BEHAVIORAL HEALTH SYSTEMS

BHS Provider Guide
Authorization and Claims Procedures

Welcome to BHS!

We are pleased that you have chosen to affiliate with our provider network. BHS has been cited as one of the top 25 fastest growing specialty PPOs in the country thanks to the involvement of quality providers such as you. Please take a few minutes to read through this information to familiarize yourself with BHS.

We ask that BHS covered members contact our office prior to receiving behavioral health services. Speaking directly with the member allows us to perform our intake process, verify the member's eligibility, and explain plan benefits and any applicable cost-sharing. Once we have verified eligibility and coverage, we will contact you to schedule the initial appointment, discuss the availability of EAP visits and provide you with copayment, coinsurance, plan deductibles, and any additional benefit information you may need. We will also advise you of any pre-authorization requirements specific to the member's plan and answer any additional questions you may have.

Emergencies

In an emergency, patient safety is the highest priority. Our covered members should first seek the care they need rather than attempt to call the BHS office. The member or a family member should contact us as soon as possible after emergency care has been obtained. However, if a BHS member in crisis calls you or presents to your office, a BHS Care Coordinator will be available should you wish to discuss any crisis services provided, revised treatment recommendations, or to advise us of the patient's condition. A BHS Care Coordinator is available 24 hours a day/7 days a week.

Authorization Procedures

BHS administers many different EAP/Mental Health/Substance Abuse benefit plans. The authorization requirements and covered services may differ from one plan to the next. However, all plans require that any recommended treatment or services be determined medically necessary by BHS either before, during or after care is rendered. BHS evaluates each treatment plan on the basis of problem acuity, degree of functional impairment, and the appropriateness and effectiveness of the treatment that is recommended and/or provided. Each case is individually evaluated and there is no pre-defined course of treatment for "like" conditions.

If the member's plan requires pre-authorization or if you would like a courtesy predetermination of benefits, please take the following steps after completing your initial assessment:

1. Contact the referring BHS Care Coordinator after the initial visit to give your preliminary report and recommendations.
2. Forward the BHS forms (which include the Clinical Assessment Report and Treatment Plan, and Patient Information/ Authorization forms) to our Clinical Services Division by fax or mail.
3. BHS will send you written notification of the authorization of coverage for continued treatment.

Pre-Authorization

Most, but not all, of BHS' clients' benefit plans require pre-authorization of certain outpatient services. These typically include, but may not be limited to, psychological testing, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Intensive Outpatient Programs, and Applied Behavioral Analysis (ABA). Contact BHS for information regarding our pre-authorization forms, review processes and additional instructions if your recommended treatment plan includes any of these treatment services or you would like to confirm whether pre-authorization is required for a particular type or intensity of service.

Authorization for Psychological Testing

If the member's plan requires preauthorization or for a courtesy predetermination of benefits, psychologists should submit the **Psychological Testing Preauthorization Request** prior to conducting any psychological tests.

Authorization for ECT

If the member's plan requires preauthorization or for a courtesy predetermination of benefits, please submit a completed **ECT Preauthorization Request** prior to the initial treatment. If the patient subsequently requires additional treatments, please submit another request form and a note summarizing the patient's progress to the initial treatments.

Required Clinical Documentation

We attempt to keep paperwork to a minimum. These guidelines should assist in identifying which forms, if any, are needed for certain visits:

1. ***Patient Information/Authorization*** – To be completed by the client/patient at the first visit.
2. ***Clinical Assessment Report and Treatment Plan*** To be completed by the treating provider for the following:
   a. The majority of BHS' clients' benefit plans comply with the Mental Health Parity and Addiction Equity Act. For this reason, there is no pre-authorization requirement for most outpatient office-based services such as initial assessment, psychotherapy and evaluation/management of psychiatric medications. For those plans which require outpatient pre-approval, you must complete this form following the initial assessment and submit it to BHS for review and approval. Even for plans that do not require outpatient pre-authorization, you may submit this form to BHS for a courtesy predetermination of coverage.
   b. If at any point in an episode of care it is necessary to determine the medical necessity of the treatment being recommended/provided, BHS will send written notification to you. The notification letter will include a request for an updated Clinical Assessment Report and Treatment Plan. Your updated report must reflect the

