

# Transportation

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# Transportation

## Benefits

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



Medical Transportation includes both emergent and non-emergent services.

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## Billing Information

### National Provider Identifier (NPI)

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

### Paper Claims

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

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



Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message “Electronic Filing Required”.

### Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D ([wpc-edi.com/](http://wpc-edi.com/))
- Companion Guides for the 837P, 837I, or 837D in the Provider Services
  - Web Portal User Guide (via within the Web Portal)



The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal ([Web Portal](#)) or via batch submission through a host system. Please refer to the [Colorado General Billing Information Manual](#) for additional electronic information.

## Emergency Transportation

### Emergency Ambulance and Air Ambulance Transport

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

#### Exclusions

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

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



### Types of Emergency Transportation

#### Ambulance services

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

#### Air ambulance

Air ambulance benefits are provided when:



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

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

## **Non-Emergent Transportation**

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

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



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

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

### **Types of Non-Emergent Transportation**

#### **General Instructions**

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

#### **Transportation services billed by the State designated entity**

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



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

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

**Exclusions**

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

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



**Mobility Vehicle**

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

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



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

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

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

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

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

**Wheelchair Van**

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



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

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

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

**Non-Emergent Ambulance Services**

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

**Air Ambulance**

Air ambulance benefits are provided when:



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

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

**Over-the-Cap**

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

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



**Air/Train**

Air and train transport are benefits of the Colorado Medical Assistance Program only when a client’s, physician-certified, medical or physical condition precludes the use of client-purchased public or private transportation, or when other less costly, medically appropriate means of Colorado Medical Assistance Program transportation are not available. Air and train transport are permissible for out-of-state travel.



In extreme circumstances air transport may be available for in state travel when it is the most cost effective, medically appropriate means of transportation for the client’s condition. All air and train transportation must be prior authorized by the State-authorizing agency. The State designated entity obtains prior authorization from the State.

**Bus**

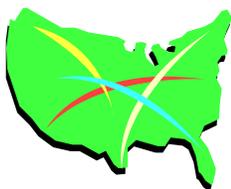
Bus transportation may be a benefit when the client’s condition does not allow the client to purchase public or private transportation and when other less costly, medically appropriate means of Colorado Medical Assistance Program transportation are not available.



**Out-of-State Transportation**

Benefits are provided when:

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



### Ancillary Services

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

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



### Prior Authorization Requests (PARs) for Transportation

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

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

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

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

### General Requirements

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



All complete PARs are reviewed by the authorizing agency. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR. The results of the PAR review are posted online and included in PAR letters sent to both the State designated entity and the client. Read the results carefully as some line items may be approved and others denied. Requests for prior authorization must be submitted and approved before services are rendered.

**The services rendered must match the approved transportation services exactly.**

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

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

To request an exception, more information on electronic submission, or any other questions regarding PARs submitted to the ColoradoPAR Program, please contact the ColoradoPAR Program at 1-888-454-7686 or refer to the Department’s [ColoradoPAR Program](#) web page.

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

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

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

### Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for fiscal agent use only.		
<b>Invoice/Pat Account Number</b>	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) which help identify the claim or client.
<b>1. Client Name</b>	Text	Required Enter the client's last name, first name and middle initial. Example: Adams, Mary A.
<b>2. Client Identification Number</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>3. Sex</b>	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Enter an "X" in the appropriate box.
<b>4. Date of Birth</b>	6 digits (MMDDYY)	Required Enter the client's birth date using MMDDYY format. Example: January 1, 1978 = 010178.

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

Field Label	Completion Format	Instructions
13. Indicate Length of Necessity	None	Not Required Not applicable to transportation PAR
14. Estimated Cost of Equipment	None	Not Required Not applicable to transportation PAR
15. Services To Be Authorized Preprinted	None	Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service to be provided. Example: Over-The-Cap Wheelchair van Example: Over-The-Cap Mobility van
17. Procedure, Supply or Drug Code	Digits	Required Enter the HCPCS code for each service that will be billed on the claim form. The authorizing agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Number of Services	Digits	Required Enter the number of units for services requested. The authorizing agency will complete this field if it is left blank. (Over-The-Cap: 1 unit = 1 way trip)
19. Authorized No. of Services	None	Leave Blank The authorizing agency indicates the number of services authorized. This number may or may not equal number requested in Field 18 (Number Of Services).
20. A=Approved D=Denied	None	Leave Blank Providers should check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	Text	Not Required
Telephone Number	Text	Not Required
22. Primary Care Physician Address	Text	Not Required
23. PCP Provider Number	8 Digits	Not Required

