Name _____

Date _____ Score _____

ASSIGNMENT SHEET

CHAPTER 9: HEALTH CARE COVERAGE

Unit 1: Fundamentals of Managed Care

WORDS TO KNOW CHALLENGE

A. Word Search: Provide the term for each definition below. Then find the terms and the words in italics that are hidden in the puzzle. (Abbreviations may be used.)

1. Standard claims *form* of the Centers for Medicare and Medicaid Services to submit for third-*party* payment. _____
2. Federal government insurance program for persons over age 62 and certain disabled persons. _____
3. Private *insurance* to supplement Medicare benefits for non-covered services. _____
4. A *group* of physicians who continue to practice independently in their own offices. _____
5. Coding system used to *document* diseases, injuries, illnesses, and modalities. _____
6. Another name for *encounter* form. _____
7. Transferring words into numbers to facilitate use of *computers* in claims processing. _____
8. Moneys paid for an insurance *contract.* _____
9. *Fee* schedule based on relative *value* of resources that physicians spend to provide services to Medicare patients. _____
10. The person who has been insured; insurance *policy* holder. _____
11. Prior authorization must be obtained before the patient is admitted to the hospital or receives some specified outpatient or in-office *procedures.* _____

V A L U E R M I N S U R A N C E
E R A C I D E M N C Z A U C O D
R A M I F I D A C O A T I E N T
B O C A R E I D Q D H E A L T H
R W O R A H C M S 1 5 0 0 L R D
V S M M C H A J P N S W X L A T
S U P E R B I L L G Y B P F C J
P B U D I C D 9 C M F O R M T Q
O S T I F E N C O U N T E R E U
L C E F E E G P R T F A M I P A
I R R I P A R T Y S X D I K U L
C I S L N C O G J X K O U Z M I
Y B M L B T U X D O C U M E N T
M E D I G A P R O C E D U R E Y
P R E C E R T I F I C A T I O N

B. Word Scramble: Unscramble the following terms.

1. _____ N I P L E M E T M
2. _____ D H B R I T Y A E U L R
3. _____ D R Y O S C E N A
4. _____ N S C T I O S E A
5. _____ T D E I R C M N A Y P T E
6. _____ S E N O P C M S A
7. _____ N N O C O R D A I T I O F O S F E E T I B N
8. _____ M M U E P I R
9. _____ M B R I T S E N M U E R E

UNIT REVIEW

A. Short Answer

1. What type of medical insurance has created competition in the insurance industry? _____
2. Why are HMOs so popular? _____
3. How did the phrase "managed care" originate? _____
4. What is generally the cost of health care to employees whose employer offers an HMO as part of their benefit package? _____
5. Describe managed care today. _____
6. What is the initial purpose of the HMO? _____
7. What are the two major types of health insurance? _____
8. In regard to health insurance coverage, how can the medical assistant be helpful to patients? _____
9. Where can patients find the names of physicians who participate in their HMO? _____
10. Describe a helpful practice that should be performed at the beginning of each office visit regarding the patient's insurance card. _____

Name _____

11. List the four conditions of the birthday rule in regard to insurance coverage. _____

_____

_____

_____

_____

12. What is critical to ensure successful reimbursement for medical services rendered to patients? _____

_____

_____

13. List the subject areas of which the medical assistant must be knowledgeable to process medical claims forms, and explain why they are important. _____

_____

_____

_____

B. Matching: Match the term in column I with its description in column II.

	COLUMN I	COLUMN II
_____	1. Attending physician	a. Fixed amount paid to physician per month
_____	2. Signed authorization	b. Physician who admits the patient to the hospital
_____	3. Advance directives	c. Total charges that have not been paid
_____	4. Admitting physician	d. Patient authorizes payment directly to the physician
_____	5. Capitation	e. Physician who cares for patient in hospital
_____	6. Balance billing	f. Permission to release medical information
_____	7. Assignment of benefits	g. Also known as a living will
_____	8. Accounts receivable	h. Charges insurance did not pay
_____	9. Claim	i. Request for insurance company payment