BEHAVIORAL HEALTH SYSTEMS
ASSESSMENT REPORT AND TREATMENT PLAN
THERAPY

Check One: ☐ Initial Assessment ☐ Continuing Care Today's Date: _____

Patient Name: _____ Date of Birth: ____-____-____ Age:____ ☐ Male ☐ Female

Insured Employer: _____ Provider Name, Licensure:_____

A. Current Problems (Check all that apply):

- ☐ Depressed mood
- ☐ Sleep disturbance: ____ ↑ ____ ↓
- ☐ Anhedonia
- ☐ Guilt
- ☐ Decreased energy
- ☐ Poor concentration
- ☐ Appetite disturbance
- ☐ Helplessness
- ☐ Worthlessness
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Obsessions/Compulsions
- ☐ Dissociative state
- ☐ Elevated mood
- ☐ Impaired judgment
- ☐ Hyperactivity
- ☐ Impulsiveness
- ☐ Grandiosity
- ☐ Distractibility
- ☐ Fears
- ☐ Irritability
- ☐ Anger
- ☐ Delusions
- ☐ Paranoia
- ☐ Hallucinations: ____ AH ____ VH
- ☐ Agitation
- ☐ Withdrawn
- ☐ Memory loss
- ☐ Confusion
- ☐ Delirium
- ☐ Binging
- ☐ Purging
- ☐ Weight change: ____ ↑ ____ ↓
- ☐ Somatic complaints
- ☐ Grief
- ☐ Oppositional
- ☐ Physical fighting
- ☐ Learning disability
- ☐ Marital conflict
- ☐ Family conflict

Symptoms have been present for:
☐ < 1 Mo ☐ 1-6 Mos ☐ 7-12 Mos ☐ > 1 Yr

☐ Physical/Sexual Trauma Victim At What Age: _____
☐ Physical/Sexual Trauma Perpetrator

Legal problems: _____

Substance Abuse (including substance, amount, and frequency):

_____

_____

B. Psychiatric Treatment History:

- ☐ None
- ☐ Outpatient
- ☐ Intensive Outpatient Program
- ☐ Partial Hospitalization Program
- ☐ Inpatient
  - ☐ w/in past 12 mos
  - ☐ 2 or more admissions

C. Current Medications:

Is patient prescribed psychotropic medication? ☐ Yes ☐ No

If Yes, indicate problems/conditions treated:

_____

_____

List all current psychotropic medications, dosage and frequency.

_____

_____

Is patient compliant with medication? ☐ Yes ☐ No

Prescribing provider: ☐ Psychiatrist ☐ PCP ☐ Pediatrician ☐ Other

D. Other Pertinent Medical Information:

E. Current Risk Assessment (Check all that apply):

Suicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt
Describe:_____

Homicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt
Describe:_____

Other dangerous or self-injurious behaviors: _____

F. Current Level of Functioning (Please rate level of impairment in each area):

	None	Minimal	Mild	Moderate	Severe	Profound	Comments
Marriage/family	0	1	2	3	4	5	_____
Work/school performance	0	1	2	3	4	5	_____
Social	0	1	2	3	4	5	_____
Activities of daily living	0	1	2	3	4	5	_____

Other Factors / Pertinent Information Impacting Treatment:

_____

_____

Patient Name: _____

G. Treatment Plan (Must be behaviorally measurable and have an expected time frame for achievement):

Goal #1 _____

Objectives:

1

2

3

Goal #2 _____

Objectives:

1

2

3

Goal #3 _____

Objectives:

1

2

3

Alternate plan should the patient fail to progress as expected:

H. DSM 5 Diagnoses:

_____

_____

_____

_____

I. Treatment Services Requested At This Time:

	# Sessions / Frequency
☐ Individual Therapy (90834/37)	_____
☐ Brief Individual Therapy (90832)	_____
☐ Family Therapy (90846/47)	_____
☐ Marital / Couples Therapy (90847)	_____
☐ Group Therapy (90853)	_____
☐ Other/CPT Code: _____	_____

Estimated TOTAL number of sessions to complete treatment: _____

J. Other Services Recommended:

☐ None
☐ Family
☐ Marital / Couples
☐ Group
☐ AA / NA
☐ Other Support Group: _____
☐ Psychological Testing
☐ Substance Abuse Assessment
☐ Medication Evaluation
☐ Intensive Outpatient Program
☐ Partial Hospitalization
☐ Inpatient Treatment
☐ Other: _____

