QUEST Integration Provider Education

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Learning Objectives

QUEST Integration Program

- Care Management Model / Role of QUEST Integration Support Team (Pages 3-4)
- Commitment to Quality (Page 5)
- Provider Grievance, Complaint and Appeal Process (Pages 6-7)
- Cultural Competency (Page 8)
- Provider Responsibilities (Page 9)
- Role of the PCP (Page 10)
- Provider Contracting (Page 11)
- Fraud, Waste and Abuse (Page s 12-14)
- Reporting Requirements (Page 15)
- The Health Plan's medical records documentation requirements (Page 16)
- Methods of KP's Updates (Page 17)
- Authorization & Referral Management (Pages 18-22)
- Prior Authorization Process and Requirements (Page 23)
- Claims Submission Process (Page 24)
- Helpful Tips for Billing (Page 25)
- Completing a CMS-1500 & UB04 Form (Pages 26-45)
- Contact Information (Page 46)

Your KP Team

Care Management Model / Role of QUEST Integration Support Team

- **Role of Service Coordinators**
  - Perform face-to-face Health and Functional Assessments
  - Develop and implement care plan with member
  - Support PCP and other providers in providing quality medical care
  - Encourage member to participate in own health and goals
  - Refer members to community and other programs or agencies when services are not available at Kaiser
  - Provide continuity of care when members transition to other programs
  - Assist member in accessing care and services at Kaiser
  - Provide care coordination and management for members with special health care needs
  - Supplementing and NOT duplicating other services
  - Service Coordinators work closely with the clinic and hospital teams

Continue: Your KP Team

Care Management Model / Role of QUEST Integration Support Team

- **Can help QI members:**
  - Understand their health plan benefits
  - Make appointments and access services
  - Become familiar with other community agencies when needed
- **Can help providers by:**
  - Coordinating timely access and use of medical services
  - Tracking compliance and assisting with education

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Kaiser Permanente: Commitment to Quality

- QUEST Integration's Quality Improvement (QI) Program encompasses all quality improvement activities within the health plan, including programs / standards that focus on:
  - Improve health outcomes by integrating programs and benefits
  - Clinical quality
  - Access and affordability
  - Streamline care when health status change
  - Customer service and operational excellence

Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to
QUEST members

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Provider Grievance, Complaint and Appeal Process

Member Grievance and Appeal Rights

- **Member Rights and Responsibilities are outlined in the QI Member Handbook. They include, but are not limited to:**

- The member's right to file grievances and appeals and their requirements, and timeframes for filing;

- The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;

- The availability of assistance in filing a grievance or an appeal;

- The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent to do so;

- The toll-free numbers to file a grievance or an appeal; and

- When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the health plan's adverse action is upheld

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Continue…

- **Member feedback and complaints-several options outlined in the member manual**

  - Talk with doctor, nurse, or patient advocate in the clinic or hospital
  - Fill out 'Let us hear from you' form in the clinic
  - Write to the Customer Service Center
  - Call Customer Service Center at **432-5955 (Oahu)**; toll-free at **1-800-966-5955** or **TTY** through **711 or 1-877-447-5990**. Someone can help write the complaint.
  - Ask Service Coordination team for help by calling **808-432-5330 (Oahu)** or toll-free at **1-800-651-2237.**

- **At a minimum, Kaiser must:**

  - Have systems that includes a grievance and appeals process
  - Provide members, or authorized representative, reasonable assistance in completing forms and taking steps related to the member grievance system
  - Meet specific time-frames to comply in making decisions about the disposition of grievances and appeals
  - Refer to the State's grievance and appeals systems, any grievances and appeals not resolved through the health plan
  - Provide information on How to File Grievances and Appeals with the State

Cultural Competency

- Multi-faceted cultural competency strategy
- Deliver the highest quality of care to every member, regardless of:
  - Race
  - Ethnicity
  - Language
  - Cultural background
  - Religion
- Increase cultural awareness within our work environment, as well as within our provider network.

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Provider Responsibilities

- As health care professionals involved in the members' care, providers have many responsibilities.

