b>			
CDASS Per Member/ Per Month (PM/PM)	T2040	UC	1 unit = 1 month
Home Modifications	S5165	UC	1 unit = 1 modification
Homemaker	S5130	UC	1 unit = 15 minutes
IHSS Health Maintenance Activities	H0038	UC	1 unit = 15 minutes
IHSS Homemaker	S5130	UC, KX	1 unit = 15 minutes
IHSS Personal Care	T1019	UC, KX	1 unit = 15 minutes
IHSS Relative Personal Care	T1019	UC, HR, KX	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UC, TF	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UC	1 unit = 1 month
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit = 1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month
Relative Personal Care	T1019	UC, HR	1 unit = 15 minutes
Respite Care, ACF	S5151	UC	1 unit = 1 day
Respite Care, In Home	S5150	UC	1 unit = 15 minutes

<b>CCT- EBD 65+ Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Respite Care, NF	H0045	UC	1 unit = 1 day
<b>Demonstration Services</b>			
Assistive Technology, Extended	T2029	UC	1 unit = 1 purchase
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
Independent Living Skills Training (ILST)	H2014	UC	1 unit = 15 minutes
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Substance Abuse Counseling Transitional, Group	H0047	UC, HF, HQ	1 unit = 1 hour
Substance Abuse Counseling Transitional, Individual	H0047	UC, HF	1 unit = 1 hour
Transitional Behavioral Health Supports	H0025	UC	1 unit = 30 minutes
Transitional Specialized Day Rehabilitation Services	S5101	UC	1 unit = 4-5 hours
Vision	V2799	UC	1 unit = 1 procedure

<b>CCT- EBD 18- 64 Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Adult Day Services, Basic	S5105	UC	1 unit = 4-5 hours
Adult Day Services, Specialized	S5105	UC, TF	1 unit = 3-5 hours

**CCT- EBD 18- 64 Services Procedure Code Table  
(Special Program Code 95)**

Description	Procedure Code + Modifier(s)		Units
<b>Qualified Services</b>			
Consumer Directed Attendant Support Services (CDASS), (Cent/Unit)	T2025	UC	1 unit = 1 cent
CDASS Per Member/ Per Month (PM/PM)	T2040	UC	1 unit = 1 month
Home Modifications	S5165	UC	1 unit = 1 modification
Homemaker	S5130	UC	1 unit = 15 minutes
IHSS Health Maintenance Activities	H0038	UC	1 unit = 15 minutes
IHSS Homemaker	S5130	UC, KX	1 unit = 15 minutes
IHSS Personal Care	T1019	UC, KX	1 unit = 15 minutes
IHSS Relative Personal Care	T1019	UC, HR, KX	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UC, TF	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UC	1 unit = 1 month
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Mobility Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
Non-Medical Transportation, Wheelchair Van To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit = 1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month

<b>CCT- EBD 18- 64 Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Relative Personal Care	T1019	UC, HR	1 unit = 15 minutes
Respite Care, ACF	S5151	UC	1 unit = 1 day
Respite Care, In Home	S5150	UC	1 unit = 15 minutes
Respite Care, NF	H0045	UC	1 unit = 1 day
<b>Demonstration Services</b>			
Assistive Technology, Extended	T2029	UC	1 unit = 1 purchase
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
Independent Living Skills Training (ILST)	H2014	UC	1 unit = 15 minutes
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Substance Abuse Counseling Transitional, Group	H0047	UC, HF, HQ	1 unit = 1 hour
Substance Abuse Counseling Transitional, Individual	H0047	UC, HF	1 unit = 1 hour
Transitional Behavioral Health Supports	H0025	UC	1 unit = 30 minutes
Transitional Specialized Day Rehabilitation Services	S5101	UC	1 unit = 4-5 hours
Vision	V2799	UC	1 unit = 1 procedure

<b>CCT- CMHS Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Adult Day Services, Basic	S5105	UC	1 unit = 4-5 hours

<b>CCT- CMHS Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Qualified Services</b>			
Adult Day Services, Specialized	S5105	UC, TF	1 unit = 3-5 hours
Consumer Directed Attendant Support Services (CDASS), (Cent/Unit)	T2025	UC	1 unit = 1 cent
CDASS Per Member/ Per Month (PM/PM)	T2040	UC	1 unit = 1 month
Home Modifications	S5165	UC	1 unit = 1 modification
Homemaker	S5130	UC	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UC, TF	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UC	1 unit = 1 month
Non-Medical Transportation, Taxi	A0100	UC	1 unit = 1 way trip
<b>Non-Medical Transportation, Mobility Van</b>			
Mileage Band 1 (0-10 miles)	A0120	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN	1 unit = 1 way trip
<b>Non-Medical Transportation, Mobility Van To and From Adult Day</b>			
Mileage Band 1 (0-10 miles)	A0120	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0120	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0120	UC, TN, HB	1 unit = 1 way trip
<b>Non-Medical Transportation, Wheelchair Van</b>			
Mileage Band 1 (0-10 miles)	A0130	UC	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN	1 unit = 1 way trip
<b>Non-Medical Transportation, Wheelchair Van To and From Adult Day</b>			
Mileage Band 1 (0-10 miles)	A0130	UC, HB	1 unit = 1 way trip
Mileage Band 2 (11-20 miles)	A0130	UC, TT, HB	1 unit = 1 way trip
Mileage Band 3 (over 20 miles)	A0130	UC, TN, HB	1 unit = 1 way trip
Personal Care	T1019	UC	1 unit = 15 minutes
Personal Emergency Response System (PERs), Install/Purchase	S5160	UC	1 unit = 1 purchase
PERs, Monitoring	S5161	UC	1 unit = 1 month
Relative Personal Care	T1019	UC, HR	1 unit = 15 minutes
Respite Care, ACF	S5151	UC	1 unit = 1 day
Respite Care, NF	H0045	UC	1 unit = 1 day
Assistive Technology, Extended	T2029	UC	1 unit = 1 purchase

<b>CCT- CMHS Services Procedure Code Table (Special Program Code 95)</b>			
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>		<b>Units</b>
<b>Demonstration Services</b>			
Caregiver Education	S5110	UC	1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC	1 unit = 1 purchase
Dental	D2999	UC	1 unit = 1 procedure
Enhanced Nursing, RN	T1002	UC	1 unit = 15 minutes
Home Delivered Meals	S5170	UC	1 unit = 1 delivery/meal
Home Modifications, Extended	S5165	UC, KG	1 unit = 1 modification
Independent Living Skills Training (ILST)	H2014	UC	1 unit = 15 minutes
Intensive Case Management	T1016	UC	1 unit = 15 minutes
Peer Mentorship	H2015	UC	1 unit = 15 minutes
Substance Abuse Counseling Transitional, Group	H0047	UC, HF, HQ	1 unit = 1 hour
Substance Abuse Counseling Transitional, Individual	H0047	UC, HF	1 unit = 1 hour
Transitional Behavioral Health Supports	H0025	UC	1 unit = 30 minutes
Transitional Specialized Day Rehabilitation Services	S5101	UC	1 unit = 4-5 hours
Vision	V2799	UC	1 unit = 1 procedure