Field Label	Completion Format	Instructions
<b>24. Name and Address of Provider Requesting Prior Authorization</b>	Text	Required Enter the complete name and address of the State designated entity requesting prior authorization.
<b>25. Name and Address of Provider Who will Render Service</b>  <b>Telephone Number</b>	Text	Required Enter the name and address of the State designated entity that will receive reimbursement from the State and properly disperse funds to the appropriate transportation provider. Enter the telephone number of rendering State designated entity.
<b>26. Signature</b>  <b>Telephone Number</b>	Text	Required The State designated entity representative must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR. Enter the telephone number of the requesting State designated entity.
<b>27. Date Signed</b>	6 Digits	Required Enter the date the PAR form is signed by the requesting State designated entity.
<b>28. Provider Number</b>	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
<b>29. Service Provider Number</b>	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the State designated entity. The rendering provider must be enrolled in the Colorado Medical Assistance Program.
<b>30. Comments or Reasons For Denial of Benefits</b>	None	Leave Blank Providers should check the PAR on-line or refer to the PAR letter.
<b>31. PA Number Being Revised</b>	Text	Conditional Complete if revising the original PAR. Enter the prior authorization number of the <b>original PAR</b> that is being revised.

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

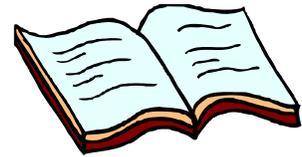
If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix C.

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

## Procedure Coding

### Transportation HCPCS codes

The Colorado Medical Assistance Program uses the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program clients and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.



HCPCS are used to identify and reimburse transportation services.

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

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

The XU-Split unit modifier is no longer valid.

### Transportation Codes and PAR Requirements

Code	Description	PAR Requirements
A0021	Ambulance service, outside state per mile, transport- Emergency	No PAR
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	No PAR
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	No PAR
A0100	Nonemergency transportation; taxi	No PAR
A0110	Nonemergency transportation and bus, intra- or interstate carrier	No PAR
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	No PAR
A0130	Nonemergency transportation: wheelchair van	No PAR
A0140	Nonemergency transportation and air travel (private or commercial), intra- or interstate	ColoradoPAR Always
A0180	Nonemergency transportation: ancillary: lodging - recipient	ColoradoPAR Sometimes
A0190	Nonemergency transportation: ancillary: meals - recipient	ColoradoPAR Sometimes

Code	Description	PAR Requirements
A0200	Nonemergency transportation: ancillary: lodging - escort	ColoradoPAR Sometimes
A0210	Nonemergency transportation: ancillary: meals - escort	ColoradoPAR Sometimes
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way	No PAR
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	No PAR
A0425	Ground mileage, per statute mile	No PAR
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	No PAR
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)	No PAR
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	No PAR
A0429	Ambulance service, basic life support, emergency transport (BLS - emergency)	No PAR
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	ColoradoPAR Always
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	ColoradoPAR Always
A0433	Advanced life support, level 2 (ALS 2)	No PAR
A0434	Specialty care transport (SCT)	No PAR
A0999	Unlisted ambulance service	No PAR
S0209	Wheelchair van, mileage, per mile	No PAR
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	ColoradoPAR Always
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	ColoradoPAR Always
T2001	Nonemergency transportation; patient attendant/escort	No PAR
T2003	Nonemergency transportation; encounter/trip	No PAR
T2005	Nonemergency transportation; stretcher van	No PAR
T2049	Nonemergency transportation; stretcher van, mileage; per mile	No PAR

## Transportation Billing Instructions

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

### Diagnosis Codes

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

### Dates of Services

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

### Span Billing

Span billing is not allowed for transportation services.

### Place of Service Codes

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

### Procedure Codes

Each detail line must include a valid procedure code.

### Units of Service

Units represent the number of services provided.

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

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

### Meals and Lodging

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

### Required Attachments

Claims that require attachments must be billed on paper.