  - Administrative/Contractual
  - Member-Related
  - Reporting

- Our QUEST Integration network includes health care providers of all types and specialties.
  - Primary Care Physicians
  - Specialists
  - Hospitals
  - Skilled Nursing Facilities
  - Hospice
  - Home and Community Based Service (HCBS) providers
  - Community Care Foster Family Home (CCFFH) formerly known as RACC.
  - Behavioral Health providers
  - Transportation

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Role of the PCP – Primary Care Physician

The PCP is responsible for:

- Supervising, coordinating, and providing all primary care to each assigned member
- Coordinating and initiating referrals for specialty care (both in and out of network)
- Maintaining continuity of each member's health care
- Maintaining member's medical record that includes documentation of all services provided by PCP

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Provider Contracting

- Ongoing Extensive provider training and support

  - Orientation for new providers (in person or telephone)
  - Provider Education sessions twice a year
  - Notification of changes via newsletters, websites and individual mailings.
  - If additional provider education is required, please contact your QI Contract Manager.

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Fraud, Waste and Abuse

Like all of us in Hawaii, Kaiser Permanente recognizes that acting responsibly with our resources is critical to our success. In addition, the Deficit Reduction Act of 2005 requires us to formally show our resolve in combating fraud, waste and abuse, especially in the administration of Federal and State health care programs such as Medicare and Medicaid. Therefore, Kaiser has revised the three policies described below. The Deficit Reduction Act requires that we make these policies available for all physicians, employees and you, our outside network partners.

1. **Providing Information for Combating Fraud, Waste and Abuse, The Ability of Employees to Report Wrongdoing:** This policy serves as a compendium of the existing tools that we, along with federal and state agencies and individuals, use to fight fraud, waste and abuse in the administration of federal and state health programs in our region. Examples of these tools include summaries of federal and state laws on false claims, and protection of employees who report suspected violations (including child and adult abuse). It also includes our own existing policies and procedures for detecting and preventing fraud.

Continue…

2. Prevention, Detection, and Correction of Fraud, Waste and Abuse: This policy articulates our commitment to control fraud, waste and abuse through prevention, detection and correction of any violation of a Federal or State law, regulatory requirement, contractual obligation or organizational policy or procedure.

3. Responsible Reporting of and Responding To Compliance / Ethics Concerns: This policy provides guidance regarding the internal reporting of compliance and ethics concerns, highlighting expectations of individuals who report concerns, and for the organization in responding to them. Additionally, it outlines our standards for investigation and corrective actions regarding violations of state or federal law, regulatory requirement, contractual obligation or organizational policy or procedure. Any retaliation can seriously undermine the reporting process; therefore, this policy also aims to protect employees and staff from retaliation when they make a good faith report.

Please contact Community Medical Services at (808) 432-7529 if you have any questions.

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To Prevent Fraud, Waste and Abuse

- Make a copy of the QUEST Integration Member ID card and photo ID before rendering services
- Validate member's current address, telephone number, and caregiver name prior to services at each visit

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Reporting Requirements

- **DHS requires the plan to maintain a health information system that integrates all data to evaluate and report statistical data related to:**

    - Quality
    - Utilization
    - Costs
    - Other matters (DHS may request from time to time)

- QUEST Integration contracted providers are required to submit complete and accurate encounter data (i.e. claims billed, medical records, etc.).

- The Health Plan may request medical records for the purpose of validating encounters or paying claims. Providers have 60 days from the date of request by the health plan or DHS to submit the medical records. Non-compliance may result in payment recovery from provider.

- Audits are conducted to ensure compliance.

- **Circumstances and situations under which provider may bill a member for services or assess charges or fees**

    - Member self-refers to a provider within the network without following Kaiser's procedures (e.g. without obtaining prior authorization) and Kaiser denies payment to the provider
    - Member requests and agrees to pay for a Medicaid non-covered service such as cosmetic dermatology
    - Member has a cost share

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The Health Plan's medical records documentation requirements

Copies of Records and Other Information:

To the extent permitted by Law and without charge, Provider shall promptly forward to KP and the applicable Payor (i) copies of initial consultation reports upon completion of such consultations and (ii) summaries of patient care or patient results upon completion of such patient care or discharge, both as directed by KP. Upon request and without charge, Provider shall promptly furnish to KP and the applicable Payor copies of Records, including medical records of Members transferred or repatriated following termination of this Agreement pursuant to Section 4.2 (Termination of this Agreement) or following suspension or exclusion of participation of a Practitioner or Facility under Section 4.3 (Suspension or Exclusion of Participation). Upon request and consistent with applicable Law, Provider shall transmit Records to KP and the applicable Payor by facsimile or other electronic means. Subject to reasonable request and notification, KP may arrange for copying of Records to which it/they is/are entitled under this Agreement through a copying service. In addition, Provider shall supply KP with periodic reports and other information (including Provider's policies and procedures, patient care protocols, any mutually agreed upon quality indicators, survey reports, investigations, assessments, formal evaluations or citations) pertaining to Covered Services provided to Members by Provider in such manner and time frames that enable KP to conduct its QI and UM activities and to meet all federal, state, accreditation and contractual reporting requirements (including with respect to QI and UM activities, and Delegated Activities). Upon request, Provider shall provide any data, information and records that KP is required to review for KP's QI and UM programs, licensing, accreditation, or otherwise as required by Law and KP's government contracts.

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Methods of KP's Updates:
To Providers on the Program and Health Plan Changes

- Face to face educational sessions every 6 months – recording available
- Individual meetings as requested and/or necessary
- Periodic provider education meetings
- Provider Newsletter
- Email announcements

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Authorizations & Referral Management

ARM

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ARM functions

- Pre-, concurrent & retro payment authorization decisions Intraregional including for our network providers on Kauai, Molokai, Lanai and National KP providers as well as non KP providers.
- Formal notification to referring KP and non-Kaiser providers and patients of denied services
- Risk identification – financial/utilization
- Referral guideline development
- Feed to QA line
- Coordinate/arrange for out of area inpt. admits to non KP facilities within US

- Serve as coordinator/advisor for KP Hawaii Transplant Committee
- Ensure that planned & referred services **comply with benefits** regulated and approved by the Dept. of Insurance prior to delivery of care.
- Ensure the referral **criteria/guidelines** are met.
- Assess **availability of** requested services **in-network**

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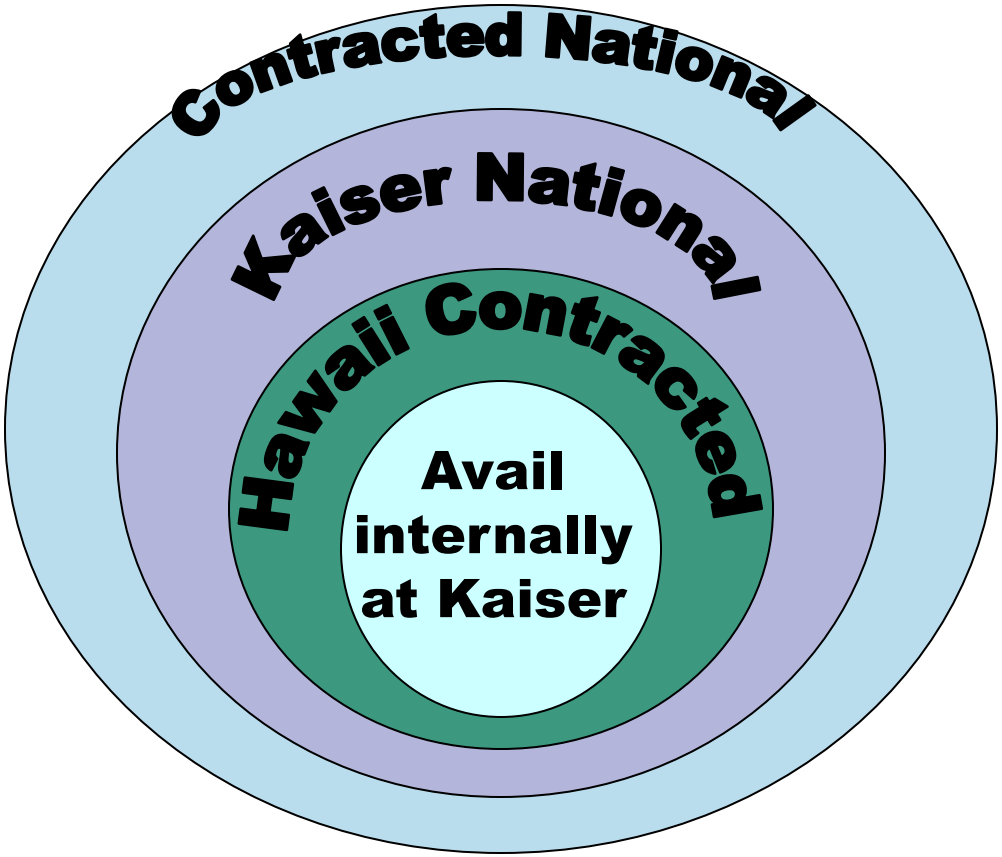
The Referral Triage Flow