<b>CCT- DD Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
<b>Behavioral Services</b>				
Line Service	H2019	UC		1 unit = 15 minutes
Behavioral Consultation	H2019	UC, HI, TG		1 unit = 15 minutes
Behavioral Counseling, Individual	H2019	UC, TF, TG		1 unit = 15 minutes
Behavioral Counseling, Group	H2019	UC, TF, HQ		1 unit = 15 minutes
Behavioral Plan Assessment	T2024	UC, HI		1 unit = 15 minutes

<b>CCT- DD Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
<b>Day Habilitation</b>				
Specialized Day Habilitation	T2021	UC, HQ	Level 1	1 unit = 15 minutes
	T2021	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2021	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2021	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2021	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2021	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes
	T2021	UC, SC, HQ	Level 7	1 unit = 15 minutes
Supported Community Connections	T2021	UC	Level 1	1 unit = 15 minutes
	T2021	UC, HI	Level 2	1 unit = 15 minutes
	T2021	UC, TF	Level 3	1 unit = 15 minutes
	T2021	UC, TF, HI	Level 4	1 unit = 15 minutes
	T2021	UC, TG	Level 5	1 unit = 15 minutes
	T2021	UC, TG, HI	Level 6	1 unit = 15 minutes
	T2021	UC, SC	Level 7	1 unit = 15 minutes
<b>Dental</b>				
Dental, Basic/ Preventive	D2999	UC, HI		1 unit = 1 dollar
Dental, Major	D2999	UC, TF		1 unit = 1 dollar
<b>Non- Medical Transportation</b>				
To/From Day Program, Mileage Range	T2003	UC	0-10 Miles	1 unit = 2 trips per day
	T2003	UC, HI	11-20 Miles	1 unit = 2 trips per day
	T2003	UC, TF	21- up Miles	1 unit = 2 trips per day
Other (Public Conveyance)	T2004	UC		1 unit = 1 dollar
<b>Pre-Vocational Services</b>				
Pre-Vocational Services	T2015	UC, HQ	Level 1	1 unit = 15 minutes
	T2015	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2015	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2015	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2015	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2015	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes

<b>CCT- DD Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
<b>Residential Services</b>				
Group Home	T2016	UC, HQ	Level 1	1 unit = 15 minutes
	T2016	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2016	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2016	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2016	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2016	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes
	T2016	UC, SC, HQ	Level 7	1 unit = 15 minutes
Personal Care Alternative	T2016	UC	Level 1	1 unit = 1 day
	T2016	UC, HI	Level 2	1 unit = 1 day
	T2016	UC, TF	Level 3	1 unit = 1 day
	T2016	UC, TF, HI	Level 4	1 unit = 1 day
	T2016	UC, TG	Level 5	1 unit = 1 day
	T2016	UC, TG, HI	Level 6	1 unit = 1 day
	T2016	UC, SC	Level 7	1 unit = 1 day
Host Home	T2016	UC, TT	Level 1	1 unit = 1 day
	T2016	UC, HI, TT	Level 2	1 unit = 1 day
	T2016	UC, TF, TT	Level 3	1 unit = 1 day
	T2016	UC, TF, HI, TT	Level 4	1 unit = 1 day
	T2016	UC, TG, TT	Level 5	1 unit = 1 day
	T2016	UC, TG, HI, TT	Level 6	1 unit = 1 day
	T2016	UC, SC, TT	Level 7	1 unit = individual approved rate
<b>Supported Employment</b>				
Supported Employment, Individual, All Levels (1-6)	T2019	UC, SC	All Levels (1-6)	1 unit = 15 minutes
Supported Employment, Group	T2019	UC, HQ	Level 1	1 unit = 15 minutes
	T2019	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2019	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2019	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2019	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2019	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes
Job Development, Individual, Level 1-2	H2023	UC	Level 1-2	1 unit = 15 minutes
Job Development, Individual, Level 3-4	H2023	UC, HI	Level 3-4	1 unit = 15 minutes
Job Development, Individual, Level 5-6	H2023	UC, TF	Level 5-6	1 unit = 15 minutes

<b>CCT- DD Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
Job Development, Group, All Levels	H2023	UC, HQ	All Levels (1-6)	1 unit = 15 minutes
Job Placement, Individual, All Levels (1-6)	H2024	UC	All Levels (1-6)	1 unit = 1 dollar
Job Placement, Group, All Levels (1-6)	H2024	UC, HQ	All Levels (1-6)	1 unit = 1 dollar
<b>Specialized Medical Equipment</b>				
Specialized Medical Equipment and Supplies, Disposable	T2028	UC		1 unit = 1 dollar
Specialized Medical Equipment	T2029	UC, TF		1 unit = 1 dollar
Vision	V2799	UC, HI		1 unit = 1 dollar
<b>Demonstration Services</b>				
Assistive Technology, Extended	T2029	UC		1 unit = 1 purchase
Caregiver Education	S5110	UC		1 unit = 15 minutes
Community Transition Services, Coordinator	T2038	UC		1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	UC		1 unit = 1 purchase
Enhanced Nursing, RN	T1002	UC		1 unit = 15 minutes
Home Accessibility Adaptations, Extended	S5165	UC, KG		1 unit = 1 modification
Intensive Case Management	T1016	UC		1 unit = 15 minutes
Peer Mentorship	H2015	UC		1 unit = 15 minutes
Substance Abuse Counseling Transitional, Group	H0047	UC, HF, HQ		1 unit = 1 hour
Substance Abuse Counseling Transitional, Individual	H0047	UC, HF		1 unit = 1 hour

<b>CCT- SLS Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
Assistive Technology *	T2035	UC		1 unit = 1 dollar
Mentorship	H2021	UC		1 unit = 15 minutes
Personal Care	T1019	UC, TF		1 unit = 15 minutes
Personal Emergency Response (PERs)	S5161	UC		1 unit = 1 dollar
Vehicle Modifications *	T2039	UC		1 unit = 1 dollar
Vision *	V2799	UC, HI		1 unit = 1 dollar
<b>Behavioral Services</b>				
Line Services	H2019	UC		1 unit = 15 minutes
Behavioral Consultation	H2019	UC, HI, TG		1 unit = 15 minutes
Behavioral Counseling, Group	H2019	UC, TF, HQ		1 unit = 15 minutes
Behavioral Counseling, Individual	H2019	UC, TF, TG		1 unit = 15 minutes
Behavioral Plan Assessment	T2024	UC, HI		1 unit = 15 minutes
<b>Day Habilitation</b>				
Specialized Day Habilitation	T2021	UC, HQ	Level 1	1 unit = 15 minutes
	T2021	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2021	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2021	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2021	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2021	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes
Supported Community Connections	T2021	UC	Level 1	1 unit = 15 minutes
	T2021	UC, HI	Level 2	1 unit = 15 minutes
	T2021	UC, TF	Level 3	1 unit = 15 minutes
	T2021	UC, TF, HI	Level 4	1 unit = 15 minutes
	T2021	UC, TG	Level 5	1 unit = 15 minutes
	T2021	UC, TG, HI	Level 6	1 unit = 15 minutes
<b>Dental</b>				
Dental, Basic/ Preventive Services *	D2999	UC, HI		1 unit = 1 dollar
Dental, Major Services *	D2999	UC, TF		1 unit = 1 dollar
<b>Homemaker</b>				
Homemaker, Basic	S5130	UC, HI		1 unit = 15 minutes