### Air and Train Transportation

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

### Timely Filing

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



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

## Paper Claim Reference Table

The following paper claim form reference table shows required, optional, and conditional fields and detailed field completion instructions for transportation claims on the Colorado 1500 claim form

Field Label	Completion Format	Instructions
<b>Invoice/Pat Acct Number</b>	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
<b>Special Program Code</b>	N/A	N/A
<b>1. Client Name</b>	Up to 25 characters: letters & spaces	Required Enter the client's last name, first name, and middle initial.
<b>2. Client Date Of Birth</b>	Date of Birth 8 digits (MMDDCCYY)	Required Enter the patient's birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. Use the birth date given on the eligibility verification response. Example: 07012003 for July 1, 2003.
<b>3. Medicaid ID Number (Client ID Number)</b>	7 characters: a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number exactly as it appears on the eligibility verification response. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
<b>4. Client Address</b>	Not required	Submitted information is not entered into the claim processing system.
<b>5. Client Sex</b>	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
<b>6. Medicare ID Number</b>	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number.  The term "Medicare-Medicaid enrollee" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.

Field Label	Completion Format	Instructions
<b>7. Client Relationship to Insured</b>	Check box Self    Spouse <input type="checkbox"/> <input type="checkbox"/> Child   Other <input type="checkbox"/> <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an "x" in the box that identifies the person's relationship to the policyholder.
<b>8. Client is Covered By Employer Health Plan</b>	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder's name and group number. Also complete fields 9 and 9A.
<b>9. Other Health Insurance Coverage</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
<b>9A. Policyholder Name and Address</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
<b>10. Was Condition Related to</b>	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an "x" in the appropriate box. Enter the date of the accident in the marked boxes.
<b>11. CHAMPUS Sponsors Service/SSN</b>	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.

Field Label	Completion Format	Instructions
<p><b>12. Pregnancy</b></p> <p><b>HMO</b></p> <p><b>NF</b></p>	<p>Check box <input type="checkbox"/></p>	<p>Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum).</p> <p>Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO.</p> <p>Conditional Complete if the client is a nursing facility resident.</p>
<p><b>13. Date of illness or injury or pregnancy</b></p>	<p>6 digits: MMDDYY</p>	<p>Optional Complete if information is known. Enter the following information as appropriate to the client's condition:</p> <p>Illness      Date of first symptoms</p> <p>Injury        Date of accident</p> <p>Pregnancy    Date of Last Menstrual Period (LMP)</p>
<p><b>14. Medicare Denial</b></p>	<p>Check box</p> <p><input type="checkbox"/> Benefits Exhausted</p> <p><input type="checkbox"/> Non-covered services</p>	<p>Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.</p> <p>Enter a check mark or an "x" in the Benefits Exhausted box if a Medicare payment voucher shows that Medicare has denied payment because a limited benefit is exhausted. A copy of the Medicare denial notice must be provided upon request.</p> <p>Enter a check mark or an "x" in the Non-covered Services box if a Medicare publication or denial notice shows the billed service(s) is/are not a Medicare covered benefit. A copy of the Medicare denial or Medicare publication showing that the service is not covered must be provided upon request.</p> <p>Bill claims for Medicare denied services and Medicare crossover claims separately.</p>

Field Label	Completion Format	Instructions
<p><b>14A. Other Coverage Denied</b></p>	<p>Check box                      No <input type="checkbox"/>                      Yes <input type="checkbox"/>                      Pay/Deny Date                      6 digits: MMDDYY</p>	<p>Conditional                      Complete if the client has commercial health care insurance coverage.                      Enter a check mark or an "x" in the "No" box if the other coverage has paid a portion of the billed charges.                      If the other coverage payment amount is the same or more than the Colorado Medical Assistance Program benefit, the Colorado Medical Assistance Program will not make additional payment.                      Enter a check mark or an "x" in the "Yes" box if the other coverage carrier has denied payment or has applied all of the allowed benefit to a deductible.                      Enter the date of the other coverage payment or denial.</p>
<p><b>15. Name of Supervising Physician Provider Number</b></p>	<p>Text                      8 digits</p>	<p>Conditional                      Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician (see Provider Participation).                      Enter the eight digit Colorado Medical Assistance Program provider number assigned to the on-premises supervising physician.</p>
<p><b>16. For services related to hospitalization, give hospitalization dates</b></p>	<p>6 digits: MMDDYY</p>	<p>Admitted <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YY"/> Discharged <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YY"/></p> <p>Conditional                      Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge, if known. If the client is still hospitalized, the discharge date may be omitted. This information is not edited</p>
<p><b>17. Name and address of facility where services rendered Provider Number</b></p>	<p>Text (address is optional)                      8 digits</p>	<p>Conditional                      Complete for services provided in a hospital or nursing facility. Enter the name of the hospital or nursing facility. This information is not edited.                      Complete for services provided in a hospital or nursing facility. Enter the Colorado Medical Assistance Program provider number of hospital or nursing facility, if known. This information is not edited.</p>

