

# TERM Provider Claims Resources

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Dear TERM Provider,

Your time and expertise shared in the support of TERM-referred clients is immensely valuable within our community. You play an exceptionally important role in helping to reduce the risk of abuse and neglect in families involved with Child and Family Well-Being (CFWB).

The following resources were developed in partnership with Optum's Claims and Provider Services Departments with the intent to offer concrete support and guidance around submission of claims for services rendered to TERM clients. The resources are provided for informational and instructional purposes and do not constitute billing advice. It is our hope that these resources will assist with streamlining your claims submission practices and more efficiently utilize your time to meet the needs of your clients.

Please feel free to contact us at 877-824-8376 (Option 1) for any questions about TERM related processes. Please be in touch with Optum's Claims Department for any questions specific to reimbursement, denials, and claims processes more generally at 877-824-8376 (Option 2). We also welcome and appreciate you sharing any ideas you might have about how we can better serve you. Thank you for partnering with Optum TERM in serving the clients of the County of San Diego.

Respectfully,

Optum TERM Team

## Common Billing Questions – FAQ for TERM providers

- What information should be entered for the Insured's ID in box 1a?
  - For cases funded by CFWB, this information is the client's Case/State ID # listed on the referral form.
  - For cases funded by Medi-Cal, this information is the client's Medi-Cal policy # listed on the referral form.
- Can I sign a Claims form digitally or does it have to be done by hand?
  - Yes, a digital signature is acceptable.
- Is the client's signature required in box numbers 12 and 13?
  - No, the client is not required to sign these boxes. It is adequate to document 'SOF' or 'Signature on File' on these lines.
- How do I bill?
  - Claims can be sent on the CMS1500 form to the following address: CFWB Claims, Attention to: Optum, P.O. Box 600340, San Diego, CA 92160-0340. Claims can also be faxed to 877-364-6945.
- Where do I get the required claims form?
  - The CMS1500 claims form can be purchased from retailers such as Amazon and Staples. These forms can also be requested from Optum's Provider Services Department at no cost by calling 1-877-824-8376, option 3.
- Can I submit claims electronically?
  - Contact Claims directly to discuss options for setting up electronic submission of claims. Please contact Claims at 1-877-824-8376, option 2.
- Why are my claims being denied?
  - For specific questions related to your claims submissions, please begin by referencing the Explanation of Benefits (EOB) for the specific denial explanation. If requiring further assistance, please contact Optum's Claim's Department by calling 1-877-824-8376, option 2.

## Helpful Billing and Claims Tips – FAQ for TERM Providers

- Provide accurate data and complete all required fields on the claim.
- Be sure all billing staff are familiar with current billing and contract requirements.
- Familiarize all billing staff with the appropriate client information to document in the insured's ID in box 1a.
- Document 'Homeless' in box 5 of the CSM1500 form if a client is currently homeless.
- Remain aware of and utilize appropriate modifiers for services that require modifiers.
- Verify the effective dates for any authorization and remain aware of how many services are covered within the authorization period.
- For any requests to update any information related to authorized services, dates, and service frequency contact the assigned PSW to discuss the request.

# How To Complete the CMS1500 Claim Form



## Client Information

Box 1: Select "Other"

Box 1a: State ID # (CWFB Funded) or Medi-Cal Policy # (Medi-Cal Funded)

Box 2-6: Client demographics to include Name, DOB, Address, and Gender

Box 12, 13: Enter "Signature on File" or SOF

## Provider/Line item details

Box 19: Indicate whether submission is an updated form with comment

"Corrected Claim" or whether the service is facilitated by an intern by entering the intern's full name, i.e., John Smith, AMFT.

Box 21: Diagnostic Codes according to DSM-V-TR. When CFWB funded, Z-codes are adequate. Medi-Cal funding requires that a Title 9 diagnosis be submitted for reimbursement.

Box 23: Enter the authorization number. When multiple authorizations exist, you may enter a range or list each one individually. The authorization number(s) can be found on the authorization letter sent to you by TERM.

Box 24a: Date(s) of Service. Each CMS-1500 form can reflect up to 6 Dates of Service. Line Item details/charges about services rendered by Provider.

Box 24b: Place of Service. Common approved Places of Service include: 02-Telehealth other than in Client's home, 10- Telehealth in Client's home, 11-Office.

Box 24d: Approved CPT Codes only. Include any approved, relevant modifiers. Common modifiers include: 93- Telephone, 95-Video and Telephone, and TU-Bilingual Rate Applies.

Box 24e: Corresponds to diagnosis in Box 21 A-L.

Box 24f: Charge(s) for the rendered service. Rates are pre-determined during the contracting phase.

Box 24g: Indicate the number of units billed. CPT Code T1017 (Case Management) are billed in units of 15mins. For example, a 30 minute T1017 service would reflect 2 units in box 24g.