<b>CCT- SLS Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
Homemaker, Enhanced	S5130	UC, TF		1 unit = 15 minutes
Home Accessibility Adaptations *	S5165	UC		1 unit = 1 dollar
<b>Non- Medical Transportation</b>				
To/From Day Program, Mileage Range *	T2003	UC	0-10 Miles	1 unit = 2 trips per day
	T2003	UC, HI	11-20 Miles	1 unit = 2 trips per day
	T2003	UC, TF	21- up Miles	1 unit = 2 trips per day
Mileage Not Day Program *	T2003	UC, HB		1 unit = 4 trips per week
Other (Public Conveyance) *	T2004	UC		1 unit = 1 dollar
<b>Pre-Vocational Services</b>				
Pre-Vocational Services	T2015	UC, HQ	Level 1	1 unit = 15 minutes
	T2015	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2015	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2015	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2015	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2015	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes
<b>Professional Services</b>				
Massage Therapy	97124	UC		1 unit = 15 minutes
Movement Therapy, Bachelors Degree	G0176	UC, HN		1 unit = 15 minutes
Movement Therapy, Masters Degree	G0176	UC		1 unit = 15 minutes
Hippotherapy, Group	S8940	UC, HQ		1 unit = 15 minutes
Hippotherapy, Individual	S8940	UC		1 unit = 15 minutes
Rec Pass, Access Fee	S5199	UC		1 unit = 1 dollar
<b>Respite Care</b>				
Respite Care, Camp	T2036	UC		1 unit = 1 dollar
Respite Care, Group	S5151	UC, HQ, TG		1 unit = 1 dollar
Respite Care, Individual, 15 Minutes	S5150	UC, TG		1 unit = 15 minutes
Respite Care, Individual, Day	S5151	UC, TG		1 unit = 1 dollar

<b>CCT- SLS Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Qualified Services</b>				
<b>Specialized Medical Equipment and Supplies</b>				
Specialized Medical Equipment and Supplies, Disposable	T2028	UC		1 unit = 1 dollar
Specialized Medical Equipment	T2029	UC, TF		1 unit = 1 dollar
<b>Supported Employment</b>				
Supported Employment, Individual, All Levels (1-6)	T2019	UC, HI	All Levels (1-6)	1 unit = 15 minutes
Supported Employment, Group	T2019	UC, HQ	Level 1	1 unit = 15 minutes
	T2019	UC, HI, HQ	Level 2	1 unit = 15 minutes
	T2019	UC, TF, HQ	Level 3	1 unit = 15 minutes
	T2019	UC, TF, HI, HQ	Level 4	1 unit = 15 minutes
	T2019	UC, TG, HQ	Level 5	1 unit = 15 minutes
	T2019	UC, TG, HI, HQ	Level 6	1 unit = 15 minutes
Job Development, Individual, Level 1-2	H2023	UC	Level 1-2	1 unit = 15 minutes
Job Development, Individual, Level 3-4	H2023	UC, HI	Level 3-4	1 unit = 15 minutes
Job Development, Individual, Level 5-6	H2023	UC, TF	Level 5-6	1 unit = 15 minutes
Job Development, Group, All Levels	H2023	UC, HQ	All Levels (1-6)	1 unit = 15 minutes
Job Placement, Individual, All Levels (1-6)	H2024	UC	All Levels (1-6)	1 unit = 1 dollar
Job Placement, Group, All Levels (1-6)	H2024	UC, HQ	All Levels (1-6)	1 unit = 1 dollar
<b>Demonstration Services</b>				
Caregiver Education	S5110	UC		1 unit = 15 minutes
Community Transition Services, Coordinator *	T2038	UC		1 unit = 1 transition
Community Transition Services, Items Purchased *	A9900	UC		1 unit = 1 purchase
Enhanced Nursing, RN	T1002	UC		1 unit = 15 minutes
Home Accessibility Adaptations, Extended *	S5165	UC, KG		1 unit = 1 modification

<b>CCT- SLS Services Procedure Code Table (Special Program Code 95)</b>				
<b>Description</b>	<b>Procedure Code</b>	<b>Modifier(s)</b>	<b>Level</b>	<b>Units</b>
<b>Demonstration Services</b>				
Independent Living Skills Training (ILST)	H2014	UC		1 unit = 15 minutes
Intensive Case Management *	T1016	UC		1 unit = 15 minutes
Substance Abuse Counseling Transitional, Group	H0047	UC, HF, HQ		1 unit = 1 hour
Substance Abuse Counseling Transitional, Individual	H0047	UC, HF		1 unit = 1 hour
<b>* Outside of Service Plan Authorization Limit (SPAL)</b>				

## Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the “Claim Notes/LBOD” field.

### Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section.

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

Billing Instruction Detail	Instructions
<b>LBOD Completion Requirements</b>	<ul style="list-style-type: none"> <li>• Electronic claim formats provide specific fields for documenting the LBOD.</li> <li>• Supporting documentation must be kept on file for 6 years.</li> <li>• For paper claims, follow the instructions appropriate for the claim form you are using.                             <ul style="list-style-type: none"> <li>➤ <i>UB-04:</i> Occurrence code 53 and the date are required in FL 31-34.</li> <li>➤ <i>Colorado 1500:</i> Indicate “LBOD” and the date in box 30 - Remarks.</li> <li>➤ <i>2006 ADA Dental:</i> Indicate “LBOD” and the date in box 35 - Remarks</li> </ul> </li> </ul>
<b>Adjusting Paid Claims</b>	<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><b>Adjust the claim within 60 days</b> 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><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
<p><b>Denied Paper Claims</b></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><b>Correct the claim errors and refile within 60 days</b> of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<p><b>Returned Paper Claims</b></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><b>Correct the claim errors and re-file within 60 days</b> 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><b>LBOD</b> = the stamped fiscal agent date on the returned claim.</p>
<p><b>Rejected Electronic Claims</b></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><b>Correct claim errors and refile within 60 days</b> of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p><b>LBOD</b> = the date shown on the claim rejection report.</p>
<p><b>Denied/Rejected Due to Client Eligibility</b></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><b>File the claim within 60 days</b> of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p><b>LBOD</b> = the date shown on the eligibility rejection report.</p>
<p><b>Retroactive Client Eligibility</b></p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> <li>• Identifies the patient by name</li> <li>• States that eligibility was backdated or retroactive</li> <li>• Identifies the date that eligibility was added to the state eligibility system.</li> </ul> <p><b>LBOD</b> = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

Billing Instruction Detail	Instructions
<p><b>Delayed Notification of Eligibility</b></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><b>File the claim within 60 days</b> 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 Appendix H of the Appendices in the Provider Services <a href="#">Billing Manuals</a> section) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> <li>• Claims must be filed within 365 days of the date of service. No exceptions are allowed.</li> <li>• This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.</li> <li>• Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.</li> <li>• The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.</li> <li>• If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed.</li> </ul> <p><b>LBOD</b> = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p><b>Electronic Medicare Crossover Claims</b></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><b>File the claim within 120 days</b> of the Medicare processing/payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>
<p><b>Medicare Denied Services</b></p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client 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><b>File the claim within 60 days</b> 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><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>