Field Label	Completion Format	Instructions
<b>17A. Check box if laboratory work performed outside physician office</b>	Check box <input type="checkbox"/>	Conditional Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. Practitioners may not request payment for services performed by an independent or hospital laboratory.
<b>18. ICD-9-CM</b>  <b>Diagnosis or nature of illness or injury</b>	1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Codes: 3, 4, or 5 characters. 1 <sup>st</sup> character may be a letter. Text	Required Enter diagnosis code 780.  Written description is not required. If entered, the written description must match the code(s).
<b>Transportation Certification attached</b>	Check box <input type="checkbox"/>	Conditional Complete for emergency transportation and wheelchair van services. Enter a check mark or an "x" to certify that you have a transportation certificate or trip sheet on file for this service.
<b>Durable Medical Equipment</b> <b>Line #</b> <b>Make</b> <b>Model</b> <b>Serial Number</b>	N/A	N/A
<b>Prior Authorization #:</b>	6 characters: Letter plus 5 digits	Conditional Complete if services require prior authorization. Enter the 6-character prior authorization number from the approved Prior Authorization Request (PAR) letter. Do not use the preprinted PAR number (if any) that appears on the PAR form. Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR letter unless advised to do so by the authorizing agency or the fiscal agent. Do not bill prior authorized and non-prior authorized services on the same claim form.

Field Label	Completion Format	Instructions																		
<p><b>19A.-19L Detail Billing Lines – Labels</b></p>	<p>At least one detail billing line must be completed fully</p>	<p>Required Enter the date using MMDDYY format. Compete the “From” field for single-day services. Do not complete the “To” field. When billing for the same procedure provided on consecutive days, complete both the “From” and “To” fields using MMDDYY format (Span Billing).</p>																		
<p><b>19A. Date of Service</b></p>	<p>From: 6 digits MMDDYY To: 6 digits MMDDYY</p>	<p>Required The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service. Single date of service From To  <table border="1" data-bbox="889 806 1300 856"> <tr> <td>01</td> <td>01</td> <td>2014</td> <td></td> <td></td> <td></td> </tr> </table>                     Or From To  <table border="1" data-bbox="889 932 1300 982"> <tr> <td>01</td> <td>01</td> <td>2014</td> <td>01</td> <td>01</td> <td>2014</td> </tr> </table>                     Span dates of service  <table border="1" data-bbox="889 1024 1300 1075"> <tr> <td>01</td> <td>01</td> <td>2014</td> <td>01</td> <td>31</td> <td>2014</td> </tr> </table>                     Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields. Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates. <b>County transportation and Community based services</b> Providers should refer to specific billing instructions on the use of span billing.</p>	01	01	2014				01	01	2014	01	01	2014	01	01	2014	01	31	2014
01	01	2014																		
01	01	2014	01	01	2014															
01	01	2014	01	31	2014															
<p><b>19B. Place of Service</b></p>	<p>2 digits</p>	<p>Required Enter a place of service code 41 for land transportation and 42 for air transportation.</p>																		
<p><b>19C. Procedure Code (HCPCS)</b></p>	<p>5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits</p>	<p>Required Refer to the transportation codes listed in the Transportation Codes and PAR Requirements table in this manual.</p>																		
<p><b>Modifier</b></p>	<p>N/A</p>	<p>N/A</p>																		

Field Label	Completion Format	Instructions
19D. Rendering Provider Number	N/A	N/A
19E. Referring Provider Number	N/A	N/A
19F. Diagnosis	3 digits	Required Enter diagnosis code 780.
19G. Charges	Up to 7 digits: Currency 99999.99	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>
19H. Days or Units	Up to 4 digits	<p>Required</p> <p>Enter the number of units or the number of services for each procedure billed. Days or units must be whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers.</p> <p>Example: Do not enter 1.0 to signify one unit. A HCPCS code must appear only once per date of service. The same HCPCS codes may be billed for one date of service. If more than one of the same service is provided on the same day, increase the units and charges accordingly.</p> <p>Example: When the HCPCS code narrative indicates one way, the units should be increased to two for a round trip.</p> <p>When the HCPCS code narrative indicates a round trip, bill one unit.</p> <p><b>Bus, Train or Air and Special Transportation Services</b></p> <p>Units represent the number of one-way trips taken. Do not bill for mileage.</p>