24j: NPI

Box 25: Federal Tax ID Number/Social Security Number of "Pay To"

Box 28: Total charge for all services (lines 24a., 1-6) rendered

Box 31: Provider signature and date. Electronic signature is adequate.

Box 32: Service facility location information. If services are rendered in Client's home, enter Client's home address.

Box 33: "Pay To" Provider's name, address, and telephone number. Enter Agency or Group address if you are working under an Agency or Group (e.g., The San Diego Outpatient Group). Box 25 should correspond to provider or Agency/Group reflected here.

# 1 500 Claim Type Image



## HEALTH INSURANCE CLAIM FORM

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

1a

2-6

19

21

24

25

31

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										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 <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					8. RESERVED FOR NUCC USE				
ZIP CODE					TELEPHONE (Include Area Code) ( ) ( )					CITY					STATE				
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										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.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.									
15. OTHER DATE MM DD YY QUAL.										16. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.									
22. RE submission CODE										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										24. B. PLACE OF SERVICE									
24. C. EMG										24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER									
24. E. DIAGNOSIS POINTER										24. F. \$ CHARGES									
24. G. DAYS OF UNITS										24. H. EPID/Family Plan									
24. I. ID. QUAL.										24. J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For gov. claims, use back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$									
29. AMOUNT PAID \$										30. Revd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # ( )										33. BILLING PROVIDER INFO & PH # ( )									
SIGNED										DATE									
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0936-1187 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

## Navigating TERM Authorization Letters: Completing CMS 1500 Claims Form

The following are samples of TERM generated authorization letters that capture key areas used when completing the CMS 1500 Claim Form, as well as areas that orient the provider to understanding how treatment services are funded.










Each sample authorization letter is followed by a letter key that is intended to support the provider's navigation and understanding of the authorization letter.

The first authorization letter reflects a Medi-Cal funded authorization for Child Family Well-Being (CFWB) treatment services that will be rendered to a child. The second authorization letter reflects a CFWB funded authorization of services rendered to a child. Finally, the third authorization letter reflects a CFWB funded authorization of group services.

Monday, October 7, 2024

**Prov, Termy** 123 Healing Rd.  
San Diego, CA 92108Phone: (619) 555-5555  
Fax: (619) 444-4444

We have authorized the following treatment services:

Client: <b>Last, First</b> 		Client ID: 123456789  Insured ID:77777777F	
<b>Authorization #</b> 	<b>Date and Type of Service</b> 	<b># of Units</b> 	<b>Frequency</b> 
001	10/21/2024-10/20/2025  A&E- Child  -A&E- Child Psych Assessment and Med Eval	1 Unit	1 Once a year
<i>Comment:</i>	INDIVIDUAL THERAPY 		

Please bill with the applicable CPT code listed above and what is included in your fee schedule. Please ensure to bill with any applicable modifiers.

Should you have any questions, please contact us at (877) 824-8376 option 3, then option 4.

Disclaimer: Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

Payment for services is subject to client's Medi-Cal eligibility. Authorization is neither a statement of benefit coverage nor a guarantee of payment. Incomplete submissions re not authorized and will not be reimbursed. If a client has other health coverage (OHC), you must bill OHC first. The 'Good Thru' date is the last day authorized. Please submit a request for additional days to Optum Public Sector.

All providers serving children and youth ages 0-21 are REQUIRED to complete Child and Adolescent Needs Assessment and Strengths (CANS) & Pediatric Symptom Checklist (PSC) outcome tools. Please submit completed tools to Optum Public Sector.

Incomplete submissions are not authorized and without authorization, services may not be reimbursed.

Fax to: (866) 220-4495 or

Mail to: Optum Utilization Management at PO Box 601370 San Diego, CA 92160-1370



## Medi-Cal Funded Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a Medi-Cal funded authorization.	Funding source will inform the ID number entered in box 1a.
B	Addressee reflects the provider/practice mailing address.	Use the mailing address when completing box 33 of the CMS-1500 form. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this individual's demographic information to complete boxes 2-6.
D	In Medi-Cal funded cases, the Insured ID is the client's 9-digit Medi-Cal Policy ID.	Enter the client's 9-digit Medi-Cal Policy ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23 of the CMS-1500 form. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column reflects that <i>only</i> the Psych Assessment and Med Eval is authorized at the start of the authorization period in Medi-Cal funded cases.	CPT coded entered in box D.
G	Number of units authorized during the authorization period. Please request additional units by coordinating with UM. One unit of A&E Child Psych Assessment and Med Eval is authorized in the year.	
H	The number of units that can be billed during the described period. When additional units are needed (ex. Multiple individual sessions in one week) and clinically indicated, coordinate with UM and the assigned PSW.	Enter in box G.
I	Date range reflects the period in which the client is authorized to receive services. Medi-Cal funded therapy is initially authorized for a period of one year.	
J	<i>Child</i> designates that the service is authorized to a child. The modifier 'TJ' must be entered for each CPT code authorized and being billed during a child's treatment. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box D.
K	Comment describing the service modality that is authorized. When authorized to a group practice, this area will also reflect the provider who is authorized to render treatment.	Box 31 is signed by the treatment rendering provider designated in the comments section.