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



# CCT PAR and Claim Examples

## CCT-BI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT					
CCT - Persons with Brain Injury Demonstration					
					<input checked="" type="checkbox"/> CCT-UC
					PA Number being revised:
					Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE	5. DATE OF DISCHARGE	
<b>Doe, Jane</b>	<b>A555555</b>	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	<b>4/7/1954</b>		
6. REQUESTING PROVIDER #	7. CLIENT'S COUNTY	8. CASE NUMBER (AGENCY USE)		9. DATES COVERED	
<b>12345678</b>	<b>Alamosa</b>			From: <b>05/01/12</b>	Through: <b>04/30/13</b>
STATEMENT OF REQUESTED SERVICES					
10. Qualified Services Description	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total \$ Authorized	15. Comments:
S5102 Adult Day Services (UC)		182	\$45.88	\$8,350.16	
T2029 Assistive Technology, per purchase (UC)					
H0025 Behavioral Programming (UC)					
T2025 CDASS, (Cent/Unit) (UC)					
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)					
H2018 Day Treatment (UC)					
S5165 Home Modifications (UC)					
T2013 Independent Living Skills Training (ILST) (UC)					
H0004 Mental Health Counseling, Family (UC)	HR				
H0004 Mental Health Counseling, Group (UC)	HQ				
H0004 Mental Health Counseling, Individual (UC)					
A0100 Non Medical Transportation (NMT), Taxi (UC)					
A0120 NMT, Mobility Van					Mileage Band 1 (0-10 mi) (UC)
A0130 NMT, Wheelchair Van					Mileage Band 1 (0-10 mi) (UC)
T1019 Personal Care (UC)	TG	2080	\$3.53	\$7,342.40	
S5160 Personal Emergency Response System (PERs), Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR, TG				
H0045 Respite Care, NF (UC)					
S5150 Respite Care, In Home (UC)					
T1006 Substance Abuse Counseling, Family (UC)	HR, HF				
H0047 Substance Abuse Counseling, Group (UC)	HQ, HF				
H0047 Substance Abuse Counseling, Individual (UC)	HF				
T2033 Supported Living Program (UC)					
T2016 Transitional Living, per day (UC)					
Demonstration Services Description					
S5110 Caregiver Education (UC)		20	\$12.19	\$243.80	
T2038 Community Transition Services, Coordinator (UC)		1	\$2,000.00	\$2,000.00	one time
A9900 Community Transition Services, Items Purchased (UC)		1	\$1,500.00	\$1,500.00	one time
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)		728	\$10.80	\$7,862.40	
S5165 Home Modifications, Extended (UC)	KG				
T1016 Intensive Case Management (UC)		2000	\$21.10	\$42,200.00	
H2015 Peer Mentorship (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					
16a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)				\$15,692.56	16c. Grand Total
16b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)				\$53,806.20	\$69,498.76
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)					\$0.00
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT SERVICES EXPENDITURES + HOME HEALTH EXPENDITURES)					\$69,498.76
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)					365
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)					\$190.41
A. Monthly State Cost Containment Amount					\$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling					\$0.00
21. Immediately prior to CCT Services enrollment, this client lived in a: <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> No <input type="checkbox"/> Hospital <input type="checkbox"/> No					
22. CASE MANAGER NAME	23. AGENCY	24. PHONE #	25. EMAIL	26. DATE	
<b>Authorized Case Manager</b>	<b>Business Name</b>	<b>111-111-1111</b>	<b>authorizedcms@business.com</b>	<b>5/2/2012</b>	
27. CASE MANAGER'S SUPERVISOR NAME	28. AGENCY	29. PHONE #	30. EMAIL	31. DATE	
<b>Authorized Case Manager's Supervisor</b>	<b>Business Name</b>	<b>222-222-2222</b>	<b>authorizedcms@business.com</b>	<b>5/2/2012</b>	
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY					
CASE PLAN: <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: <input type="checkbox"/> Return for correction- Date:					
REGULATION(S) upon which Denial or Return is based:					
DEPARTMENT APPROVAL SIGNATURE:					DATE:
<input type="checkbox"/> CCT-BI-CE <input type="checkbox"/> CCT-BI-300					

### CCT-CMHS (formerly MI) PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT					<input checked="" type="checkbox"/> CCT-UC
CCT - Community Mental Health Supports Demonstration					PA Number being revised:
					Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1. CLIENT NAME <b>Porter, Client</b>		2. CLIENT ID <b>A888888</b>		3. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. BIRTHDATE <b>12/25/1999</b>
5. REQUESTING PROVIDER # <b>12345678</b>	6. CLIENT'S COUNTY <b>Jefferson</b>	7. CASE NUMBER (AGENCY USE)		8. DATES COVERED From: <b>07/01/12</b> Through: <b>06/30/13</b>	
STATEMENT OF REQUESTED SERVICES					
9. Qualified Services Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments:
S5105 Adult Day Services, Basic (UC)					
S5105 Adult Day Services, Specialized (UC)	TF	96	\$27.83	\$2,671.68	
T2031 Alternative Care Facility (ACF) (UC)					
T2025 Consumer Directed Attendant Support Services (CDASS) (UC)					
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)			\$310.00		
S5165 Home Modifications (UC)					
S5130 Homemaker (UC)		600	\$3.47	\$2,082.00	
T2029 Medication Reminder, Install/Purchase (UC)					
S5185 Medication Reminder, Monitoring (UC)					
A0100 Non-Medical Transportation, Taxi (UC)					
A0120 Non-Medical Transportation, Mobility Van (UC)					
A0130 Non-Medical Transportation, Wheelchair Van (UC)					
A0425 Non-Medical Transportation, Wheelchair Van Mileage (UC)					
T1019 Personal Care (UC)					
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR				
H0045 Respite Care, NF (UC)					
S5151 Respite Care, ACF (UC)					
Demonstration Services Description					
T2029 Assistive Technology (UC)					
S5110 Caregiver Education (UC)					
T2038 Community Transition Services, Coordinator (UC)		1	\$2,000.00	\$2,000.00	one time
A9900 Community Transition Services, Items Purchased (UC)		1	\$1,500.00	\$1,500.00	one time
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)					
S5165 Home Modifications, Extended (UC)	KG				
H2014 Independent Living Skills Training (ILST) (UC)					
T1016 Intensive Case Management (UC)		1000	\$21.10	\$21,100.00	
H2015 Peer Mentorship (UC)					
H0047 Substance Abuse Counseling, Transitional, Group (UC)	HQ, HF				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)	HF				
H0025 Transitional Behavioral Health Supports (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					
15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF A QUALIFIED SERVICES)				<b>\$4,753.68</b>	15c. Subtotal
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)				<b>\$24,600.00</b>	<b>\$29,353.68</b>
16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts					<b>\$0.00</b>
17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)					<b>\$29,353.68</b>
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)					<b>365</b>
19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)					<b>\$80.42</b>
A. Monthly State Cost Containment Amount					<b>\$5,361.22</b>
B. Divided by 30.42 days = Daily Cost Containment Ceiling					<b>\$176.24</b>
20. CDASS (amounts must match client's allocation worksheet)		Effective Date:	Monthly Allocation Amt:	<b>\$0.00</b>	Monthly Admin Fee: <b>\$0.00</b>
21. Immediately prior to CCT enrollment, this client lived in a long term care facility? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
22. CASE MANAGER NAME <b>Authorized Case Manager</b>		23. AGENCY <b>Business Name</b>	24. PHONE # <b>111-111-1111</b>	25. EMAIL <b>authorizedcm@business.com</b>	26. DATE <b>7/1/2012</b>
27. CASE MANAGER'S SUPERVISOR NAME <b>Authorized Case Manager's Supervisor</b>		28. AGENCY <b>Business Name</b>	29. PHONE # <b>222-222-2222</b>	30. EMAIL <b>authorizedcms@business.com</b>	31. DATE <b>7/1/2012</b>
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY					
32. CASE PLAN: <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: Return for correction- Date:					
33. REGULATION(S) upon which Denial or Return is based:					
34. DEPARTMENT APPROVAL SIGNATURE:					35. DATE:
36. <input type="checkbox"/> CCT-MI-CE <input type="checkbox"/> CCT-MI-300					