C. Fill in the Blank

1. _____ was established to aid personnel and dependents of the armed services with medical expenses.
2. _____ was established for disabled veterans, their spouses, and their dependents to aid with medical expenses.
3. A predetermined amount that the insured must pay before the insurance company pays is called the _____.
4. A printed description of the benefits provided by the insurer to the beneficiary is known as the _____.
5. _____ is the term given to the primary care physician for coordinating the patient's care to specialists, hospital admissions, and so on.
6. A specific amount that the insured must pay toward the charge for professional services rendered is called _____.
7. The _____ is the one who writes his or her signature on the back of a check that is made out to him or her.
8. A list of approved professional services for which the insurance company will pay along with the maximum fee is called a(n) _____.
9. A(n) _____ is a printed form that has patient information and a listing of the services and code numbers with the total charges.
10. A program that provides complete health care for children and encourages early detection of health problems is known as _____.
11. _____ is a system of medical team members organized into groups to provide quality and cost-effective care that encompasses both the delivery of health care and the payment of services.

D. True or False: Place a "T" for true or "F" for false in the space provided. For false statements, explain why they are false.

_____ 1. An indemnity plan is a company that bills the physician for medical services.

_____

_____ 2. The Medicare fee schedule is a list of approved professional services that includes the maximum fee that Medicare will pay for each service.

_____

_____ 3. A preexisting condition is a condition that existed before the insured's policy was issued.

_____

_____ 4. A contract is an agreement between two or more parties for certain services or obligations to be discussed.

_____

_____ 5. For patients who are minors or who are incompetent, a guardian must sign for any release of information and for any services to be completed.

_____

_____ 6. Utilization management refers to a panel that keeps track of what services were ordered and checks if medical care was completed.

_____

_____ 7. The usual fee is the charge that physicians make for services for their private patients.

_____

_____ 8. A skilled nursing facility is a medical facility licensed primarily to provide skilled nursing care to patients ordered by Workers' Compensation.

_____

CASE STUDIES

Scenario 1

Ms. Tinsky calls the office to complain about her bill. She was under the impression that, because your office accepted her insurance and was an in-network provider, everything would be covered. She is concerned about a charge for a diagnostic test she had done at the local hospital that the insurance company is refusing to pay.

Critical Thinking Questions

1. How should you handle Ms. Tinsky? _____

_____

_____

2. What should you always tell a patient to do before having any test or procedure performed? _____

_____

_____

3. What repercussions may the practice suffer because of this situation? _____

_____

_____

Name _____

Scenario 2

John Appleby calls the insurance and billing department to complain about charges that are not being paid at the usual rate by his insurance company. He says he checked his explanation of benefits and it listed Dr. James as a participating provider. He doesn't understand the discrepancy in the amounts paid and those listed in his EOB.

Critical Thinking Questions

1. What could be a possible cause for the difference in rates paid? _____
2. What suggestions could you make to the patient to prevent this from happening in the future? _____
3. What explanation can you provide the patient with to answer his complaint? _____

UNIT APPLICATION

Research Activities

A. Search the Internet for three of the larger health insurance companies and review their provider directories. Compile statistics on how many in-network providers each has, how many different specialties they list, and which areas of the country they provide coverage for.

B. Check the laws in your state and research if it is permissible to reject patients for health care coverage due to "preexisting conditions." Report which companies reject patients and if there is any recourse for the rejected patient.

C. Create a table that compares and contrasts the differences among HMOs, PPOs, and POS plans.

CERTIFICATION AND REGISTRATION PREPARATION

_____ 1. If both parents have equal insurance coverage, what determines insurance coverage for the children?
   a. Birthday rule
   b. Secondary coverage
   c. Father's insurance
   d. Mother's insurance

_____ 2. Under HIPAA guidelines, what must the office have in order to give information to the insurance company?
   a. Signature on file
   b. Explanation of benefits
   c. Authorization to release medical information
   d. Permission from the patient

_____ 3. Which of the following would be a pre-paid group practice serving a specific geographic area?
   a. PPO
   b. HMO
   c. PAT
   d. POS