Field Label	Completion Format	Instructions
<b>19H. Days or Units</b> (continued)	Up to 4 digits	<b>Meals and Lodging</b> Report units as the number of days of lodging and days of meals provided. Do not complete units to represent the number of meals provided. When the HCPCS code narrative indicates a round trip, bill one unit.
<b>19I. Co-pay</b>	1 digit	Conditional Complete if co-payment is required of this client for this service. 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
<b>19J. Emergency</b>	Check mark	Conditional If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
<b>19K. Family Planning</b>	N/A	N/A
<b>19L. EPSDT</b>	N/A	N/A
<b>Medicare SPR Date (unlabeled field)</b>	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> <li>▪ Do not complete this field if Medicare denied all benefits.</li> <li>▪ Do not combine items from several SPRs/ERAs on a single claim form.</li> <li>▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA.</li> </ul> Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.
<b>20. Total Charges</b>	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in field 19G (Charges). Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 or 2, etc.).

Field Label	Completion Format	Instructions
21. Medicare Paid	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.
22. Third Party Paid	7 digits: Currency 99999.99	Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher. Do <b>not</b> enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.
23. Net Charge	7 digits: Currency 99999.99	Required Colorado Medical Assistance Program claims (Not Medicare Crossover) Claims without third party payment. Net charge equals the total charge (field 20). Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount. Medicare Crossover claims Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount. Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.
24. Medicare Deductible	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.
25. Medicare Coinsurance	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.

Field Label	Completion Format	Instructions
<p><b>26. Medicare Disallowed</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>
<p><b>27. Signature (Subject to Certification on Reverse) and Date</b></p>	<p>Text</p>	<p>Required Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent <b>Unacceptable signature alternatives:</b> Claim preparation personnel may not sign the enrolled provider’s name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. “Signature on file” notation is not acceptable in place of an authorized signature.</p>
<p><b>28. Billing Provider Name</b></p>	<p>Text</p>	<p>Required Enter the name of the individual or organization that will receive payment for the billed services.</p>
<p><b>29. Billing Provider Number</b></p>	<p>8 digits</p>	<p>Required Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
<p><b>30. Remarks</b></p>	<p>Text</p>	<p>Conditional Use to document the Late Bill Override Date for timely filing.</p>

## Colorado 1500 Transportation Claim Example

STATE OF COLORADO  
 DEPARTMENT OF  
 HEALTH CARE POLICY AND  
 FINANCING

INVOICE/PAY ACCT NUMBER  
 \_\_\_\_\_  
 SPECIAL PROGRAM CODE  
 \_\_\_\_\_

### HEALTH INSURANCE CLAIM

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PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client, Ima A</b>	2. CLIENT DATE OF BIRTH <b>10/16/1975</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>D333333</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 checked="" 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 EMPLOYER NAME: _____
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 checked="" type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto;"></div>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN _____
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	13. DATE OF: _____	

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PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: _____	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 <b>780</b>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	18A. OTHER COVERAGE DENIED <input type="checkbox"/> YES
1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

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19A. DATE OF SERVICE FROM	19B. DATE OF SERVICE TO	19C. PLACE OF SERVICE	19D. PROCEDURE CODE (HCPCS)	19E. MODIFIERS	19F. RENDERING PROVIDER NUMBER	19G. REFERRING PROVIDER NUMBER	19H. DIAGNOSIS F S T	19I. CHARGES	19J. DAYS OR UNITS	19K. COPAY	19L. EMERG ENCY	19M. FAMILY PLANNING	19N. EPSDT
01/10/2014	01/10/2014	41	A0429				1	\$150.00	1		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>01/20/2014</b>	20. TOTAL CHARGES → <b>\$150.00</b>
28. BILLING PROVIDER NAME <b>ABC Ambulance Company</b>	20. REMARKS
29. BILLING PROVIDER NUMBER <b>12345678</b>	

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21. MEDICARE PAID <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto;"></div>	24. MEDICARE DEDUCTIBLE <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto; text-align: center;">\$0.00</div>
22. THIRD PARTY PAID <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto; text-align: center;">\$0.00</div>	25. MEDICARE COINSURANCE <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto; text-align: center;">\$0.00</div>
23. NET CHARGE <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto; text-align: center;">\$150.00</div>	26. MEDICARE DISALLOWED <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto;"></div>