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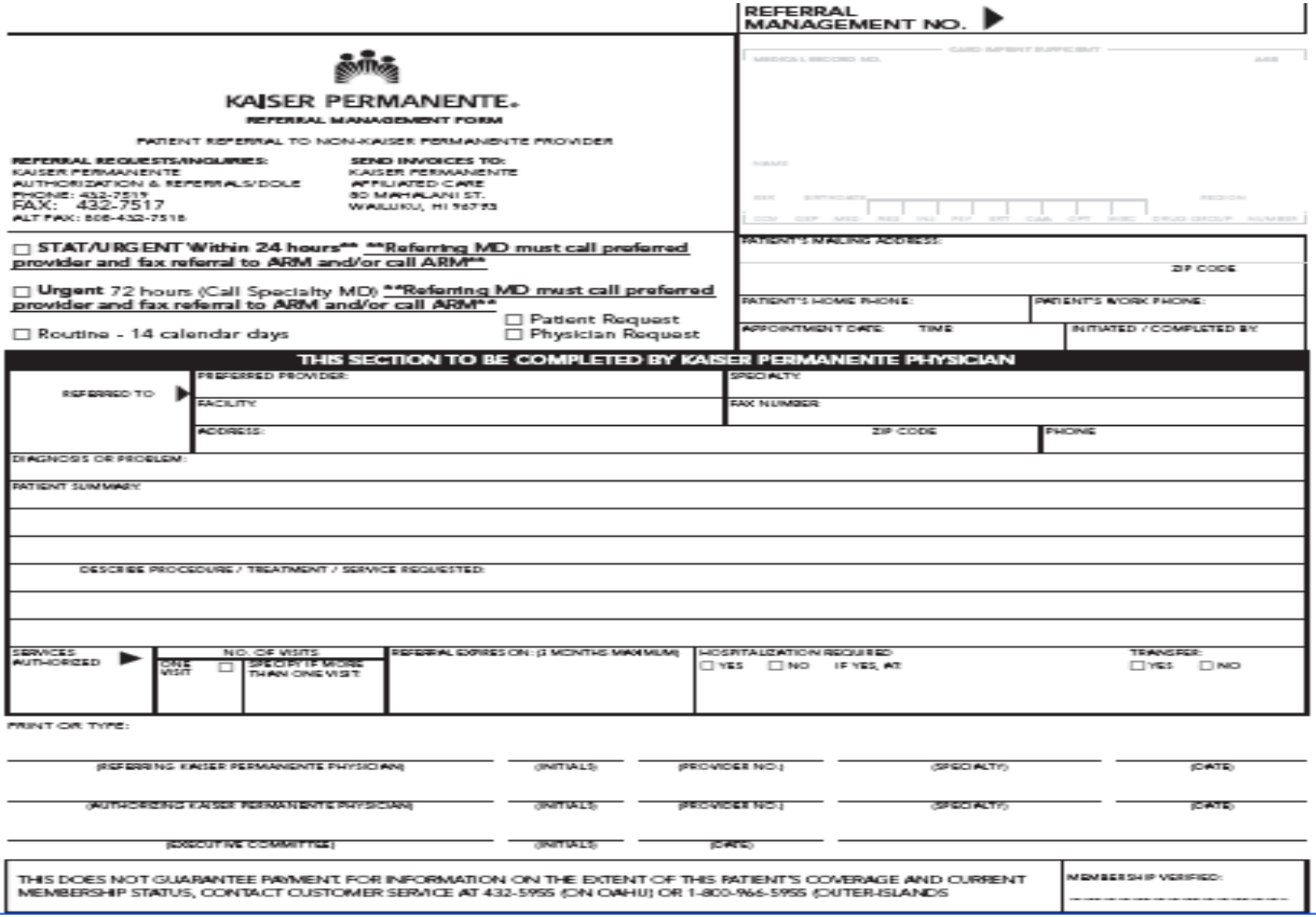
Referral Form