### CCT-DD PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING								
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT <b>CCT - Persons with Developmental Disabilities Demonstration</b>					<input checked="" type="checkbox"/> CCT-UC			
					PA Number being revised:			
					Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
1. CLIENT NAME		2. CLIENT ID		3. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. BIRTHDATE: 3/20/1986			
Client, Ima		A333333		5. SUPPORT LEVEL (1-7) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7				
6. REQUESTING PROVIDER #		7. CLIENT'S COUNTY		8. CASE NUMBER (AGENCY USE)				
12345678		Boulder		9. DATES COVERED				
				From: 3/23/12 Through: 3/22/2013				
STATEMENT OF REQUESTED SERVICES								
10. Qualified Services Description			11. Support Level	12. Modifier	13. Max # Units	14. Cost Per Unit	15. Total \$ Authorized	16. Comments:
<i>Behavioral Services</i>								
H2019 Line Services (UC)								
H2019 Behavioral Consultation (UC)								
H2019 Behavioral Counseling, Individual (UC)								
H2019 Behavioral Counseling, Group (UC)								
T2024 Behavioral Plan Assessment (UC)								
<i>Day Habilitation</i>								
T2021 Specialized Day Habilitation (UC)								
T2021 Supported Community Connections (UC)								
<i>Dental</i>								
D2999 Dental, Basic/ Preventive (UC)								
D2999 Dental, Major (UC)								
<i>Non-Medical Transportation</i>								
T2003 To/From Day Program, Mileage Range (UC)								
T2004 Other (Public Conveyance) (UC)								
<i>Pre-Vocational Services</i>								
T2015 Pre-Vocational Services (UC)								
<i>Residential Services</i>								
T2016 Group Home (UC)								
T2016 Personal Care Alternative (UC)								
T2016 Host Home (UC)								
<i>Supported Employment</i>								
T2019 Supported Employment, Individual, All Levels (1-6) (UC)								
T2019 Supported Employment, Group (UC)								
H2023 Job Development, Individual (UC)								
H2023 Job Development, Individual (UC)								
H2023 Job Development, Individual (UC)								
H2023 Job Development, Group, All Levels (1-6) (UC)								
H2024 Job Placement, Individual, All Levels (1-6) (UC)								
H2024 Job Placement, Group, All Levels (1-6) (UC)								
<i>Specialized Medical Equipment</i>								
T2028 Specialized Medical Equipment, Disposable (UC)								
T2029 Specialized Medical Equipment (UC)								
V2799 Vision (UC)								
<i>Demonstration Services Description</i>								
T2029 Assistive Technology (UC)								
S5110 Caregiver Education (UC)								
T2038 Community Transition Services, Coordinator (UC)								
A9900 Community Transition Services, Items Purchased (UC)								
T1002 Enhanced Nursing, RN (UC)								
S5165 Home Accessibility Adaptations, Extended (UC)								
T1016 Intensive Case Management (UC)								
H2015 Peer Mentorship (UC)								
H0047 Substance Abuse Counseling, Transitional, Group (UC)								
H0047 Substance Abuse Counseling, Transitional, Individual (UC)								
17a. TOTAL AUTHORIZED CCT QUALIFIED SERVICES EXPENDITURES (SUM OF QUALIFIED SERVICES)						\$4,473.04	17c. Subtotal	
17b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICES EXPENDITURES (SUM OF DEMONSTRATION SERVICES)						\$23,440.36	\$27,913.40	
18. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)						\$0.00		
19. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)						\$27,913.40		
20. NUMBER OF DAYS COVERED (FROM FIELD 9 ABOVE)						365		
21. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)						\$76.48		
22. Immediately prior to CCT enrollment, this client lived in a long term care facility? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
23. CASE MANAGER NAME		24. AGENCY		25. PHONE #		26. EMAIL		27. DATE
Authorized Case Manager		Business Name		111-111-1111		authorizedcm@business.com		3/24/2012
28. CASE MANAGER'S SUPERVISOR NAME		29. AGENCY		30. PHONE #		31. EMAIL		32. DATE
Authorized Case Manager's Supervisor		Business Name		222-222-2222		authorizedcms@business.com		3/24/2012
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY								
33. CASE PLAN: <input type="checkbox"/> Approved Date:			<input type="checkbox"/> Denied Date:			Return for correction- Date:		
34. REGULATION(S) upon which Denial or Return is based:								
35. DEPARTMENT APPROVAL SIGNATURE:						36. DATE:		
37. <input type="checkbox"/> CCT-DD-CE <input type="checkbox"/> CCT-DD-300								