Monday, October 7, 2024

**Prov, Termy **B****

123 Healing Rd.  
San Diego, CA 92108

Phone: (619) 555-5555  
Fax: (619) 444-4444

We have authorized the following treatment services:

Client: <b>Last, First <b>C</b></b>		Client ID: 123456789 <b>D</b> Insured ID:0T000-0	
<b>Authorization # <b>E</b></b>	<b>Date and Type of Service <b>F</b></b>	<b># of Units <b>G</b></b>	<b>Frequency <b>H</b></b>
001	10/21/2024-04/21/2025 <b>I</b> A&E- Child <b>J</b> -A&E- Child Psych Assessment and Med Eval	1 Unit	1 Once a year
002	10/21/2024-04/21/2025 CM-Child- CM- Child Team Conference	12 Units	1 Twice a month
003	10/21/2024-04/21/2025 TCM- Child- TCM-Child Targeted Case Management	12 Units	1 Twice a month
004	10/21/2024-04/21/2025 INDIV-Child – INDIV- Child Therapy	23 Units	1 Weekly

Please bill with the applicable CPT code listed above and that is included in your fee schedule. Please ensure to bill with any applicable modifiers: 93-Telephone, 95-Telehealth, TU-Bilingual rate applies, TJ-Child and/or Adolescent. **K**

Should you have any questions, please contact us at (877) 824-8376.

Disclaimer: This authorization is being issued on behalf of Child and Family Well-Being. Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

\*All CFWB Initial Treatment Plans and Group Intake Assessments are due 14 days from the authorization start date.

\*All treatment plan updates are due every 12 weeks thereafter.

\*Discharge summaries should be submitted on completion or termination of services.

\*CFWB psychological evaluations are due 30 days from the authorization or receipt of background records from CFWB.

Fax to: (877) 624-8376

Mail to: Optum TERM at PO Box 601340 San Diego, CA 92160-1340

## CFWB Funded Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a CFWB funded authorization.	Funding source will inform the ID number entered in box 1a.
B	Addressee reflects the provider/practice mailing address.	Use the mailing address when completing box 33. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this individual's demographic information to complete boxes 2-6
D	In CFWB funded cases, the Insured ID is the client's State ID.	Enter the client's State ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23 of the CMS-1500 form. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column will reflect the services/CPT codes the client is authorized to receive. CFWB funded cases will be authorized to receive Psych Assessment and Med Eval, Team Conference, Targeted Case Management, and Therapy.	CPT code entered in box D.
G	Number of units authorized during the authorization period.	
H	The number of units that can be billed during the described period. When additional units are needed (ex. Multiple sessions during a one week period) and clinically indicated, coordinate with the assigned PSW.	Enter in box G.
I	Date range reflects the period in which the client is authorized to receive services. CFWB funded therapy is initially authorized for a period of 6 months.	
J	<i>Child</i> designates that the service is authorized for a child. The modifier TJ must be entered for each CPT code authorized and being billed during a child's treatment. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box D.
K	Consider any applicable modifiers. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box D.

Monday, October 7, 2024

**THE BEST GROUP PRACTICE INC **B****

123 Healing Rd.  
San Diego, CA 92108

Phone: (619) 555-5555  
Fax: (619) 444-4444

We have authorized the following treatment services:

Client: <b>Last, First <b>C</b></b>		Client ID: 123456789 <b>D</b> Insured ID:0T000-0	
<b>Authorization # <b>E</b></b>	<b>Date and Type of Service <b>F</b></b>	<b># of Units <b>G</b></b>	<b>Frequency <b>H</b></b>
001	10/21/2024-04/21/2025 <b>I</b> A&E- A&E Psych Assessment and Med Eval	1 Unit	1 Once a year
002	10/21/2024-04/21/2025 DVIA- DV- Additional 30min for Intake/Assessment for DV	1 Unit	1 Once a year
003	10/21/2024-04/21/2025 CM-CM- Team Conference	12 Units	2 Monthly
004	10/21/2024-04/21/2025 TCM- TCM- Targeted Case Management	12 Units	2 Monthly
005	10/21/2024-04/21/2025 GROUP- GROUP- Group Therapy	26 Units	1 Weekly
Client: Last, First		Client ID:123456789 Insured ID: 0T000-0	
<b>Authorization #</b>	<b>Date and Type of Service</b>	<b># of Units</b>	<b>Frequency</b>
<i>Comment:</i>	<i>AUTHORIZING PROVIDER: TERMY PROV DOMESTIC VIOLENCE VICTIM GROUP <b>J</b></i>		

Please bill with the applicable CPT code listed above and that is included in your fee schedule. Please ensure to bill with any applicable modifiers: 93-Telephone, 95-Telehealth, TU-Bilingual rate applies, TJ-Child and/or Adolescent.