REFERRAL MANAGEMENT NO. ▶

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REFERRAL MANAGEMENT FORM

PATIENT REFERRAL TO NON-KAISER PERMANENTE PROVIDER

REFERRAL REQUESTS/INQUIRIES:
KAISER PERMANENTE
AUTHORIZATION & REFERRALS/DOLE
PHONE: 432-7517
FAX: 432-7517
ALT FAX: 808-432-7518

SEND INVOICES TO:
KAISER PERMANENTE
AFFILIATED CARE
60 MAHALANI ST.
WAILUKU, HI 96793

☐ STAT/URGENT Within 24 hours** **Referring MD must call preferred provider and fax referral to ARM and/or call ARM**

☐ Urgent 72 hours (Call Specialty MD) **Referring MD must call preferred provider and fax referral to ARM and/or call ARM**

☐ Routine - 14 calendar days

☐ Patient Request
☐ Physician Request

PATIENT'S MAILING ADDRESS:

ZIP CODE

PATIENT'S HOME PHONE:

PATIENT'S WORK PHONE:

APPOINTMENT DATE: TIME:

INITIATED / COMPLETED BY:

THIS SECTION TO BE COMPLETED BY KAISER PERMANENTE PHYSICIAN

REFERRED TO: ▶

PREFERRED PROVIDER:

SPECIALTY:

FACILITY:

FAX NUMBER:

ADDRESS:

ZIP CODE

PHONE:

DIAGNOSIS OR PROBLEM:

PATIENT SUMMARY:

DESCRIBE PROCEDURE / TREATMENT / SERVICE REQUESTED:

SERVICES AUTHORIZED ▶

NO. OF VISITS:
ONE VISIT ☐
SPECIFY IF MORE THAN ONE VISIT:

REFERRAL EXPIRES ON: (3 MONTHS MAXIMUM)

HOSPITALIZATION REQUIRED:
☐ YES ☐ NO IF YES, AT:

TRANSFER:
☐ YES ☐ NO

PRINT OR TYPE:

(REFERRING KAISER PERMANENTE PHYSICIAN) (INITIALS) (PROVIDER NO.) (SPECIALTY) (DATE)

(AUTHORIZING KAISER PERMANENTE PHYSICIAN) (INITIALS) (PROVIDER NO.) (SPECIALTY) (DATE)

(EXECUTIVE COMMITTEE) (INITIALS) (DATE)

THIS DOES NOT GUARANTEE PAYMENT FOR INFORMATION ON THE EXTENT OF THIS PATIENT'S COVERAGE AND CURRENT MEMBERSHIP STATUS. CONTACT CUSTOMER SERVICE AT 432-5955 (ON OAHU) OR 1-800-966-5955 (OUTER ISLANDS)

MEMBERSHIP VERIFIED:

Referral / Prior Authorization Process and Requirements

- **Prior Authorization: Call the Kaiser QI Service Coordinator office at 808-432-5330 or 1-800-651-2237 for:**
  - Any member needing LTSS / HCBCS
  - Ground transportation for medically necessary care on island of residence
  - Air and ground transportation, meals and lodgings for medically necessary care on another island or on the mainland

- **Referral Process is used for medical related services provided outside of KP : Call KP ARM / UM at 808-432-5687:**
  - Durable Medical Equipment (DME)
  - Home Care, home-based services
  - Extended Care services (SNF/ICF nursing home, rehab)

Claims Submission Process

- **Participating physicians/providers must submit claims on the member's behalf**
- **Claims filing timeline is one (1) year from the date of service or the receipt date of the primary payer's EOB**
- **Electronic Claims Submission: TBD**
- **Paper Claim**
  - Use a CMS 1500 for physician and ancillary claims
  - Use a UB04 for facility or hospital claims