### CCT-EBD (18-64) PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT					<input checked="" type="checkbox"/> CCT-UC
<b>CCT- Persons who are Elderly, Blind, and Disabled Demonstration, 18-64</b>					PA Number being revised:
					Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1. CLIENT NAME <b>Doe, John</b>		2. CLIENT ID <b>A666666</b>		3. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
				4. BIRTHDATE <b>2/14/1967</b>	
5. REQUESTING PROVIDER # <b>12345678</b>	6. CLIENT'S COUNTY <b>Pueblo</b>	7. CASE NUMBER (AGENCY USE)		8. DATES COVERED From: <b>08/15/12</b> Through: <b>08/14/13</b>	
STATEMENT OF REQUESTED SERVICES					
9. Qualified Services Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments:
S5105 Adult Day Services, Basic (UC)					
S5105 Adult Day Services, Specialized (UC)	TF				
T2031 Alternative Care Facility, (ACF) (UC)					
T2025 Consumer Directed Attendant Support Services (CDASS) (UC)					
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)			\$310.00		
S5165 Home Modifications (UC)					
S5130 Homemaker (UC)		1060	\$3.47	\$3,678.20	
H0038 IHHS Health Maintenance Activities (UC)					
S5130 IHHS Homemaker (UC)	KX				
T1019 IHHS Personal Care (UC)	KX				
T1019 IHHS Relative Personal Care (UC)	HR, KX				
S5185 Medication Reminder, Monitoring (UC)					
T2029 Medication Reminder, Install/Purchase (UC)					
A0100 Non-Medical Transportation, Taxi (UC)					
A0120 Non-Medical Transportation, Mobility Van (UC)					
A0130 Non-Medical Transportation, Wheelchair Van (UC)					
A0425 Non-Medical Transportation, Wheelchair Van Mileage (UC)					
T1019 Personal Care (UC)		1060	\$3.47	\$3,678.20	
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR				
H0045 Respite Care, NF (UC)					
S5150 Respite Care, In Home (UC)					
S5151 Respite Care, ACF (UC)					
<b>Demonstration Services Description</b>					
T2029 Assistive Technology (UC)					
S5110 Caregiver Education (UC)					
T2038 Community Transition Services, Coordinator (UC)		1	\$2,000.00	\$2,000.00	one time
A9900 Community Transition Services, Items Purchased (UC)		1	\$1,500.00	\$1,500.00	one time
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)					
S5165 Home Modifications, Extended (UC)	KG				
H2014 Independent Living Skills Training (ILST) (UC)					
T1016 Intensive Case Management (UC)					
H2015 Peer Mentorship (UC)					
H0047 Substance Abuse Counseling, Transitional, Group (UC)	HQ, HF				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)	HF				
H0025 Transitional Behavioral Health Supports (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					
15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICES EXPENDITURES (SUM OF QUALIFIED SERVICES)				<b>\$7,356.40</b>	15c. Subtotal
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICES EXPENDITURES (SUM OF DEMONSTRATION SERVICES)				<b>\$3,500.00</b>	<b>\$10,856.40</b>
16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts					<b>\$0.00</b>
17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)					<b>\$10,856.40</b>
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)					<b>365</b>
19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)					<b>\$29.74</b>
A. Monthly State Cost Containment Amount					<b>\$5,082.88</b>
B. Divided by 30.42 days = Daily Cost Containment Ceiling					<b>\$167.09</b>
20. CDASS (amounts must match client's allocation worksheet)		Effective Date:	Monthly Allocation Amt:	<b>\$0.00</b>	Monthly Admin Fee: <b>\$0.00</b>
21. Immediately prior to CCT enrollment, this client lived in a long term care facility? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
22. CASE MANAGER NAME <b>Authorized Case Manager</b>		23. AGENCY <b>Business Name</b>	24. PHONE # <b>111-111-1111</b>	25. EMAIL <b>authorizeddcm@business.com</b>	26. DATE <b>8/15/2012</b>
27. CASE MANAGER'S SUPERVISOR NAME <b>Authorized Case Manager's Supervisor</b>		28. AGENCY <b>Business Name</b>	29. PHONE # <b>222-222-2222</b>	30. EMAIL <b>authorizedcms@business.com</b>	31. DATE <b>8/15/2012</b>
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY					
32. CASE PLAN: <input type="checkbox"/> Approved Date:		<input type="checkbox"/> Denied Date:		Return for correction- Date:	
33. REGULATION(S) upon which Denial or Return is based:					
34. DEPARTMENT APPROVAL SIGNATURE:					35. DATE:
36. <input type="checkbox"/> CCT-PD-CE <input type="checkbox"/> CCT-PD-300					

### CCT-EBD (65+) PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING														
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT														
CCT- Persons who are Elderly, Blind, and Disabled Demonstration, 65+												<input checked="" type="checkbox"/> CCT-UC		
												PA Number being revised:		
												Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
1. CLIENT NAME <b>Client, Ima</b>			2. CLIENT ID <b>A777777</b>			3. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F			4. BIRTHDATE <b>11/15/1923</b>					
5. REQUESTING PROVIDER # <b>12345678</b>		6. CLIENT'S COUNTY <b>Delta</b>		7. CASE NUMBER (AGENCY USE)			8. DATES COVERED From: <b>09/03/12</b> Through: <b>09/02/13</b>							
STATEMENT OF REQUESTED SERVICES														
9. Qualified Services Description										10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments
S5105 Adult Day Services, Basic (UC)														
S5105 Adult Day Services, Specialized (UC)										TF				
T2031 Alternative Care Facility (ACF) (UC)														
T2025 Consumer Directed Attendant Support Services (CDASS) (UC)														
T2040 CDASS Per Member/ Per Month (PMPM) (UC)												\$310.00		
S5165 Home Modifications (UC)											1	\$8,500.00	\$8,500.00	
S5130 Homemaker (UC)											624	\$3.47	\$2,165.28	3x week for 52 weeks
H0038 IHHS Health Maintenance Activities (UC)														
S5130 IHHS Homemaker (UC)										KX				
T1019 IHHS Personal Care (UC)										KX				
T1019 IHHS Relative Personal Care (UC)										HR, KX				
T2029 Medication Reminder, Install/Purchase (UC)														
S5185 Medication Reminder, Monitoring (UC)														
A0100 Non-Medical Transportation, Taxi (UC)														
A0120 Non-Medical Transportation, Mobility Van (UC)														
A0130 Non-Medical Transportation, Wheelchair Van (UC)														
A0425 Non-Medical Transportation, Wheelchair Van Mileage (UC)														
T1019 Personal Care (UC)											500	\$3.47	\$1,735.00	
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)														
S5161 PERs, Monitoring (UC)														
T1019 Relative Personal Care (UC)										HR				
H0045 Respite Care, NF (UC)														
S5150 Respite Care, In Home (UC)														
S5151 Respite Care, ACF (UC)														
Demonstration Services Description														
T2029 Assistive Technology (UC)														
S5110 Caregiver Education (UC)														
T2038 Community Transition Services, Coordinator (UC)														
A9900 Community Transition Services, Items Purchased (UC)														
D2999 Dental (UC)														
T1002 Enhanced Nursing, RN (UC)														
S5170 Home Delivered Meals (UC)														
S5165 Home Modifications, Extended (UC)										KG				
H2014 Independent Living Skills Training (ILST) (UC)											300	\$9.33	\$2,799.00	
T1016 Intensive Case Management (UC)														
H2015 Peer Mentorship (UC)														
H0047 Substance Abuse Counseling, Transitional, Group (UC)										HQ, HF				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)										HF	52	\$72.94	\$3,792.88	
H0025 Transitional Behavioral Health Supports (UC)														
S5101 Transitional Specialized Day Rehabilitation Services (UC)														
V2799 Vision (UC)														
15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)												\$12,400.28	15c. Subtotal	
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)												\$6,591.88	\$18,992.16	
16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts													\$0.00	
17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)													\$18,992.16	
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)													365	
19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)													\$52.03	
A. Monthly State Cost Containment Amount													\$5,082.88	
B. Divided by 30.42 days = Daily Cost Containment Ceiling													\$167.09	
20. CDASS (amounts must match client's allocation worksheet)				Effective Date:	Monthly Allocation Amt:	\$0.00	Monthly Admin Fee: \$	\$0.00						
21. Immediately prior to CCT enrollment, this client lived in a long term care facility?												<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
22. CASE MANAGER NAME			23. AGENCY		24. PHONE #		25. EMAIL		26. DATE					
Authorized Case Manager			Business Name		111-111-1111		authorizedcm@business.com		9/3/2012					
27. CASE MANAGER'S SUPERVISOR NAME			28. AGENCY		29. PHONE #		30. EMAIL		31. DATE					
Authorized Case Manager's Supervisor			Business Name		222-222-2222		authorizedcms@business.com		9/3/2012					
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY														
32. CASE PLAN: <input type="checkbox"/> Approved Date:				<input type="checkbox"/> Denied Date:				Return for correction- Date:						
33. REGULATION(S) upon which Denial or Return is based:														
34. DEPARTMENT APPROVAL SIGNATURE:												35. DATE:		
36. <input type="checkbox"/> CCT-ELD-CE <input type="checkbox"/> CCT-ELD300														