Should you have any questions, please contact us at (877) 824-8376.

Disclaimer: This authorization is being issued on behalf of Child and Family Well-Being. Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

Fax to: (877) 624-8376

Mail to: Optum TERM at PO Box 601340 San Diego, CA 92160-1340

## CFWB Funded GROUP Authorization Letter Key

	Description	CMS-1500 Application
<b>A</b>	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a CFWB funded authorization as all groups are CFWB funded.	Funding source will inform the ID number entered in box 1a.
<b>B</b>	Addressee reflects the provider/practice mailing address.	Use the mailing address when completing box 33. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
<b>C</b>	Name of the individual authorized to receive services.	Use this name to complete boxes 2-6.
<b>D</b>	In CFWB funded cases, the Insured ID is the client's State ID.	Enter the client's State ID in box 1a.
<b>E</b>	Authorization number assigned to each CPT code/service.	Enter in box 23. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
<b>F</b>	This column will reflect the services/CPT code the client is authorized to receive and bill. CFWB funded group cases will be authorized to receive Psych Assessment and Med Eval, Intake/Assessment Additional 30 min, Team Conference, Targeted Case Management, and Group Therapy.	CPT code entered in box D.
<b>G</b>	Number of units authorized during the authorization period.	
<b>H</b>	The number of units that can be billed during the described period. When additional units are needed (ex. Intake/Assessment) and clinically indicated, coordinate with the assigned PSW.	Enter in box G.
<b>I</b>	Date range reflects the period in which the client is authorized to receive services. CFWB funded group therapy is initially authorized for a period of 6 months.	
<b>J</b>	Comment describing the service authorized. When authorized to a group practice, this area will also reflect the provider who is authorized to render treatment.	Box 31 is signed by the treatment rendering provider designated in the comments section.

# Sample CMS 1500 Claims Form

## Individual Therapy

The following two pages include sample CMS 1500 Claims Forms to capture how a provider would submit claims for individual therapy services. In the first sample, the individual therapy was rendered to an adult while the second sample reflects individual therapy with a child. Both samples include submission of claims for reimbursement of three separate services rendered to the client.

- 1) CPT Service Code 90791 for the Initial Intake Assessment
- 2) CPT Service Code 99366 for the provider's attendance at a CFT meeting
- 3) CPT Service Code 90837 for Individual Therapy lasting 60 minutes

Both samples also include use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the samples, Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The child sample includes the use of the 'TJ' Modifier code to denote that the service was rendered to a child. The required use of this Modifier is effective as of 9/1/2024. The 'TJ' Modifier is not required when billing CPT codes H0032 (CFWB Report), 99499 (No Shows- Psych Eval).

When multiple Modifiers are being documented by the provider, the language Modifier should be entered as the primary Modifier.

These samples further illustrate usage of Modifiers to capture services rendered via telehealth through use of the '95' Modifier code.

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).  
 Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while the Client is in the community (02-Place of Service).  
 Line 3 CPT Code 90837 depicts an individual therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).  
 Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Codes 90791 and 90837. Up to six dates can be captured per CMS 1500 Claims Form.  
 If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.



# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>Medi-Cal Policy ID or CFWB State ID</b>																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client Name</b>										3. PATIENT'S BIRTH DATE <b>01 01 1993</b>					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																								
5. PATIENT'S ADDRESS (No., Street) <b>1234 Disneyland Way</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																								
CITY <b>Wonderful World</b>					STATE <b>CA</b>					8. RESERVED FOR NUCC USE					CITY																								
ZIP CODE <b>54321</b>					TELEPHONE (Include Area Code) <b>( ) ( ) ( )</b>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																								
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) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S BIRTH DATE MM DD YY																								
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? (State of California) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. INSURED'S BIRTH DATE MM DD YY																								
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? (State of California) <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURED'S BIRTH DATE MM DD YY																								
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. Other (Specify and Signify)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes complete items 9, 9a, and 9d.</i>																								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>																								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER <b>17b</b>										19. ADDITIONAL CLAIM INFORMATION (Signify)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																								
19. ADDITIONAL CLAIM INFORMATION (Signify) <b>Corrected Claim or Intern Name - Only Use When Applicable</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER <b>1333325-326 or 1333325, 1452658</b>																								
24. A. DATE(S) OF SERVICE (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. #										25. FEDERAL TAX I.D. NUMBER <b>88-8888888</b>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (or govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>475.00</b>					29. AMOUNT PAID \$ <b>0</b>					30. Rsvd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>Termy Prov LMFT</b>										32. SERVICE FACILITY LOCATION INFORMATION <b>Termy Prov, LMFT 123 Healing Rd. Sun Diego, CA 92108</b>					33. BILLING PROVIDER INFO & PH # <b>(619) 555-5555</b>					33. BILLING PROVIDER INFO & PH # <b>(619) 555-5555</b>																			
SIGNED <b>Termy Prov</b> DATE <b>12/23/23</b>										SIGNED <b>Termy Prov</b> DATE <b>12/23/23</b>					SIGNED <b>Termy Prov</b> DATE <b>12/23/23</b>					SIGNED <b>Termy Prov</b> DATE <b>12/23/23</b>																			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).  
 Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while Client is in the community (02-Place of Service).  
 Line 3 CPT Code 90837 depicts an individual therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).  
 Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Code 90791. Up to six service dates can be captured per CMS 1500 Claims Form.  
 Services provided to a child must be accompanied by the 'TJ' modifier, as noted below in CPT Codes 90791, 90837. The 'TJ' modifier must follow the language modifier. Up to six service dates can be captured per CMS 1500 Claims Form.



**HEALTH INSURANCE CLAIM FORM**

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>Medi-Cal Policy ID or CFWB State ID</b>														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client Name</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>04 01 2016</b>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) <b>1234 Disneyworld Avenue</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)									
CITY <b>Wonderful World</b>					STATE <b>CA</b>					8. RESERVED FOR NUCC USE					CITY									
ZIP CODE <b>54321</b>					TELEPHONE (Include Area Code) <b>( ) ( ) ( )</b>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:									
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) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S BIRTH DATE MM DD YY									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT?					b. RESERVED FOR NUCC USE									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT?					c. OTHER ACCIDENT?									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. OTHER INSURED'S SIGNATURE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes complete items 9, 9a, and 9d.</i>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY									
17. NAME OF REFERRING PROVIDER										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY									
19. ADDITIONAL CLAIM INFORMATION (Signatures) <b>Corrected Claim or Intern Name - Only Use When Applicable</b>										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. ICD-9 CODES OR NATURE OF ILLNESS (Relate to service line below (24E)) <b>F43.10</b>										22. RESUBMISSION CODE					22. RESUBMISSION CODE									
24. A. DATE(S) OF SERVICE										24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					24. F. S CHARGES									
B. PLACE OF SERVICE										E. DIAGNOSIS POINTER					G. DAYS OR UNITS									
C. EMG										A.					H. EPSDT Family Plan									
12 15 23 12 15 23 10										90791 TU 95 TJ					250.00 1 NPI 5279384									
12 22 23 12 22 23 02										99366 95					75.00 1 NPI 5279384									
12 23 23 12 23 23 10										90837 95 TJ					150.00 1 NPI 5279384									
25. FEDERAL TAX I.D. NUMBER <b>88-8888888</b>										26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE <b>\$ 475</b>				
25. SSN EIN <input checked="" type="checkbox"/>										29. AMOUNT PAID <b>\$ 0</b>					30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <b>Termly Prov LMFT</b>										32. SERVICE FACILITY LOCATION INFORMATION <b>Termly Prov, LMFT 123 Healing Rd. Sun Diego, CA 92108</b>					33. BILLING PROVIDER INFO & PH # <b>(619) 555-5555</b>									
SIGNED DATE <b>12/23/23</b>										a. NPI					b. NPI									

NUCC Instruction Manual available at: www.nucc.org



## Sample CMS 1500 Claims Form

### Group Therapy

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for group therapy services. The sample include submission of claims for reimbursement of three separate services rendered to the client.

- 1) CPT Service Code 90791 for the Initial Intake Assessment
- 2) CPT Service Code 99366 for the provider's attendance at a CFT meeting
- 3) CPT Service Code 90853 for Group Therapy

The sample also includes use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the sample, language Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The sample further illustrates usage of Modifiers to capture services rendered via telehealth through use of the '95' Modifier code.

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).  
 Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while the Client is in the community (02-Place of Service).  
 Line 3 CPT Code 90853 depicts a group therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).  
 Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Codes 90791 and 90837. Up to six dates can be captured per CMS 1500 Claims Form.  
 If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.



