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 1500 claim form

Client information

Box1: 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 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"

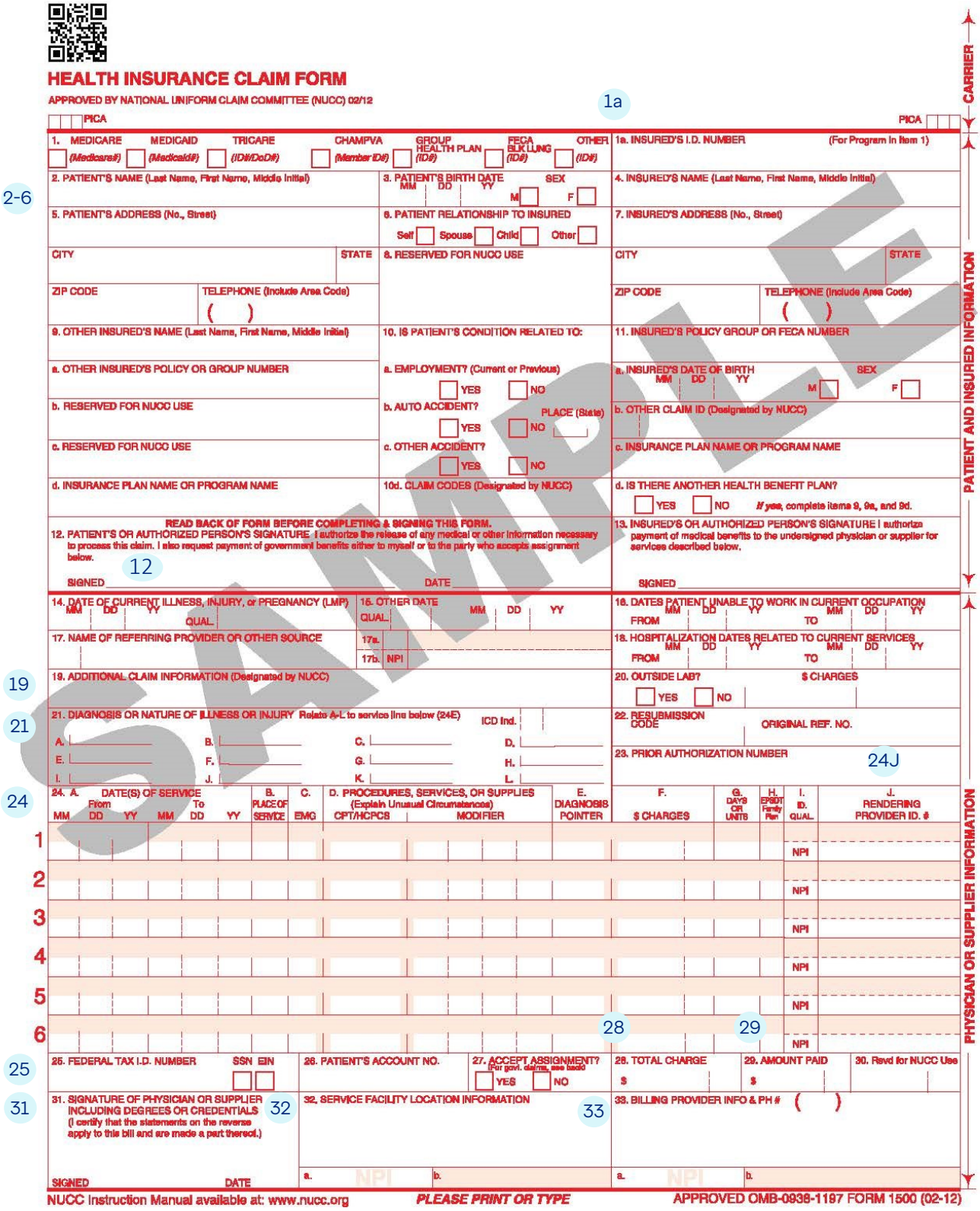
Box 28: Total charge for all services (lines 24a., 1-6) rendered

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

Box32: 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.

1500 claim type image



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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 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. 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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1a 2-6 12 19 21 24 24J 28 29 25 31 32 33

SAMPLE

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.

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

PICA

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): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1993 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

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

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

CITY: Wonderful World STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 54321 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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 Signature on File DATE 12/15/2023

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 Signature on File

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): Corrected Claim or Intern Name - Only Use When Applicable

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. F43.10 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	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		90837	TU 95	A.	150.00	1		NPI	5279384
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 88-8888888

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 475.00

29. AMOUNT PAID $ 0

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.)

Termy Prov LMFT

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

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

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.

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM 04 DD 01 YY 2016 SEX M ☒ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyworld Avenue

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

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

CITY: Wonderful World STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 54321 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 Signature on File DATE 12/15/2023

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 Signature on File

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): Corrected Claim or Intern Name - Only Use When Applicable

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. F43.10 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	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		90837	95	A.	150.00	1		NPI	5279384
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 88-8888888

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 475

29. AMOUNT PAID $ 0

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 Termy Prov LMFT DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

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

INE

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

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 (X) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM 05 DD 01 YY 1990 SEX M (X) F ( )

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Wonderful World STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 54321 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 Signature on File DATE 12/15/2023

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 Signature on File

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): Corrected Claim or Intern Name - Only Use When Applicable

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. F43.10 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	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															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 88-8888888

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 400.00

29. AMOUNT PAID $ 0

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.)

Termy Prov LMFT

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

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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

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.

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.

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE ( ) (Medicare#) MEDICAID ( ) (Medicaid#) TRICARE ( ) (ID#/DoD#) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (ID#) FECA BLK LUNG ( ) (ID#) OTHER (X) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Medi-Cal Policy ID or CFWB State ID

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1993 SEX M (X) F ( )

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Wonderful World STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 54321 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 Signature on File DATE 12/15/2023

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 Signature on File

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): Corrected Claim or Intern Name - Only use when applicable

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. F43.10 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	12	15	23	12	15	23	02		90791	95	A.	175.00	1		NPI	5279384
2	12	22	23	12	22	23	10		90847	TU 95	A.	150.00	1		NPI	5279384
3	12	23	23	12	22	23	02		T1017	93	A.	30.00	1		NPI	5279384
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 88-8888888

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 355.00

29. AMOUNT PAID $ 0

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.)

Termy Prov LMFT

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555

Termy Prov, LMFT
123 Healing Rd.
Sun Diego, CA 92108

a. NPI b.

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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

PICA

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 (X) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): CFWB State ID

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

3. PATIENT'S BIRTH DATE MM 07 DD 01 YY 1972 SEX M (X) F ( )

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

5. PATIENT'S ADDRESS (No., Street): 1234 Disneyland Way

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Wonderful World STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 54321 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 Signature on File DATE 12/15/2023

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 Signature on File

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

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17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected Claim or Intern Name - Only Use When Applicable

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. R69 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	12	15	23	12	15	23	11		99499		A.	200. 00	1		NPI	5279384
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 88-8888888

26. PATIENT'S ACCOUNT NO.:

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

28. TOTAL CHARGE $ 200. 00

29. AMOUNT PAID $ 0

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.)

Termy Prov PhD

SIGNED DATE 12/23/23

32. SERVICE FACILITY LOCATION INFORMATION

Termy Prov, PhD
123 Healing Rd.
San Diego, CA 92108

a. NPI b.

33. BILLING PROVIDER INFO & PH # (619) 555-5555

Termy Prov, PhD
123 Healing Rd.
San Diego, CA 92108

a. NPI b.

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