1500

NEW YORK STATE | The Empire Plan

Please submit claims to:
Carelon Behavioral Health
P.O. Box 1850 Hicksville,
NY 11802

HEALTH INSURANCE CLAIM FORM

New York State Government Employees Health Insurance Program

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

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. 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. 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCT10NS ISSUED BY APPLICABLE PROGRAMS.

NOT1CE: Any parson who knowingly fllaa a slalamanlof claim containing any misrepresentation or any false, lncomplata or misleading Information may be guilty of a criminal act punishable under , __ and may be subject to civil panaHies.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TAICAAE 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 inlonnation 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 nonmedicalinlonnation 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 CFA 411.24(a). If Item 9 Is completed, the patient's signature aLnhortzes release of the Information to the health plan or agency shown. In Medicare assigned or TRICI\RE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intennediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-aJVered services. Coinsurance and the deductible are based upon the charge detennination of the Medicare carrier or TAICI\AE fiscal intermediary if this is less than the charge submitted. TAICAAE is not a health insurance program bLn makes payment for health benefits provided through certain affiliations with the Uniformed Services. Inlonnation 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.

SIGNAI\JRE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submtnlng this claim lor payment from federal funds, I certify that: 1) the Information on this fonn Is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient infonnation required to allow the government to make an inlonned eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions lor payment including bin not limited to the Federalanti-kickbaclk statute and Physician Sell-Referral law (commonly known as Stark law); 5} the services on this fonn were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly pennitted by Medicare or TRICARE; 6} for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1} they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an Integral, although Incidental part of a covered physician service, 3) they must be of kinds commonly furnished In physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TAICAAE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Unlfonned Services or a cMIlan employee of the United States Government or a contract employee of the United States Government, either cMiian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services perfomned were lor a Black Lung-related disorder.

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

NOTICE: Any one who misrepresents or falsifies essentialInformation to receive payment from Federal funds requested by this fonn may upon conviction be subject to line and Imprisonment under applicable Federal laws.

NOTICE TO PAT1ENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMAT10N (PRIVACY ACT STATEMENT)

We are aLnhorized by CMS, TRICARE and OWCP to ask you for inlonnation needed in the administration of the Medicare, TRICARE, FECA, and Blaclk Lung programs. Authority to collect infonnation 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 infonnation we obtain to complete claims under these programs is used to identify you and to detennine 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 infonnation 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 Federalprogram, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose infonnation aboLn the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses lor infonnation 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 TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility lor medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the servicesfsupplies received are aLnhorized 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 TRICAREICHAMPVA; 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 indMdual 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 TRICI\RE.

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

IIIs mandatory that you tell us If you know that another party Is responsible for paying lor your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties lor withholding this infonnation.

You should be aware that P.L. 10Q-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify Information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERT1FICATION)

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 lull, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of aLnhorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPUER): 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 prosecLned under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number lor this information collection is 0938-1197. The time required to complete this inlonnation collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the infonnation collection. If you have any comments concerning the accuracy of the time estimate(s} or suggestions for improving this fonn, please write to: CMS, 7500 Security Boulevard, Attn: PAA Reports Clearance Officer, Mail Stop C4-26-<15, Baltimore, Maryland 21244-1850. This address is lor comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Tips for Completing the CMS-1500 Claim Form

This document is to help you provide valid information for timely payment of your claim.

Please review this guide and/or access the National Uniform Claim Committee's (NUCC) 1500 Health Insurance Claim Form Reference Instruction Manual. It is available at www.nucc.org

Claim Forms

☐ Submit only the CMS-1500 (02-12) claim form.

☐ You may order additional forms at www.achievesolutions.net/empire.

Submitting Paper Claims

Carelon Behavioral Health
P.O. Box 1850
Hicksville, NY 11802

General Guidelines

Complete the forms with the following tips in mind:

☐ Type or print all information. Entries should be in black ink.

☐ Do not highlight the claim form or attachments—it is hard for the scanner to read.