# HEALTH INSURANCE CLAIM FORM

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

PICA										PICA																																												
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>Medi-Cal Policy ID or CFWB State ID</b>																																												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client Name</b>										3. PATIENT'S BIRTH DATE <b>05 01 1990</b>					SEX <b>X</b> <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																		
5. PATIENT'S ADDRESS (No., Street) <b>1234 Disneyland Way</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																		
CITY <b>Wonderful World</b>					STATE <b>CA</b>					8. RESERVED FOR NUCC USE										CITY																																		
ZIP CODE <b>54321</b>					TELEPHONE (Include Area Code) <b>( ) ( )</b>					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) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S BIRTH DATE MM DD YY																																		
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT?										b. AUTO ACCIDENT?																																		
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT?										c. OTHER ACCIDENT?																																		
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. OTHER SIGNATURE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes complete items 9, 9a, and 9d.</i>																																		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>																																		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																		
17. NAME OF REFERRING PROVIDER										17b. NAME OF REFERRING PROVIDER										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO																																		
19. ADDITIONAL CLAIM INFORMATION (Signatures) <b>Corrected Claim or Intern Name - Only Use When Applicable</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER <b>1333325-326 or 1333325, 1452658</b>																																		
24. A. DATE(S) OF SERVICE MM DD YY										B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/PCS MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
1 12 15 23 12 15 23 10										90791					TU 95					A.					250.00					1					NPI					5279384														
2 12 22 23 12 22 23 02										99366					95					A.					75.00					1					NPI					5279384														
3 12 23 23 12 23 23 10										90853					TU 95					A.					75.00					1					NPI					5279384														
4																																																						
5																																																						
6																																																						
25. FEDERAL TAX I.D. NUMBER <b>88-8888888</b>										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>400.00</b>					29. AMOUNT PAID \$ <b>0</b>					30. Rsvd for NUCC Use																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>Termly Prov LMFT</b>										32. SERVICE FACILITY LOCATION INFORMATION <b>Termly Prov, LMFT 123 Healing Rd. Sun Diego, CA 92108</b>										33. BILLING PROVIDER INFO & PH # ( <b>619 555-5555</b> ) <b>Termly Prov, LMFT 123 Healing Rd. Sun Diego, CA 92108</b>																																		
SIGNED <b>Termly Prov</b> DATE <b>12/23/23</b>										a. NPI					b. NPI					a. NPI					b. NPI																													

31. If it's a group, we need provider who rendered services in box 31.

# Sample CMS 1500 Claims Form

## Conjoint Therapy and Case Management

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for conjoint therapy and case management services. The sample include submission of claims for reimbursement of three separate services rendered to the client.

- 1) CPT Service Code 90791 for the Initial Intake Assessment
- 2) CPT Service Code 90847 for Conjoint Therapy
- 3) CPT Service Code T1017 for Case Management

Case Management services are billed in units of 15 minutes. For example, a 30-minute Case Management service should be documented with the number '2' under column 24g on the CMS 1500 form.

The sample also includes use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the sample, language Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The sample further illustrates usage of Modifiers to capture services rendered via telephone through use of the '93' Modifier code and telehealth through use of the '95' Modifier code.



HEALTH INSURANCE CLAIM FORM

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

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).
Line 2 CPT 90847 depicts a conjoint service rendered via telehealth (modifier 95) while the Client is at home (10- Place of Service).
Line 3 CPT T1017 depicts 1 unit of Case Management service rendered via telephone (modifier 93) while the Client is in the community (02- Place of Service).
Services rendered in languages other than English are captured with the 'TU' modifier, as noted below in Line 2 CPT Code 90847. Up to six services can be captured per CMS 1500 Claims Form.

Form with fields for patient information, insurance details, and service lines. Includes a large 'SAMPLE' watermark. Fields include: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME: Client Name; 3. PATIENT'S BIRTH DATE: 01/01/1993; 5. PATIENT'S ADDRESS: 1234 Disneyland Way; 7. INSURED'S ADDRESS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: Signature on File, 12/15/2023; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: Signature on File; 14. DATE OF CURRENT ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. ADDITIONAL CLAIM INFORMATION: Corrected Claim or Intern Name - Only use when applicable; 20. OUTSIDE LAB?; 21. ICD-10 CODE: F43.10; 22. RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER: 1333325-326 or 1333325, 1452658; 24. SERVICE LINES table with columns for date, place of service, CPT/HCPCS, modifier, diagnosis, charges, units, NPI, and provider ID; 25. FEDERAL TAX I.D. NUMBER: 88-8888888; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE: \$ 355.00; 29. AMOUNT PAID: \$ 0; 30. Rsvd for NUCC Use; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER: Terym Prov LMFT, 12/23/23; 32. SERVICE FACILITY LOCATION INFORMATION: Terym Prov, LMFT, 123 Healing Rd., Sun Diego, CA 92108; 33. BILLING PROVIDER INFO & PH #: Terym Prov, LMFT, 123 Healing Rd., Sun Diego, CA 92108, 619)555-5555.