COLORADO 1500

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

# Transportation Third Party Claim - No Mileage Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAY ACCT NUMBER
SPECIAL PROGRAM CODE

## HEALTH INSURANCE CLAIM

### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client, Ima A</b>	2. CLIENT DATE OF BIRTH <b>09/23/1999</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>D333333</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)
7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____	
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S) <b>A-OK Insurance 123 Healthcare Lane, Anytown, CO 80000 Policy #010101010</b>	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 80px; height: 20px; margin: 0 auto;"></div>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP) <input checked="" type="checkbox"/>	
14. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE) <b>Ian Client 111 Highway 2 Denver, CO 80000-000</b>	15. NAME OF SUPERVISING PHYSICIAN PROVIDER NUMBER _____	
16. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE) PROVIDER NUMBER _____	17. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES	

### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP) <input checked="" type="checkbox"/>	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 checked="" type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: <b>12/15/2013</b>
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 1. <b>780</b>	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
19A. DATE OF SERVICE FROM TO	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
20. TOTAL CHARGES → <b>\$20.00</b>	PRIOR AUTHORIZATION # _____

19A	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	D. MODIFIERS	E. RENDERING PROVIDER NUMBER	F. REFERRING PROVIDER NUMBER	F. DIAGNOSIS			G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
						P	S	T						
01/24/2014	01/24/2014	41	A0429		87654321	1			\$20.00	1		<input checked="" 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"/>
												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>01/20/2014</b>	28. BILLING PROVIDER NAME <b>ABC Ambulance Company</b>	29. BILLING PROVIDER NUMBER <b>12345678</b>	30. REMARKS	20. TOTAL CHARGES → <b>\$20.00</b>	LESS ↓	21. MEDICARE PAID <div style="border: 1px solid black; width: 80px; height: 20px;"></div>	22. THIRD PARTY PAID <div style="border: 1px solid black; width: 80px; height: 20px; text-align: center;">\$0.00</div>	23. NET CHARGE <div style="border: 1px solid black; width: 80px; height: 20px; text-align: center;">\$20.00</div>	24. MEDICARE DEDUCTIBLE <div style="border: 1px solid black; width: 80px; height: 20px; text-align: center;">\$0.00</div>	25. MEDICARE COINSURANCE <div style="border: 1px solid black; width: 80px; height: 20px; text-align: center;">\$0.00</div>	26. MEDICARE DISALLOWED <div style="border: 1px solid black; width: 80px; height: 20px;"></div>
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## Transportation Crossover Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAY ACCT NUMBER

---

SPECIAL PROGRAM CODE

### HEALTH INSURANCE CLAIM

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PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client, Ima A</b>	2. CLIENT DATE OF BIRTH <b>08/23/1940</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>D333333</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)  TELEPHONE NUMBER	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)  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 EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)  TELEPHONE NUMBER	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto;"></div>	11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

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PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <span style="font-size: 2em;">←</span>	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/IDNY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN		15. 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)		17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES	

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18. ICD-9-CM 1. <b>780</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 #: _____
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19A. DATE OF SERVICE FROM	19B. DATE OF SERVICE TO	19C. PLACE OF SERVICE	19D. PROCEDURE CODE (HCPCS)	19E. MODIFIERS	19F. RENDERING PROVIDER NUMBER	19G. REFERRING PROVIDER NUMBER	19H. DIAGNOSIS F I S T	19I. CHARGES	19J. DAYS OR UNITS	19K. COPAY	19L. EMERG ENCY	19M. FAMILY PLANNING	19N. EPSDT
01/10/2014	01/10/2014	41	A0429		87654321		1	\$20.00	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"/>
											<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"/>