### CCT-SLS PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT					<input checked="" type="checkbox"/> CCT-UC	
CCT - Supported Living Services Demonstration					PA Number being revised:	
					Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
1. CLIENT NAME	2. CLIENT ID	3. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. BIRTHDATE:	10/28/1975		
<b>Doe, John</b>	<b>A444444</b>		5. SUPPORT LEVEL (1-6)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		
6. REQUESTING PROVIDER #	7. CLIENT'S COUNTY	8. CASE NUMBER (AGENCY USE)	9. DATES COVERED			
12345678	Arapahoe		From:	03/01/12	Through: 02/28/13	
STATEMENT OF REQUESTED SERVICES						
10. Qualified Services Description	11. Support Level	12. Modifier	13. Total # Units Authorized	14. Cost Per Unit	15. Total \$ Authorized	16. Comments:
T2035 Assistive Technology (UC) *						
H2021 Mentorship (UC)						
T1019 Personal Care (UC)			624	\$4.57	\$2,851.68	3x week
S5161 Personal Emergency Response (PERs) (UC)						
T2039 Vehicle Modifications (UC) *						
V2799 Vision (UC) *						
<b>Behavioral Services</b>						
H2019 Line Services (UC)						
H2019 Behavioral Consultation (UC)		HI, TG				
H2019 Behavioral Counseling, Group (UC)		TF, HQ				
H2019 Behavioral Counseling, Individual (UC)		TF, TG				
T2024 Behavioral Plan Assessment (UC)		HI				
<b>Day Habilitation</b>						
T2021 Specialized Day Habilitation (UC)	-----					
T2021 Supported Community Connections (UC)	Level 3	TF	208	\$3.26	\$678.08	
<b>Dental</b>						
D2999 Dental, Basic/ Preventive Services (UC) *						
D2999 Dental, Major Services (UC) *		TF				
<b>Homemaker</b>						
S5130 Homemaker, Basic (UC)						
S5130 Homemaker, Enhanced (UC)		HI				
S5165 Home Accessibility Adaptations (UC) *						
<b>Non-Medical Transportation</b>						
T2003 To/From Day Program, Mileage Range (UC) *	-----					
T2003 Mileage Not Day Program (UC) *		HB				
T2004 Other (Public Conveyance) (UC) *						
<b>Pre-Vocational Services</b>						
T2015 Pre-Vocational Services (UC)	-----					
<b>Professional Services</b>						
97124 Massage Therapy (UC)						
G0176 Movement Therapy, Bachelors Degree (UC)						
G0176 Movement Therapy, Masters Degree (UC)		HI				
S8940 Hippotherapy, Group (UC)		HQ				
S8940 Hippotherapy, Individual (UC)						
S5199 Rec Pass, Access Fee (UC)						
<b>Respite Care</b>						
T2036 Respite Camp (UC)						
S5151 Respite Care, Group (UC)		HQ				
S5150 Respite Care, Individual, 15 Minutes (UC)						
S5151 Respite Care, Individual, Day (UC)						
<b>Specialized Medical Equipment and Supplies</b>						
T2028 Specialized Medical Equipment and Supplies, Disposable (UC)						
T2029 Specialized Medical Equipment (UC)						
<b>Supported Employment</b>						
T2019 Supported Employment, Individual, All Levels (1-6) (UC)		HI				
T2019 Supported Employment, Group (UC)	-----					
H2023 Job Development, Individual (UC)	Level 1-2					
H2023 Job Development, Individual (UC)	Level 3-4	HI				
H2023 Job Development, Individual (UC)	Level 5-6	TF				
H2023 Job Development, Group, All Levels (UC)		HQ				
H2024 Job Placement, Individual, All Levels (1-6) (UC)						
H2024 Job Placement, Group, All Levels (1-6) (UC)		HQ				
<b>Demonstration Services Description</b>						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC) *			1	\$2,000.00	\$2,000.00	one time
A9900 Community Transition Services, Items Purchased (UC) *			1	\$1,500.00	\$1,500.00	one time
T1002 Enhanced Nursing, RN (UC)						
S5165 Home Accessibility Adaptations, Extended (UC) *		KG				
H2014 Independent Living Skills Training (ILST) (UC)						
T1016 Intensive Case Management (UC) *			520	\$21.10	\$10,972.00	
H0047 Substance Abuse Counseling, Transitional, Group (UC)		HF, HQ				

### CCT-SLS PAR Example (Continued)

17a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)		\$3,529.76	17c. Subtotal
17b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)		\$14,472.00	\$18,001.76
18. TOTAL WITHIN SPAL EXPENDITURES (SUM OF ALL SPAL SERVICES IN COLUMN 15 ABOVE)			\$3,529.76
19. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)			\$0.00
20. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)			\$18,001.76
21. NUMBER OF DAYS COVERED (FROM FIELD 9 ABOVE)			365
22. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)			\$49.32
23. Immediately prior to CCT Services enrollment, this client lived in a long term care facility?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24. CASE MANAGER NAME	25. AGENCY	26. PHONE #	27. EMAIL
Authorized Case Manager	Business Name	111-111-1111	authorizedcm@business.com
29. CASE MANAGER'S SUPERVISOR NAME	30. AGENCY	31. PHONE #	32. EMAIL
Authorized Case Manager's Supervisor	Business Name	222-222-2222	authorizedcme@business.com
* Outside of Service Plan Authorization Limit (SPAL)			
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY			
33. CASE PLAN: <input type="checkbox"/> Approved Date:		<input type="checkbox"/> Denied Date: Return for correction- Date:	
34. REGULATION(S) upon which Denial or Return is based:			
35. DEPARTMENT APPROVAL SIGNATURE:			36. DATE:
37. <input type="checkbox"/> CCT-SLS-CE <input type="checkbox"/> CCT-SLS300			

### CCT-BI Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

#### HEALTH INSURANCE CLAIM

##### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Doe, Jane</b>	2. CLIENT DATE OF BIRTH <b>04/07/1954</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A555555</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input type="text"/>	EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

##### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM 1. <b>854</b> 2. _____ 3. _____ 4. _____	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
		DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
		PRIOR AUTHORIZATION #

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
05/01/2012 05/27/2012	12	T1019	uc	12345678	98765432	1	\$458.90	130		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05/23/2012 05/25/2012	12	S5102	UC	12345678	98765432	1	\$91.76	2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05/23/2012 05/27/2012	12	T1016	uc	12345678	98765432	1	\$422.00	20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.	20. TOTAL CHARGES → <b>\$972.66</b>	LESS ↓ 21. MEDICARE PAID <input type="text"/>	24. MEDICARE DEDUCTIBLE <input type="text"/> <b>\$0.00</b>
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>06/10/12</b>	30. REMARKS	22. THIRD PARTY PAID <input type="text"/> <b>\$0.00</b>	25. MEDICARE COINSURANCE <input type="text"/> <b>\$0.00</b>
28. BILLING PROVIDER NAME		23. NET CHARGE <input type="text"/> <b>\$972.66</b>	26. MEDICARE DISALLOWED <input type="text"/>
29. BILLING PROVIDER NUMBER			

CCL-101  
FORM NO. 94320 (REV. 02/99)  
ELECTRONIC APPLICATION

**COLORADO 1500**

### CCT-CMHS Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

#### HEALTH INSURANCE CLAIM

##### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Porter, Client</b>	2. CLIENT DATE OF BIRTH <b>12/25/1999</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A888888</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT	EMPLOYER NAME: POLICYHOLDER NAME: GROUP: 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

##### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/IDENY DATE
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM <b>295.3</b>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. _____		DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____		
3. _____		
4. _____		PRIOR AUTHORIZATION #