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

31. if it's agroup, we need provider who rendered services in box 31.

## Sample CMS 1500 Claims Form

### Evaluation No-Show Consideration Fee

TERM evaluators accepting Child and Family Well-Being evaluation referrals (CFWB, formerly CWS) through Optum TERM will be pre-authorized for one unit CPT code 99499 (no-show) and sent to providers by Optum with the referral form and questions. Evaluators that did not receive this information with the aforementioned documents should follow up directly with TERM by contacting the TERM provider line: 877-824-8376 (Option 1).

There will be only one \$200 no-show fee reimbursed per client per evaluator. This no-show consideration fee only pertains to CFWB/Probation evaluation referrals at the time of this document's publishing.

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for an evaluation no-show consideration fee (CPT Service Code 99499). This no-show consideration fee is reimbursed at a rate of \$200 considering the time blocked out for the missed evaluation and does not reimburse the provider at the same rate as a completed evaluation, attended by the client.

As displayed on the sample, Evaluators are to document the code '11' for the Place of Service and a diagnosis code of R69 when submitting for reimbursement of the evaluation no-show consideration fee.

Please Note: When granted, evaluation no-show consideration fees will be paid using CFWB funding. Therefore, a CFWB case number must be used when submitting for this fee. If evaluation services are financed by Medi-Cal, the 99499 must be reported on a different claims form than the evaluation services because it is paid for separately using CFWB funding.

Line 1 CPT Code 99499 depicts a claims submission for compensation related to a CFWB Evaluation that was not attended by the client. This reflects the Evaluator seeking reimbursement for the CFWB evaluation no-show consideration fee.

If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.



# HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>CFWB State ID</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client Name</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>07 01 1972</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
5. PATIENT'S ADDRESS (No., Street) <b>1234 Disneyland Way</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY <b>Wonderful World</b>					STATE <b>CA</b>					7. INSURED'S ADDRESS (No., Street)					8. RESERVED FOR NUCC USE				
ZIP CODE <b>54321</b>					TELEPHONE (Include Area Code) <b>( ) ( ) ( )</b>					CITY					ZIP CODE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S POLICY OR GROUP NUMBER									
b. RESERVED FOR NUCC USE										b. RESERVED FOR NUCC USE									
c. RESERVED FOR NUCC USE										c. RESERVED FOR NUCC USE									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes complete items 9, 9a, and 9d.</i>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>Signature on File</b>									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Signatures) <b>Corrected Claim or Intern Name - Only Use When Applicable</b>										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
ICD Ind. <b>R69</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER <b>1333325-326 or 1333325, 1452658</b>										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/HCP/CS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 12 15 23 12 15 23 11 99499 A. 200. 00 1 NPI 5279384																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER <b>88-8888888</b> SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (or govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>200. 00</b> 29. AMOUNT PAID \$ <b>0</b> 30. Rsvd for NUCC Use <b>619 555-5555</b>									
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.) <b>Terry Prov PhD</b> SIGNED <b>Terry Prov PhD</b> DATE <b>12/23/23</b>										32. SERVICE FACILITY LOCATION INFORMATION <b>Terry Prov, PhD 123 Healing Rd. San Diego, CA 92108</b>									
33. BILLING PROVIDER INFO & PH # ( <b>619 555-5555</b> ) a. <b>NPI</b> b. <b>NPI</b>																			

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31. if it's agroup, we need provider who rendered services in box 31.



## TERM Provider Authorization Letter to CPT Code Crosswalk

### Psychiatric Diagnostic Procedures (Intake Assessment)

Provider Auth Letter Description	CPT Code	Description	Minutes
A&E Psych Assessment and Med Eval	90791	Psychiatric diagnostic evaluation	50
A&E Psych Assessment and Med Eval	90791TU	Psychiatric diagnostic evaluation - <b>Bilingual</b>	50

### Psychotherapy (Individual, Conjoint, and Family Therapy)

Provider Auth Letter Description	CPT Code	Description	Minutes
INDIV Therapy	90834	Psychotherapy, 45 minutes with patient	45
INDIV Therapy	90834TU	Psychotherapy, 45 minutes with patient - <b>Bilingual</b>	45
INDIV Therapy	90837	Psychotherapy, 60 minutes with patient	60
INDIV Therapy	90837TU	Psychotherapy, 60 minutes with patient - <b>Bilingual</b>	60
CONJ Conjoint Therapy	90846	Family psychotherapy (without the patient present), 50 minutes	50
CONJ Conjoint Therapy	90846TU	Family psychotherapy (without the patient present), 50 minutes - <b>Bilingual</b>	50
CONJ Conjoint Therapy	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	50
CONJ Conjoint Therapy	90847TU	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes - <b>Bilingual</b>	50