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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>\$20.00</b>	LESS ↓ 21. MEDICARE PAID <div style="border: 1px solid black; width: 80px; height: 20px; margin: 2px 0;"></div> 22. THIRD PARTY PAID <div style="border: 1px solid black; width: 80px; height: 20px; margin: 2px 0; text-align: center;">\$0.00</div> 23. NET CHARGE <div style="border: 1px solid black; width: 80px; height: 20px; margin: 2px 0; text-align: center;">\$10.00</div>
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>01/20/2014</b>	30. REMARKS	
28. BILLING PROVIDER NAME <b>ABC Ambulance Company</b>	24. MEDICARE DEDUCTIBLE <div style="border: 1px solid black; width: 80px; height: 20px; margin: 2px 0; text-align: center;">\$6.00</div> 25. MEDICARE COINSURANCE <div style="border: 1px solid black; width: 80px; height: 20px; margin: 2px 0; text-align: center;">\$4.00</div> 26. MEDICARE DISALLOWED <div style="border: 1px solid black; width: 80px; height: 20px; margin: 2px 0;"></div>	
29. BILLING PROVIDER NUMBER <b>12345678</b>	MEDICARE SPR DATE	

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

COLORADO 1500

## UB-04 Paper Claim Instructional Reference Table

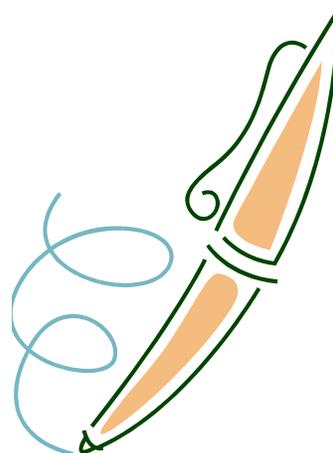
The paper claim reference table below lists required and conditional fields for the paper UB-04 claim form for Hospital based transportation claims. For complete UB-04 paper claim instructions, see the Paper Claim Instructional Reference in the [IP/OP Hospital](#) Billing manual.

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

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

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

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



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

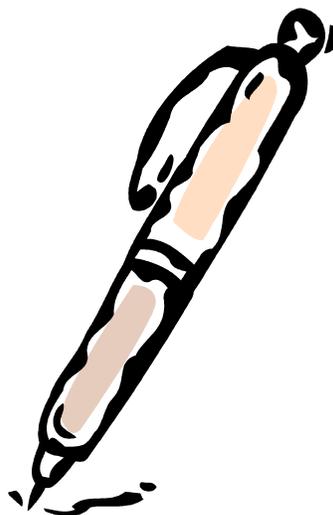
Form Locator and Label	Completion Format	Instructions
<b>18-28.Condition Codes</b> (continued)	2 Digits	<p><u>PRO Approval Codes</u></p> <p>C1 Approved as billed</p> <p>C2 Automatic approval as billed - Based on focused review</p> <p>C3 Partial approval</p> <p>C4 Admission/Services denied</p> <p>C5 Post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

Form Locator and Label	Completion Format	Instructions
<b>31-34. Occurrence Code/Date</b> (continued)	2 digits and 6 digits	<p><u>Occurrence Codes:</u></p> <p>A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50</p> <p>B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50</p> <p>C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50</p> <p><i>*Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information</i></p>
<b>35-36. Occurrence Span Code From/Through</b>	N/A	N/A
<b>38. Responsible Party Name/Address</b>	None	Submitted information is not entered into the claim processing system.
<b>39-41. Value Code-Code Value Code-Amount</b>	N/A	N/A
<b>42. Revenue Code</b>	4 digits	Required Complete for hospital based transportation. Use revenue code range 540-549.
<b>43. Revenue Code Description</b>	Text	Required Enter the revenue code description or abbreviated description.
<b>44. HCPCS/Rates/Hi PPS Rate Codes</b>	5 digits	Conditional. Use only State assigned transportation codes. Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Do not use revenue codes. HCPCS codes must be identified for the following revenue codes: <ul style="list-style-type: none"> <li>▪ 054X Ambulance</li> </ul>
<b>45. Service Date</b>	6 digits	Required. Not required for single date of service claims.

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

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

Form Locator and Label	Completion Format	Instructions
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number	N/A	Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).