Provider Name: _____ **Date:** _____

CLINICAL PROGRESS REPORT

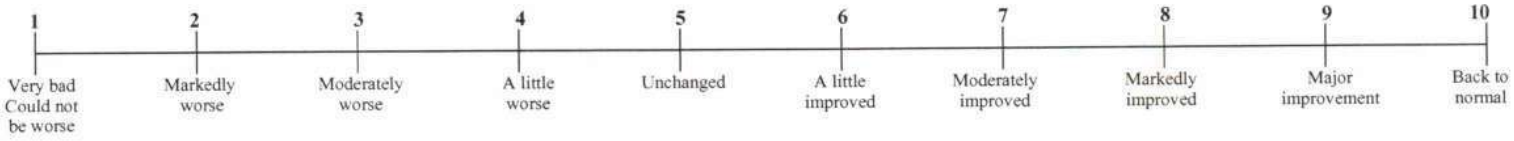
PATIENT NAME: _____ PROVIDER NAME: _____

INSURED'S EMPLOYER: _____

The purpose of this report is to identify patient's progress or lack of progress on specified goals and objectives, signs and symptoms, and level of functioning. HIPAA allows release of this information for payment purposes.

Date: ____/____/____ Duration: _____ (minutes) Score this visit: _____ (see scale below)	PROGRESS/OBSERVATIONS: GOALS ADDRESSED: GOALS/PLANS FOR NEXT VISIT: _____ PROVIDER SIGNATURE
Date: ____/____/____ Duration: _____ (minutes) Score this visit: _____ (see scale below)	PROGRESS/OBSERVATIONS: GOALS ADDRESSED: GOALS/PLANS FOR NEXT VISIT: _____ PROVIDER SIGNATURE
Date: ____/____/____ Duration: _____ (minutes) Score this visit: _____ (see scale below)	PROGRESS/OBSERVATIONS: GOALS ADDRESSED: GOALS/PLANS FOR NEXT VISIT: _____ PROVIDER SIGNATURE

Instructions: Refer to the scale below and indicate above the score that best describes the patient's overall condition at the time of each visit.



NOTE: IF PATIENT'S CONDITION WARRANTS A REVIEW OF THE TREATMENT PLAN, ITS DURATION OR FREQUENCY, PLEASE CONTACT THE BHS CLINICAL CASE MANAGER.

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ADDITIONAL CLINICAL NOTES

Patient Name: _____ Date of Birth: _____-_____-_____ Today's Date _____

Insured Employer: _____ Provider Name, Licensure: _____

These notes pertain to the following **date of service**: _____

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PATIENT INFORMATION

ABOUT THE PATIENT:

Name (L/F/M): _____
Patient SS#: _____
Home Address: _____
_____
Home Phone #: _____
Office Phone#: _____
E-Mail Address: _____
Emerg. Contact: _____
Date of Birth: _____
Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Separated
Sex: ❑Male ❑Female
Relationship to Insured: ❑ Self ❑ Spouse ❑Child ❑Other
Other Insurance Coverage: _____
Patient's Legal Guardian: _____ (if applicable)

ABOUT THE INSURED:

Name (L/F/M): _____
Insured SS#: _____
Home Address: _____
_____
Home Phone #: _____
Office Phone#: _____
Date of Birth: _____
Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Separated
Employer Name: _____
Hire Date: _____
Type of Coverage: ❑Individual ❑Family ❑Indiv & Spouse

Guardian Relationship to Patient: _____ Referred By: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to disclose my individually identifiable health information to the utilization agents of BHS. The health information to be provided includes information as to diagnosis, treatment and prognosis regarding my mental/nervous/substance abuse condition and/or treatment. It does not include the release of actual psychotherapy notes. I understand BHS will use this information for purposes of approval of coverage, processing of claims for benefit purposes, and other payment and health care operations.

Information to be provided: ❑Clinical Assessment, ❑Recommended Treatment Plan, ❑Progress Notes for dates of service related to the Recommended Treatment Plan, ❑Complete Medical Record dated _____.

I understand that: (a) I may keep a copy of this form after I sign it, and/or I may request a copy from BHS; (b) treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization; (c) the information used or disclosed under this authorization may be subject to redisclosure by BHS and no longer protected by federal privacy regulations; and (d) I may revoke this authorization at any time by notifying BHS in writing, as described below. This will not affect any action BHS took prior to receiving the revocation.

I understand that this authorization will expire on the earlier of (a) the date set by applicable state law, or (b) completion of the recommended treatment and all related payment activities.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of personal representative Relationship to patient

If you have any questions or wish to revoke this authorization, please contact the Vice President, Clinical Services, at the address/phone number shown below.

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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 ☐ 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 _____

PHYSICIAN OR SUPPLIER INFORMATION

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 MM DD YY

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.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

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