_____ 4. Which of the following is a list of approved professional services for which the insurance company will pay?
   a. Fee disclosure
   b. Fee schedule
   c. Fee slip
   d. EOB

_____ 5. An encounter form is another name for a(n):
   a. superbill
   b. acquaintance form
   c. personal data sheet
   d. explanation of charges

_____ 6. If a patient has Medicare and a Medicare HMO, which insurance is primary?
   a. Medicare
   b. neither Medicare nor the HMO
   c. HMO
   d. both Medicare and the HMO

Name _____

Date _____ Score _____

ASSIGNMENT SHEET

CHAPTER 9: HEALTH CARE COVERAGE

Unit 2: Health Care Plans

WORDS TO KNOW CHALLENGE

A. Matching: Match the term in column I with its description in column II.

	COLUMN I	COLUMN II
_____	1. Medigap	a. Approval given for meeting established standards
_____	2. Medicaid	b. Covering all areas; inclusive
_____	3. Medicare	c. An amount to be paid before insurance will pay
_____	4. Restricted	d. Compensation for damage done or loss caused
_____	5. Preauthorization	e. A federal health program for paying certain medical expenses of the aged
_____	6. Accreditation	f. Prior approval of insurance coverage and necessity of procedure
_____	7. Comprehensive	g. Limited; only for a certain group
_____	8. Utilization	h. A government health care program
_____	9. Deductible	i. Refers to situations not covered by Medicare insurance
_____	10. Indemnity	j. Put to profitable use

B. Word Scramble: Unscramble the following terms.

1. _____	T A C P N I O A T I
2. _____	N U I A N Y T
3. _____	T N O O T N C N S A I O
4. _____	C P I R D O E I
5. _____	M P U I S R M E
6. _____	T U P L M E E P N S
7. _____	U S T A T O Y T R
8. _____	O E E C H I R M P V E N S
9. _____	U E A R Z A T H P R I O N T I O
10. _____	S D R C E E T R T I

UNIT REVIEW

A. Short Answer

1. What is significant regarding premiums and benefits of private commercial insurance companies? _____
2. Why was Blue Cross health insurance originally created? _____
3. What coverage does Blue Cross now include besides hospital expenses? _____
4. Name the additional plans Blue Cross Blue Shield offers today. _____
5. What do indemnity plans require of the patient regarding payments? _____

6. What is the usual co-payment required of patients who have an HMO plan? _____

_____

7. List the available types of HMOs and briefly describe each of them.
   a. _____
   b. _____
   c. _____
   d. _____

   _____

8. What are the responsibilities of the NCQA? _____

   _____

9. In October 2001, what four changes were made to help inform Medicare recipients? _____

   _____

   _____

B. Fill in the Blank: For each plan below, identify if it is considered private or government by placing a "P" or "G" in the space provided.

_____ 1. Foundations for medical care
_____ 2. Medicare
_____ 3. Blue Shield
_____ 4. TRICARE
_____ 5. Workers' Compensation
_____ 6. Blue Cross
_____ 7. Easter Seal Rehabilitation Centers
_____ 8. Medicaid
_____ 9. Commercial health insurance
_____ 10. Health maintenance organizations

C. Fill in the Blank

1. To qualify as a(n) _____, an organization must present proof of its ability to provide comprehensive health care.
2. One of the four levels of NCQA accreditation is full accreditation given for _____ years indicating excellent performance.
3. The primary care physician is also referred to as the _____.
4. HMOs mail _____ to the provider's office to keep the office apprised of policy changes between representatives' visits.
5. Besides the four principal types of state benefits, Workers' Compensation also includes _____ for severely disabled employees.
6. Patients who have had an industrial injury should have a(n) _____ and a separate account card for that injury.
7. One common reason for delay in payment of claims is that they are _____.
8. Medicare B is the coverage that pays for _____.
9. Physicians who choose not to be participating providers must collect _____ for the services rendered.
10. If the physician provides a non-covered service for a Medicare patient, a(n) _____ must be signed by the patient.
11. There is a special _____ on the CMS-1500 form that allows the claims processor to assign a unique identification number to the claim during microfilming.