### Group Therapy (All TERM Group Therapy Services)

Provider Auth Letter Description	CPT Code	Description	Minutes
A&E Psych Assessment and Med Eva	90791	Intake/Assessment for Group	N/A
A&E Psych Assessment and Med Eva	90791TU	Intake/Assessment for Group - <b>Bilingual</b>	N/A
DVIA DV Intake Assessment	90785	Additional 30 min. for Intake/Assessment for Domestic Violence Offender and Victim Group	30
DVIA DV Intake Assessment	90785TU	Additional 30 min. for Intake/Assessment for Domestic Violence Offender and Victim Group - <b>Bilingual</b>	30
GROUP Group Therapy	90853	Group Therapy Session	N/A
GROUP Group Therapy	90853TU	Group Therapy Session - <b>Bilingual</b>	N/A

## TERM Provider Authorization Letter to CPT Code Crosswalk

### Quarterly Treatment Report

Provider Auth Letter Description	CPT Code	Description	Minutes
Report Preparation	90889	Quarterly Treatment Report – 4x per year	N/A
PLDV Plan Development	H0032	CFWB Report(s) – Initial Treatment Plan, Treatment Plan Update and Discharge Summary for TERM CWS Clients (per report)	N/A

### Care Coordination (CFT Meeting Attendance and Case Management)

Provider Auth Letter Description	CPT Code	Description	Minutes
CM Team Conference	99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional. Includes Child, Family and Interdisciplinary Team (CFT) meetings for CWS clients. <b>(1 unit per day maximum)</b>	N/A
CM Team Conference	99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional/ <b>(1 unit per day maximum)</b>	N/A
TCM Targeted Case Management	T1017	Targeted case management, each 15 minutes	15

### CANS

Provider Auth Letter Description	Billing/CPT Code	Description
CANS Report Preparation	90889	Submission of an appropriate CANS Report (1 each/1 unit)

### Psychological Testing

Provider Auth Letter Description	CPT Code	Description	Minutes
Psych Test Eval 1 <sup>st</sup> Hr	96130	* Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (Max 1 unit/1	60
Psych Test Eval 1 <sup>st</sup> Hr	96130TU	* Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (Max 1 unit/1 hour) - <b>Bilingual</b>	60
Psych Test Eval Addtl 1 Hr	96131	Each additional 1 unit/1 hour (services as described in 96130)	60
Psych Test Eval Addtl 1 Hr	96131TU	Each additional 1 unit/1 hour (services as described in 96130) - <b>Bilingual</b>	60
Neuropsych Test Admin 1 <sup>st</sup> 30 Minutes	96136	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit)	30
Neuropsych Test Admin 1 <sup>st</sup> 30 Minutes	96136TU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit) - <b>Bilingual</b>	30
Neuropsych Test Admin Addtl 30 Minutes	96137	Each additional 1 unit/30 minutes (services as described in 96136)	30



## TERM Provider Authorization Letter to CPT Code Crosswalk

Neuropsych Test Admin Addtl 30 Minutes	96137TU	Each additional 1 unit/30 minutes (services as described in 96136) - <b>Bilingual</b>	30
No Show- Psych Eval	99499	No Show Consideration Fee for Psychological Evaluations	N/A

### Neuropsychological Testing

Provider Auth Letter Description	CPT Code	Description	Minutes
Neuropsych Testing Evaluation 1st Hr	96132	* Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	60
Neuropsych Testing Evaluation 1st Hr	96132TU	* Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour - <b>Bilingual</b>	60
Neuropsych Testing Evaluation Add 1 Hr	96133	Each additional 1 unit/1 hour (services as described in 96132)	60
Neuropsych Testing Evaluation Add 1 Hr	96133TU	Each additional 1 unit/1 hour (services as described in 96132) - <b>Bilingual</b>	60
Neuropsych Test Admin 1st 30 Minutes	96136HU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit)	30
Neuropsych Test Admin 1st 30 Minutes	96136HUTU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit) - <b>Bilingual</b>	30
Neuropsych Test Admin Addtl 30 Minutes	96137HU	Each additional 1 unit/30 minutes (services as described in 96136)	30
Neuropsych Test Admin Addtl 30 Minutes	96137HUTU	Each additional 1 unit/30 minutes (services as described in 96136) - <b>Bilingual</b>	30
No Show- Psych Eval	99499	No Show Consideration Fee for Psychological Evaluations	N/A

### Psychiatric Evaluations

Provider Auth Letter Description	CPT Code	Description	Minutes
Psychiatric Evaluation 1 Hour	90899	Psychiatric Evaluations	N/A
Psychiatric Evaluation 1 Hour	90899TU	Psychiatric Evaluations - <b>Bilingual</b>	N/A