Form Locator and Label	Completion Format	Instructions
<p><b>66. Diagnosis Version Qualifier</b></p>	<p>Up to 6 digits</p>	<p>Required</p> <p>Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeroes to the diagnosis code.</p> <p>The Present on Admission (POA) indicator is required for inpatient claims. Document the POA in the gray area to the right side of the principal diagnosis code.</p> <p>Allowed responses are limited to:</p> <ul style="list-style-type: none"> <li>✓ Y = Yes – present at the time of inpatient admission</li> <li>✓ N = No – not present at the time of inpatient admission</li> <li>✓ U = Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission</li> <li>✓ W = Clinically Undetermined – the provider is unable to clinically determined whether the condition was present at the time of inpatient admission or not</li> <li>✓ “1” on UB-04 (“Blank” on the 837I) = Unreported/Not used – diagnosis is exempt from POA reporting</li> </ul> <p>Outpatient Hospital Laboratory May use diagnosis code V71(may require 4<sup>th</sup> or 5<sup>th</sup> digit)</p> <p>Hospital Based Transportation May use diagnosis code 780 (may require 4<sup>th</sup> or 5<sup>th</sup> digit)</p>
<p><b>67. Principal Diagnosis Code</b></p>	<p>Up to 6 digits</p>	<p>Required. Hospital based transportation claims enter diagnosis code. Provider may use code 780.</p>
<p><b>67A- Other 67Q. Diagnosis</b></p>	<p>N/A</p>	<p>N/A</p>
<p><b>69. Admitting Diagnosis Code</b></p>	<p>N/A</p>	<p>N/A</p>
<p><b>70. Patient Reason Diagnosis</b></p>	<p>N/A</p>	<p>N/A</p>
<p><b>71. PPS Code</b></p>	<p>N/A</p>	<p>Submitted information is not entered into the claim processing system.</p>
<p><b>72. External Cause of Injury Code (E-code)</b></p>	<p>Up to 6 digits</p>	<p>Optional</p> <p>Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".</p>

Form Locator and Label	Completion Format	Instructions
<p><b>74. Principal Procedure Code/ Date</b></p>	<p>Up to 7 characters or Up to 6 digits</p>	<p>Conditional</p> <p>Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format.</p> <p>Apply the following criteria to determine the principle procedure:</p> <p>The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and</p> <p>The principal procedure is most related to the primary diagnosis.</p>
<p><b>75. Unlabeled Field</b></p>	<p>N/A</p>	<p>N/A</p>
<p><b>76. Attending NPI – Conditional QUAL - Conditional</b></p> <p>ID - (Colorado Medical Assistance Provider #) – Required</p> <p>Attending - Last/ First Name</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Required.</p> <p>NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and <u>cannot</u> be a clinic or group number.</p> <p>(If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the client leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)</p> <p>Hospitals may enter the client's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program.</p> <p>QUAL – Enter "1D " for Medicaid</p> <p>Enter the attending physician's last and first name.</p> <p>This form locator must be completed for all services.</p>
<p><b>77. Operating-NPI/QUAL/ID</b></p>	<p>N/A</p>	<p>Submitted information is not entered into the claim processing system.</p>

Form Locator and Label	Completion Format	Instructions
<p><b>78-79. Other ID</b></p> <p><b>NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional</b></p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Conditional (see below) Complete when attending physician is not the PCP or to identify additional physicians.</p> <p>NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the Colorado Medical Assistance Program client's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted.</p> <p>The attending physician's last and first name are optional.</p>
<p><b>80. Remarks</b></p>	<p>Text</p>	<p>Enter specific additional information necessary to process the claim or fulfill reporting requirements.</p>
<p><b>81. Code-Code QUAL/CODE/VALUE (a-d)</b></p>	<p>N/A</p>	<p>Submitted information is not entered into the claim processing system</p>





## Late Bill Override Date

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

### Valid Delay Reason Codes

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



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

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

Billing Instruction Detail	Instructions
<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.</p> <p>Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H in the Appendices in the Provider Services <a href="#">Billing Manuals</a> section of the Department’s Web site) 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. 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.</p> <p><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.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p><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.</p> <p><b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.</p> <p><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.</p> <p><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.</p> <p><b>LBOD</b> = the last date of OB care by the billing provider.</p>





### **Institutional Provider Certification**

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

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

### ***Transportation Billing Manual Revisions Log***

<b>Revision Date</b>	<b>Section/Action</b>	<b>Pages</b>	<b>Made by</b>
<i>01/17/2014</i>	<i>Created</i>	<i>All</i>	<i>jg</i>
<i>01/21/2014</i>	<i>Added 2 new HCPCS: S9960 and S9961</i>	<i>13</i>	<i>cc</i>
<i>01/22/2014</i>	<i>Reformatted</i> <i>Updated claim examples</i>  <i>Added PAR Requirements for S9960 and S9961</i> <i>Updated TOC</i>	<i>Throughout</i> <i>25, 26, 27 &amp;</i> <i>40</i>  <i>13</i>  <i>i &amp; ii</i>	<i>jg</i>

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