Name _____

12. In processing Medicare forms, use ICD9 codes for _____, CPT codes for _____, and HCPCS codes for _____.

D. True or False: Place a "T" for true or "F" for false in the space provided. For false statements, explain why they are false.

_____ 1. Medicare encourages all providers to file claims electronically.

_____

_____ 2. The NPI (National Provider Identifier) is used in blocks 24k and 33 of the CMS-1500 to identify the location of the service.

_____

_____ 3. Ideally, all insurance forms should be signed and dated by the patient.

_____

_____ 4. The only time a patient's signature is not necessary is when you have been given verbal permission from that patient to release information.

_____

_____ 5. Claims will be returned to the provider if the NPI number is missing from the CMS form.

_____

_____ 6. Medicare Part B patients usually are responsible for the first $100 of covered services.

_____

_____ 7. For Medicaid patients, a general rule is that prior authorization is necessary to provide medical treatment except in an emergency.

_____

_____ 8. Workers' Compensation requires that a patient have reevaluations at intervals with his or her physician, who must promptly give a supplemental report regarding the patient's condition.

_____

CASE STUDIES

Scenario 1

Mrs. Grace, an 80-year-old Medicare patient, called the office asking for help in understanding why her bill is so high. She was under the impression that Medicare would cover 80 percent of her office fee and she would be responsible for 20 percent. However, her portion of the $175.00 charge is $159.00 and she can't understand why.

Critical Thinking Questions

1. Why may Mrs. Grace's portion of the bill be so high? _____

_____

2. What can you explain to her to help her understand the charges? _____

_____

3. What should you tell Mrs. Grace about her Medicare insurance? _____

_____

Scenario 2

Cynthia Allen calls the office and demands to know why her bill has not been paid. She and her 10-month-old daughter are covered under Medicaid and WIC. She thought that she could seek care from any doctor and it would be covered, along with any needed medications, immunizations, or other diagnostic testing.

Critical Thinking Questions

1. How would you explain the patient's Medicaid coverage to her? _____
2. Who should she speak with for answers to any questions about her coverage? _____
3. Are all physicians required to accept Medicaid patients? _____

UNIT APPLICATION

Research Activities

1. Go online and research your state's Medicaid coverage to determine what the income requirements are, who is eligible for coverage, and the reimbursement guidelines.
2. Conduct research and write a report comparing and contrasting the difference between TRICARE and CHAMPVA coverage.
3. Research the differences among HMOs, PPOs, and IPAs and list the advantages and disadvantages of each. Decide which one provides the best coverage and explain why.

CERTIFICATION AND REGISTRATION PREPARATION

_____ 1. Which of the following terms is used to describe the maximum amount of money an insurance carrier will pay for a medical service?
   a. Predetermination
   b. Preauthorization
   c. Precertification
   d. Prepayment

_____ 2. In which type of HMO are the physicians reimbursed on a capitated basis?
   a. Point-of-service
   b. Open-ended
   c. Staff model
   d. Group model

_____ 3. Which type of organization provides pre-paid health care to groups or individuals who purchase coverage?
   a. HMO
   b. PPO
   c. IPA
   d. HMP

_____ 4. Patients who must obtain a referral from their primary care physician to be seen by a specialist are part of what type of health care system?
   a. Managed care
   b. Referred care
   c. HMO/IPA
   d. Indemnity

_____ 5. A tax sheltered account, similar to an IRA, that can be used to pay for medical expenses is a(n):
   a. HSA
   b. CDHP
   c. HRA
   d. FSA

_____ 6. Medicare is only permitted to pay for services or supplies that are considered:
   a. medically sound
   b. medically necessary
   c. needed by the patient
   d. permitted by the state

_____ 7. The Centers for Medicare and Medicaid Services, or CMS, is the new name for:
   a. HHS
   b. CLIA
   c. OSHA
   d. HCFA