Kaiser Permanente – Claims Department
P.O. Box 378021
Denver, CO 80237

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Helpful Tips for Billing

- **CMS 1500 Forms**
  - Provider name on the claim (box 33) must match the contracted business name
  - Bill for a span of time (max 1 month)
  - For dual eligible members, bill for gloves on a separate claim
  - Note correct place of service on claim (box 24b)
- **UB Forms**
  - Include discharge status code (box 17)
  - Refer to contract for specific billing requirements
  - The 'XX7' bill type must be included with corrected claims
- **NDC code information**
  - Required to accompany any claim when billing with HCPCS J codes (340(b) participating entities are exempt from this requirement)
  - Valid units of measure: F2 = International Unit; GR = Gram; ML = Milliliter; UN = Unit (Each)
  - Not valid units of measure: MG and CC
- **Corrected claims**
  - Hard copy corrected claims must have 'corrected claim' written at the top of the claim and all changes circled otherwise claim will be denied as a duplicate

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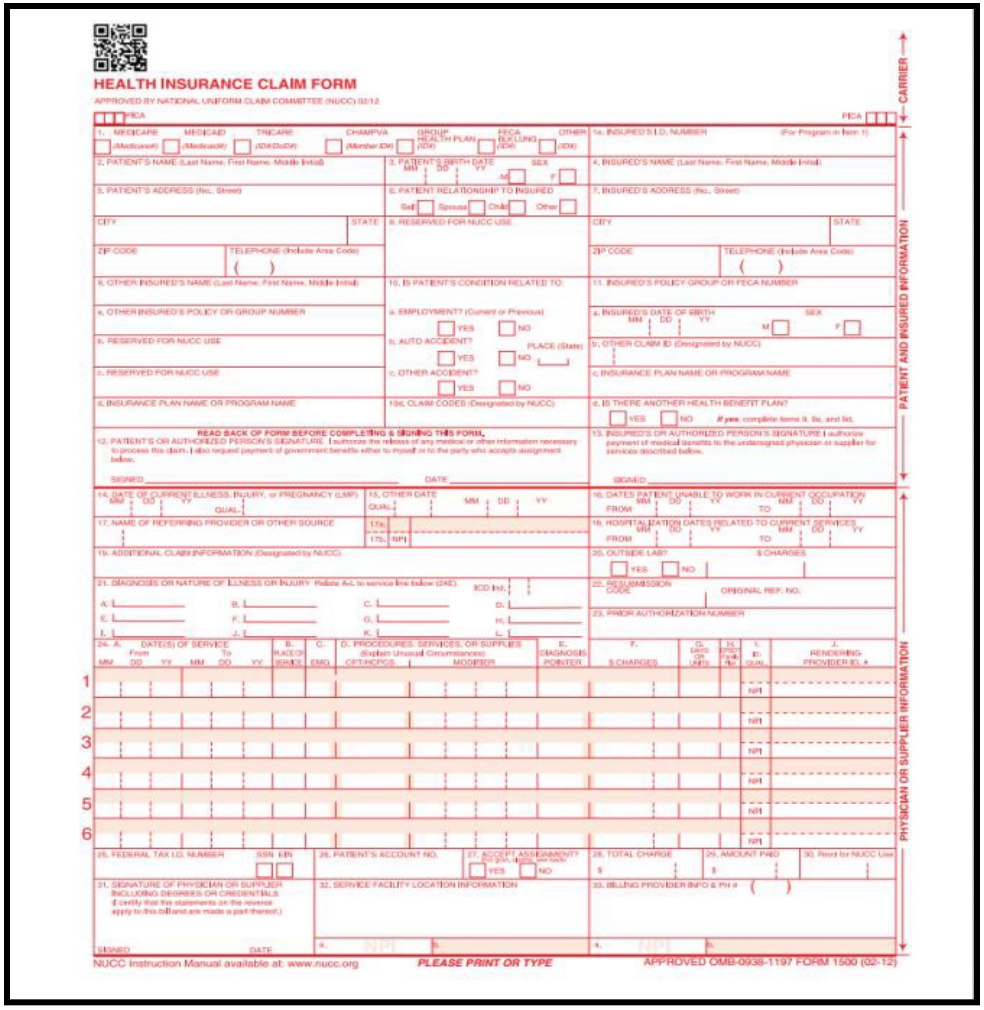
Completing A CMS-1500

