UPMC *for You*

Affiliate of UPMC Health Plan

Example of a completed claim for a 6-year EPSDT visit

PICA

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

1a. INSURED'S ID NUMBER (For Program in Item 1): 00987654302

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane, A.

3. PATIENT'S BIRTH DATE MM DD YY: SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, JANE, A.

5. PATIENT'S ADDRESS (No., Street): 199 SOUTH FRANKLIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 199 SOUTH FRANKLIN STREET

CITY: WASHINGTON — STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: WASHINGTON — STATE: PA

ZIP CODE: 16111 — TELEPHONE (Include Area Code): (724) 555-1212

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 [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 15 09 — SEX M [ ] F [X]

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

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: UPMC FOR YOU

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: YD

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

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

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

1. Z00 . 129
2. _____ . _____
3. _____ . _____
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	10	15	15	10	15	15	11		99383	EP		85 00		03	NPI	
2	10	15	15	10	15	15	11		99173	EP					NPI	
3	10	15	15	10	15	15	11		92552	EP					NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX ID NUMBER: 191919191 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 25647651

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] 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. NPI b.

33. BILLING PROVIDER INFO & PH # (724) 555-1212

DOCTOR'S OFFICE
66 PEDIATRIC STREET, WASHINGTON, PA 16111

a. 1111111111 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

UPMC *for You* encourages electronic claims submissions.

UPMC *for You*

Affiliate of UPMC Health Plan

Example of a completed claim for a 2-3 month EPSDT visit

CARRIER

PICA

PICA

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

1a. INSURED'S ID NUMBER (For Program in Item 1): 00111111101

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN, H

3. PATIENT'S BIRTH DATE MM DD YY: SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN, H

5. PATIENT'S ADDRESS (No., Street): 1 FRONT STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1 FRONT STREET

CITY: PITTSBURGH | STATE: PA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: PITTSBURGH | STATE: PA

ZIP CODE: 16111 | TELEPHONE (Include Area Code): (724) 555-1212

ZIP CODE: 16111 | TELEPHONE (Include Area Code): (724) 555-1212

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 [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 08 01 15 SEX M [X] F [ ]

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

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: UPMC FOR YOU

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO 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 [X] $ CHARGES

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

1. Z00 . 129

2. _____ . _____

3. _____ . _____

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	10 15 15	10 15 15		11		99381	EP			85 00		03	NPI	
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX ID NUMBER: 191919191 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 25647651

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] 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. NPI b.

33. BILLING PROVIDER INFO & PH # (724) 555-1212

123 Pediatrics
999 Johnston Street, Pittsburgh, PA 15444

a. 9876543219 b.

NUCC Instruction Manual available at: www.nucc.org

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

UPMC *for You* encourages electronic claims submissions.