Name _____

Date _____ Score _____

ASSIGNMENT SHEET

CHAPTER 9: HEALTH CARE COVERAGE

Unit 3: Preparing Claims

WORDS TO KNOW CHALLENGE

A. Matching: Match the term in column I with its description in column II.

COLUMN I	COLUMN II
_____ 1. Bundle	a. A number of things bound together
_____ 2. Primary	b. To meet unexpectedly, or by chance
_____ 3. International Classification of Diseases	c. A numerical listing of procedures performed in medical practice
	d. Limits the meaning
	e. A system of technical or scientific names
_____ 4. Sequenced	f. Occurring first in time, development, or sequence
_____ 5. Current Procedural Terminology	g. Compensation for money spent, or for losses or damages incurred
	h. To cut the top or end off; to lop; with insurance
_____ 6. Nomenclature	i. A comprehensive listing of diseases and disorders of the human body
_____ 7. Reimbursement	j. In order of succession
_____ 8. Encounter	
_____ 9. Modifier	
_____ 10. Truncated	

B. Word Scramble: Unscramble the following terms.

1. _____ L E N T A U M R E N C O
2. _____ A R R C R E I
3. _____ F O D I E M I R
4. _____ F I P I S C I C T Y E
5. _____ M I A P R R Y
6. _____ D U C R T T A E N
7. _____ C U N E I R M
8. _____ N T C U O O R T I Y B R
9. _____ Y S N D O E A R C

UNIT REVIEW

A. Short Answer

1. Define the phrase "third-party reimbursement." _____

2. Why were claim forms developed? _____

3. When did the first attempt at classifying the causes of deaths occur? _____

4. What significant event occurred in 1938? _____

5. List the general rules for coding.
   a. _____
   b. _____
   c. _____
   d. _____

6. List the six sections of the CPT book.
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

7. List six common errors made when filing claim forms (there are 12 listed in the text):
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____
   g. _____
   h. _____
   i. _____
   j. _____
   k. _____
   l. _____

8. Fill in the blanks.
   Coding is, in reality, the _____ of _____ or _____ of _____ or _____ into _____ to _____, which can be _____ into _____ and _____.

9. List three reasons why coding is beneficial.
   a. _____
   b. _____
   c. _____

10. What change occurred with the Catastrophic Coverage Act of 1988? _____

11. What does "sequencing" mean? _____

Name _____

12. What is the main rule to remember when coding, and what does it mean? _____

_____

_____

13. Look at a copy of an approved CMS-1500 insurance form. Where would you enter the following information?

_____ A. Health care coverage being billed
_____ B. Patient's name
_____ C. Insured's name
_____ D. Patient's condition is result of employment
_____ E. Name of insured's employer
_____ F. Indicate there is another health plan
_____ G. Diagnosis codes
_____ H. Procedure codes

CASE STUDIES

Scenario 1

Emily is an insurance and billing staff member at the Anthony Clinic. She is normally very careful and meticulous with all her job duties. However, she has been experiencing some serious health issues and problems in her home life and has been miscoding procedures and forgetting to fill out portions of insurance forms before they are filed.

Critical Thinking Questions

1. What impact could this have on the clinic? _____

_____

2. Could Emily lose her job because of this? _____

_____

_____

3. What could Emily do to help alleviate this problem? _____

_____

_____

Scenario 2

Jennifer, the staff member who handles all insurance issues, notices that there have been some charges listed on several claim forms over the past month that appear to be "bogus." She knows for a fact that certain patients didn't receive the treatments for which the insurance companies are being billed.

Critical Thinking Questions

1. What should Jennifer do? _____

_____

2. What type of offense is this? _____

_____

3. What could happen to the physician? _____

_____

UNIT APPLICATION

Performance Objective Practice

A. Complete the five insurance forms provided using the following information: Code 11, office, for places of service: (24B) The physician is Samuel E. Matthews, MD, Suite 120, 100 E. Main Street, Yourtown, US 98765-4321. His SS# is 987654321. Phone (222) 789-0123. NPI 7654321. The patients all live in Yourtown, US.

a. Juan Gomez, 293 West High Street 98765

Medicare. Phone (222) 263-5538. BD 2/17/31. Male. SS# 291166966-A. Patient is insured person. Other insurance BC, BS #2911669660; signature on file. Abdominal pain and diabetes mellitus. (Consult this unit for code numbers. Consult code book for code numbers needed for procedures.) Seen in office.