☐ The form should be free of mistakes. If corrections are made, complete a new form.

☐ Capitalize alpha characters. Do not use commas to separate numerical thousands. Do not use special characters (such as, dollar signs, decimals, or dashes).

☐ Do not type, write, or staple on the bar-code area.

☐ Do not use adhesive labels or a rubber stamp in any fields on the form.

☐ Enter the name and address of the payer in the white, open carrier area:

1st line: Name (last name, first name, middle initial)

If there is a suffix (for example, Jr, Sr) enter it after the last name, but before first name.

2nd line: First line of address

3rd line: Second line of address, if necessary

4th line: City, state (2 letters), and zip code

☐ Enter all dates using an eight-digit date format (for example, May 1, 2016 is 05/01/2016).

Form Completion Details

Legend: R: Required information
O: Not required, optional
C: Conditional, only use if helpful for specific to claim
N/R: Information not required

1. Type of health insurance coverage (O): Show the type of health insurance coverage applicable to this claim by checking the appropriate box (for example, if a Medicare claim is being filed, check the Medicare box).

1a. Insured's ID number (R): This must match the ID on the insured's ID card (i.e. 890XXXXXX)

2. Member's name (R): Enter the patient's last name, first name, and middle initial.

3. Member's birthdate and gender (R): Use the eight-digit format (MM/DD/CCYY) for birthdate. Enter an "X" to indicate the sex of the member. If gender is unknown, leave blank.

4. Insured's name (R): Enter the insured's last name, first name, and middle initial. This must match the name on the insured's ID card.

5. Member's information (R): Enter the patient's current mailing address and telephone number.

6. Member's relationship to the insured (R): Check the appropriate.

7. Insured's information (R): Enter the insured person's mailing address—only if different from the patient's address.

8. Reserved for NUCC use (N/R)

9. Other insured's name (C): If applicable, enter the other insured person's last name, first name, and middle initial. Required if field 11d is marked "yes."

9a. Other insured's policy or group number (C): Enter the other insured person's policy or group number.

9b. Reserved for NUCC use (N/R)

9c. Reserved for NUCC use (N/R)

9d. Other insured's insurance plan or program name (C): Enter the other insured person's insurance company or program name.

10a. Select whether the member's condition is related to employment (R).

10b. Select whether the member's condition is related to an auto accident and enter the state in which the accident occurred (R).

10c. Select whether the member's condition is related to any other type of accident (R).

10d. Claim codes designated by NUCC (N/R).

11. Insured's policy, group, or FECA number (O): Enter the insured's policy or group number as it appears on the insured's ID card.

11a. Insured's birthdate and sex (C): Required if the member is not the insured.

11b. Other claim ID designated by NCUU (C)

11c. Insurance plan name or program name (C): Enter the insured's insurance company or program name.

11d. Is there another health benefit plan? (R): Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim. If "yes," make sure you completed items 9, 9a, and 9b.

12. Member's or authorized person's signature for Medicaid/other information release (R): The member's signature authorizes release of medical information necessary to process the claim.

13. Insured's or authorized person's signature (C): The signature authorizes payment of benefits to the physician or supplier. If payment is authorized to the physician or supplier payment will be sent directly to the physician or the supplier. The member should not pay the provider directly, as a result.

14. Date of current illness, injury, or pregnancy (N/R)

15. Other dates (N/R)

16. Dates member was unable to work in current occupation (C): Required if member is eligible for disability or worker's compensation benefits due to this illness.

17. Name of referring physician or other source (C): Enter if applicable.

17a. ID number of referring physician (C): Not required, reserved for taxonomy code.

17b. NPI (R): Enter the 10-digit NPI number of the referring or ordering physician.

18. Hospitalization dates related to current services (C): List if claim includes charges for services rendered during an inpatient admission.

19. Additional claim information designated by NUCC (N/R)

20. Outside lab/charges (C): Select "yes" if lab test performed and billed on this claim were processed by a lab outside the physician's office and enter the amount.