CMS-1500 Form



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 MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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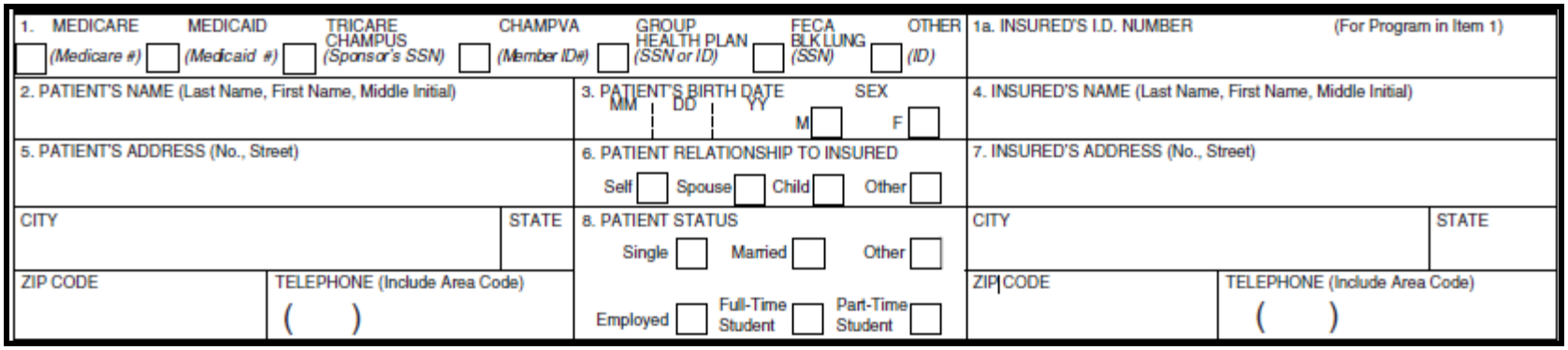
Patient Information

Box 1 – Enter an X in the box to indicate the type of plan being billed
Box 1a – Enter the Insured's ID Number
Box 2 - Last Name, First Name, Middle Initial (if any)
Box 3 - Date of Birth and Sex



Box 4 - Beneficiary Name (if different than the name in block 2)
Box 5 - Patient's Address
Box 6 - Patient's Relationship to Insured (used in conjunction with information on block 9)
Box 7 - Insured Address (used in conjunction with information on block 9)
Box 8 - Patient's Marital and Work Status

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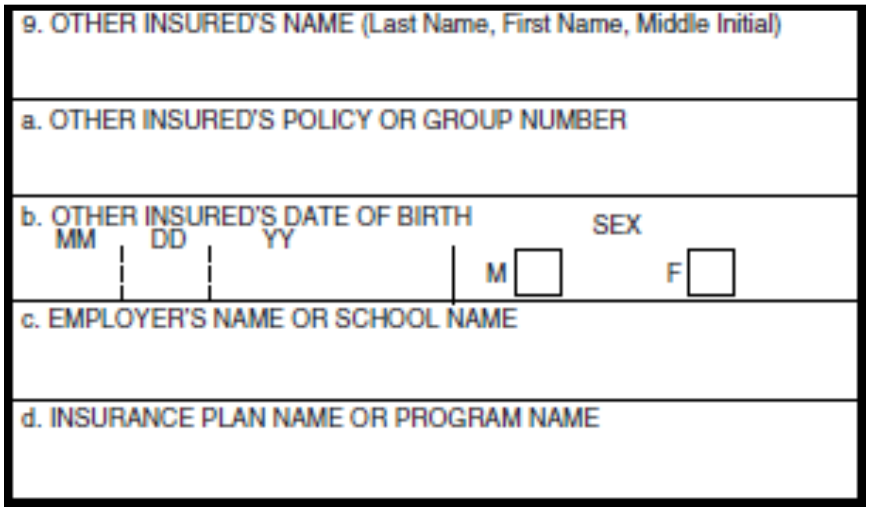
Other Insurance Information

Note: This section is completed if the Patient has other insurance (Dual Coverage)

Box 9 - Other Insured's Name. Enter the last name, first name, and middle initial of the enrollee in the other insurance policy
9a - Other Insured's Policy or Group Number
9b - Other Insured's Date of Birth, Sex
9c - Other Insured's Employer's Name
9d - Insurance Plan Name or Program Name