5/18/YY	Office visit, intermediate	30.00
	Test feces for blood	15.00
	Automated hemogram	10.00
	Blood drawing	5.00

b. LaChar Holley, 4567 Charcoal Lane 98765

Travelers Insurance. Phone (222) 122-7768. BD 10/7/60. Female. SS# 505209821. Patient is insured person. No other insurance. Not related to employment or accident. Signature on file. Arthritis, acute back pain. Seen in office.

6/15/YY	Office visit, intermediate	30.00
	X-ray lumbar spine, AP & lateral	118.00
	Blood drawing	5.00
	Automated hemogram	10.00

c. Tina Schmidt, daughter. BD 12/27/90. Phone (222) 891-7145. Insured George Schmidt, 1249 E. Remington Road 98769. Self-employed. BC and BS Insurance. SS# of insured 888207777. BD 10/6/49. No other insurance. Phone (222) 441-0050. Signature on file. Impetigo. Seen in office.

6/20/YY	Office visit, limited	27.00

d. Joan Moriarty, wife. BD 12/19/62. Insured Patrick Moriarty, 397 North Tony Road 98768. Self-employed. Metropolitan-Insurance. SS# of insured 887105566. BD 11/14/60. Phone (222) 431-6943. No other insurance. Signature on file. Cervicitis, cystitis, acute edema. Patient seen in office.

9/20/YY	Office visit, extended	46.00
	Catheterization, urethra	20.00
	Endometrial biopsy	125.00
	Urinalysis	10.00

e. Boris Kostrevski, 1493 S. James Road 98765. Medicare and Aetna Insurance. SS# of insured 505208800-A. BD 7/14/22. Phone (222) 298-6483. Signature on file. Diabetes mellitus, coronary atherosclerosis. Seen in office.

6/20/YY	Office visit, intermediate	30.00
	Assay blood fluid, glucose	10.00
	Blood drawing	5.00

Name _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐☐

PICA ☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

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

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

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. ____ . ____ 3. ____ . ____ 2. ____ . ____ 4. ____ . ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

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11. INSURED'S POLICY GROUP OR FECA NUMBER	
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a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
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b. EMPLOYER'S NAME OR SCHOOL NAME	
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c. INSURANCE PLAN NAME OR PROGRAM NAME	
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d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.	
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6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

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a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

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Performance Competency

Following completion of Performance Objective Practice, use the Performance Evaluation Checklists 9-1 and 9-2 in the workbook to perform the procedures for evaluation.

CERTIFICATION AND REGISTRATION PREPARATION

_____ 1. Which of the following would be used to identify an incision and drainage procedure?
   a. ICD
   b. CPT
   c. FDA
   d. PDA

_____ 2. How often are the coding books published?
   a. Annually
   b. Semi-anually
   c. Every three years
   d. Biennially

_____ 3. Some governmental payers and commercial insurance carriers require use of the next year's codes as of:
   a. 10-01 of the current year
   b. 06-01 of the current year
   c. 12-01 of the current year
   d. 09-01 of the current year

_____ 4. Which codes are related to medical services as opposed to surgical services?
   a. CPT
   b. ICD
   c. E/M
   d. M/E

_____ 5. Which method is best for keeping up to date on Medicare's changes?
   a. Call Medicare
   b. Request a booklet
   c. Visit its Web site
   d. Attend seminars

_____ 6. When a physician agrees to accept the "approved amount" as his or her fee, this is known as:
   a. a fee schedule
   b. accepting assignment
   c. being a preferred provider
   d. assigning benefits

_____ 7. What is the term used to describe payment by someone other than the patient for services rendered?
   a. Assignment
   b. Reimbursement
   c. Third-party reimbursement
   d. Accepting assignment

_____ 8. Which rule is designated as the main rule of coding?
   a. Birthday rule
   b. Reason rule
   c. Primary rule
   d. Reimbursement rule