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EP&DT
07/04/2012 07/24/2012	11	S5105	uc TF	12345678	98765432	1	\$222.64	8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08/21/2012 08/21/2012	12	T2038	UC	12345678	98765432	1	\$2,000.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08/21/2012 08/21/2012	11	A9900	uc	12345678	98765432	1	\$1,500.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.		20. TOTAL CHARGES → <b>\$3,722.64</b>	LESS ↓ 21. MEDICARE PAID 22. THIRD PARTY PAID NET CHARGE <b>\$3,722.64</b>	MEDICARE SPR DATE 24. MEDICARE DEDUCTIBLE <b>\$0.00</b> 25. MEDICARE COINSURANCE <b>\$0.00</b> 26. MEDICARE DISALLOWED
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>06/10/12</b>	30. REMARKS			
28. BILLING PROVIDER NAME				
29. BILLING PROVIDER NUMBER				

COL-101  
FORM NO. 94320 (REV. 02/99)  
ELECTRONIC APPLICATION

COLORADO 1500

### CCT-DD Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

#### HEALTH INSURANCE CLAIM

#### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client, Ima</b>	2. CLIENT DATE OF BIRTH <b>03/20/1986</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A333333</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — (INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S))	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input type="text"/>	EMPLOYER NAME: POLICYHOLDER NAME: GROUP: 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

#### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIAN'S OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. <b>317</b>	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2.	
3.	
4.	PRIOR AUTHORIZATION #

18A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
03/23/2012	12	T2019	UC HI	12345678	98765432	1	\$48.04	4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03/23/2012	12	H2015	UC	12345678	98765432	1	\$42.88	8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. TOTAL CHARGES → <b>\$90.92</b>	LESS	MEDICARE SPR DATE
21. MEDICARE PAID	24. MEDICARE DEDUCTIBLE	
22. THIRD PARTY PAID	25. MEDICARE COINSURANCE	
23. NET CHARGE	26. MEDICARE DISALLOWED	
<b>\$90.92</b>		

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE  
*Authorized Signature* **03/28/12**

28. BILLING PROVIDER NAME

29. BILLING PROVIDER NUMBER

30. REMARKS

### CCT-EBD (18-64) Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

#### HEALTH INSURANCE CLAIM

#### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Doe, John</b>	2. CLIENT DATE OF BIRTH <b>02/14/1967</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A666666</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT	EMPLOYER NAME: POLICYHOLDER NAME: GROUP: 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

#### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM 1. <b>428</b>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
2. _____		DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
3. _____		
4. _____		PRIOR AUTHORIZATION #

18A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P I S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
08/24/2012 08/24/2012	12	S5130	uc	12345678	98765432	1	\$27.76	8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08/24/2012 08/24/2012	12	T1016	UC	12345678	98765432	1	\$84.40	4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08/24/2012 08/24/2012	11	S5170	uc	12345678	98765432	1	\$32.40	3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL, AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.		20. TOTAL CHARGES → <b>\$144.56</b>	LESS	MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>08/30/12</b>	30. REMARKS	21. MEDICARE PAID	24. MEDICARE DEDUCTIBLE	
28. BILLING PROVIDER NAME		<input type="text"/>	<b>\$0.00</b>	
29. BILLING PROVIDER NUMBER		22. THIRD PARTY PAID	25. MEDICARE COINSURANCE	
		<input type="text"/>	<b>\$0.00</b>	
		23. NET CHARGE	26. MEDICARE DISALLOWED	
		<b>\$144.56</b>	<input type="text"/>	

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FORM NO. 94320 (REV. 02/99)  
ELECTRONIC APPLICATION

**COLORADO 1500**

### CCT-EBD (65+) Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

#### HEALTH INSURANCE CLAIM

#### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client, Ima</b>	2. CLIENT DATE OF BIRTH <b>11/15/1923</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A777777</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT	EMPLOYER NAME: POLICYHOLDER NAME: GROUP: 11. CHAMPUS SPONSORS SERVICE/SSN:
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

#### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. <b>250</b>	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2.	PRIOR AUTHORIZATION #
3.	
4.	

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPBDT
09/21/2012 09/21/2012	12	S5130	uc	12345678	98765432	1	\$27.76	8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09/21/2012 09/21/2012	12	S5165	UC	12345678	98765432	1	\$8,500.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09/21/2012 09/21/2012	12	T1016	uc	12345678	98765432	1	\$84.40	4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09/22/2012 09/22/2012	11	H0047	uc HF	12345678	98765432	1	\$72.94	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.	20. TOTAL CHARGES → <b>\$8,685.10</b>	LESS ↓	MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>09/30/12</b>	30. REMARKS	21. MEDICARE PAID \$0.00	24. MEDICARE DEDUCTIBLE \$0.00
28. BILLING PROVIDER NAME		22. THIRD PARTY PAID \$0.00	25. MEDICARE COINSURANCE \$0.00
29. BILLING PROVIDER NUMBER		23. NET CHARGE <b>\$8,685.10</b>	26. MEDICARE DISALLOWED

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**COLORADO 1500**

# CCT-SLS Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

## HEALTH INSURANCE CLAIM

### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Doe, John</b>	2. CLIENT DATE OF BIRTH <b>10/28/1975</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A444444</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	8. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT	EMPLOYER NAME POLICYHOLDER NAME GROUP 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. <b>299</b>	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2.	PRIOR AUTHORIZATION #
3.	
4.	

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
03/23/2012 03/27/2012	12	T2019	UC	12345678	98765432	1	\$54.84	12		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03/23/2012	12	T2021	UC TF	12345678	98765432	1	\$13.04	4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03/23/2012	12	T1016	UC	12345678	98765432	1	\$422.00	20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. TOTAL CHARGES → <b>\$489.88</b>	LESS ↓	MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> 03/28/12	21. MEDICARE PAID	24. MEDICARE DEDUCTIBLE
28. BILLING PROVIDER NAME	22. THIRD PARTY PAID	25. MEDICARE COINSURANCE
29. BILLING PROVIDER NUMBER	23. NET CHARGE	26. MEDICARE DISALLOWED
	<b>\$489.88</b>	

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### CCT Revisions Log

Revision Date	Additions/ Changes	Pages	Made by
09/2012	<i>Creation of reference manual</i>		cc
09/27/2012	<i>Formatted manual Added PAR and claim examples Created TOC</i>	<i>All 24-35</i>	<i>jpg</i>
10/05/2012	<i>Revised PAR form modifier instructions to include HB, TT, TN Removed A0125 from BI, EBDs, &amp; MI. Added mileage bands to BI, EBDs, &amp; MI</i>	<i>4 9-16 9-16</i>	cc
01/24/2013	<i>Revised IHHS to IHSS Added CDASS Added TG modifier to SLS, Respite Care</i>	<i>11-15 11-15 22</i>	cc
03/19/2013	<i>Removed Alternative Care Facility from all procedure code tables Revised PAR table instructions to match PAR table.</i>	<i>11-16 5-6</i>	cc
08/22/2013	<i>Added Date of Discharge requirement to PAR Reference Table</i>	<i>5</i>	cc
09/26/2013	<i>Revised modifiers for BI, CMHS, EBD, DD and SLS</i>	<i>10-23</i>	cc
03/06/2014	<i>Formatted Updated TOC Updated the BI PAR example Fixed signatures on claim exxamples</i>	<i>Throughout 1 28 35-40</i>	<i>jpg</i>