21. Diagnosis or nature of illness or injury (R): Enter the ICD-CM codes in fields 1-4, with the primary diagnosis first, followed by other diagnoses (if applicable).

22. Medicaid resubmission code/original reference number (C): List the original claim number for resubmitted claims.

23. Prior authorization number (N/R)

24. Supplemental information in fields a-h: For more information, see the National Uniform Claim Committee's Web site at www.nucc.org.

24a. Date(s) of service (R): Line items can include no more than two dates of service for the same procedure code. Grouping is allowed only for services on consecutive days.

24b. Place of service (R): Enter the appropriate two-digit Place of Service code (see last page).

24c. EMG (N/R)

24d. Procedures, services, or supplies (R): Enter a valid CPT or HCPCS code for each service rendered.

24e. Diagnosis pointer (C): Enter the diagnosis code(s) for each procedure performed—only one code per line of service.

24f. Charges (R): Enter the provider's billed charges for each service.

24g. Days or units (R): Enter the number of days or units that match the dates indicated on 24a.

24h. EPSDT family plan (C): If service was rendered as part of or in response to an EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) panel, mark an "X."

24i. ID qualifier (C): Reserved for taxonomy code qualifier, "ZZ."

24j. Rendering provider ID number (C): Enter the non-NPI ID in the shaded area of the field, the NPI number in the non-shaded area.

25. Federal tax ID number and type (R): Enter the nine-digit for SSN or EIN under which payment for services is to be made for reporting earnings to the IRS.

26. Member's account number (O): Enter the unique member number assigned by the provider.

27. Accept assignment? (C): Enter an "X" in the appropriate box.

28. Total charge (R): This is the total of all charges for each service noted in field 24f.

29. Amount paid (C): Enter the total amount paid by the member for services billed on this claim.

30. Reserved for NUCC use (N/R)

31. Signature of physician or supplier, including degrees or credentials (R): The person rendering care must sign and indicate licensure level.

32. Name and address of facility where services were rendered

32a. (R): This must be a street address and not a P.O. box. from the billing provider NPI.

32b. Other ID number (N/R)

33. Physician's or supplier's billing information (R): Enter the name, address, zip code, and phone number.

33a. NPI number (R): Enter the NPI of the billing provider or group.

33b. Other ID number (N/R)

Empire Plan Covered Place of Service Codes

Codes	Definitions
02	Telehealth
03	School
11	Office
12	Home
13	Assisted living facility
14	Group home
19	Off campus outpatient hospital
21	Inpatient hospital
22	On campus outpatient hospital
23	Emergency room-hospital
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
49	Independent clinic
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
55	Residential substance abuse treatment center
56	Psychiatric residential treatment center
57	Non-residential substance abuse treatment facility
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
81	Independent laboratory
99	Other place of service

Other Information

All data elements noted as required must be provided, but they must also be current and match what the subscriber's employer has on file. If the member's ID on the claim is illegible, or does not match what the subscriber's employer has provided, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the member's ID card, and validate that it is current at the time of each visit.

There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered "clean." To be "clean," the claim must not have any issues that might cause payment delays. Claims that are not submitted on a CMS 1500 2012-02 often will not contain the information we need to consider the claim clean and will cause the claim to take a longer processing time. Claims submitted on old claim forms may be returned.

Electronically submitted claims must also be in a HIPAA 5010 compliant format and conform to the Carelon Behavioral Health companion guide to be considered clean. If you have questions or need assistance, please contact your Beacon representative.

Claims Form Submission Timely Filing Requirements

A. If you use a Participating Provider, your Provider will typically submit a claim to the Program Administrator. Claims must be submitted within 120 days from the date of service.

B. If you use a Nonparticipating Provider, claims must be submitted no later than 120 days after the end of the Calendar Year in which Covered Medical Expenses were incurred or 120 days after Medicare or another plan processes your claim.

However, you may submit claims later if it was not reasonably possible for you to meet this deadline (for example, due to your illness); you must provide documentation.