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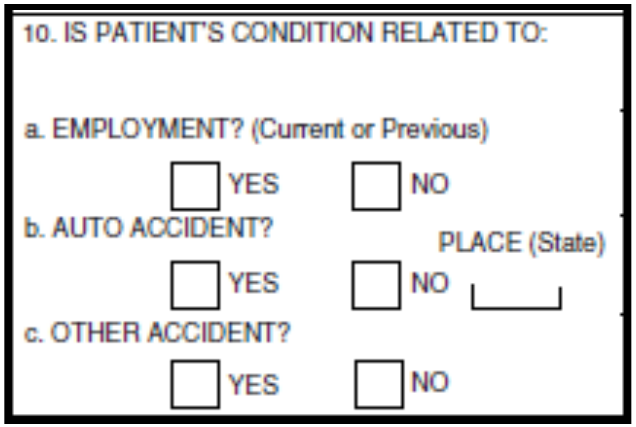
Patient's Condition

Is the Patient's condition related to Employment? Auto Accident? Other Accident?

Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24


10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

☐ YES ☐ NO

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☐ NO

c. OTHER ACCIDENT?

☐ YES ☐ NO

Patient Signatures

Box 12 - Release of Information: Patient's or Authorized Person's Signature
Box 13 - Assignment of Benefit: Insured or Authorized Person's Signature

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 _____

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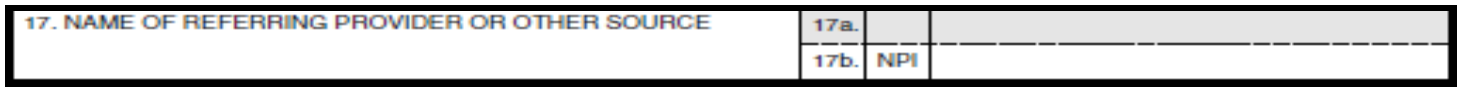
Injury or Accident Information

Box 14 - Date of Accident or the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.

Referring Provider

Box 17 – The referring physician's name formatted: Last Name, First Name, Middle Initial
Box 17a - The referring physician's Medicaid ID if the referring physician is not registered with an NPI
Box 17b – Referring Physician's NPI



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Hospitalization

Box 18 – Hospitalization dates related to current service

Comments

Box 19 - Free-form "comments" field to insert additional claim information not designated to appear in another block

Diagnosis Coding

Box 21 - Patient diagnosis. Document the condition(s) to the highest degree of specificity.

Prior Authorization Number

Box 23 - Record the Authorization number issued for the services being claimed

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Dates of Service

Box 24A – The month, day, and year for each procedure or service.

NOTE *- When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in block 24d.*

Place of Service

Box 24B - Place of Service. 2 digit code.

Procedure Code

Box 24d - The authorized HCPCS (HCFA Common Procedure Coding System) codes listed in the authorization letter.

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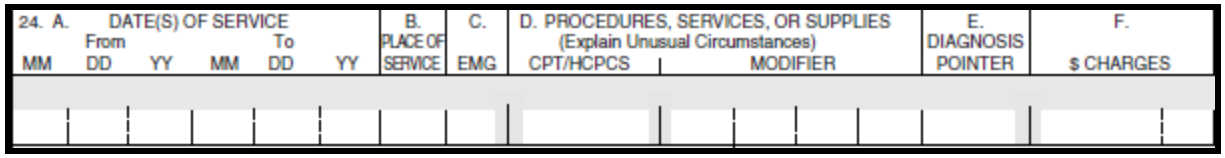
Diagnosis Pointer

Box 24E - Diagnosis code reference number as shown in block 21, to relate the date of service and the procedures performed to the appropriate diagnosis.

Charges

Box 24F - Enter the charge for each item.



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

Days or Units of Service

Box 24G - Enter the number of days or units. When multiple services are provided, enter the actual number provided.

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EPSDT Service

Box 24H - Check if the service being claimed is an EPSDT procedure.

COB - Coordination of Benefits

Box 24J - Check if the service is covered by another insurance carrier. Please attach an Explanation of Benefits form showing this service was claimed to the other carrier. Note other health coverage information in blocks 9 a-d, 6, and 7.

Federal Tax ID Number

Box 25 - Physician's Social Security Number (check SSN box) or Tax ID Number. If a Group Practice, enter the Employer Identification Number (EIN)

Total Charge

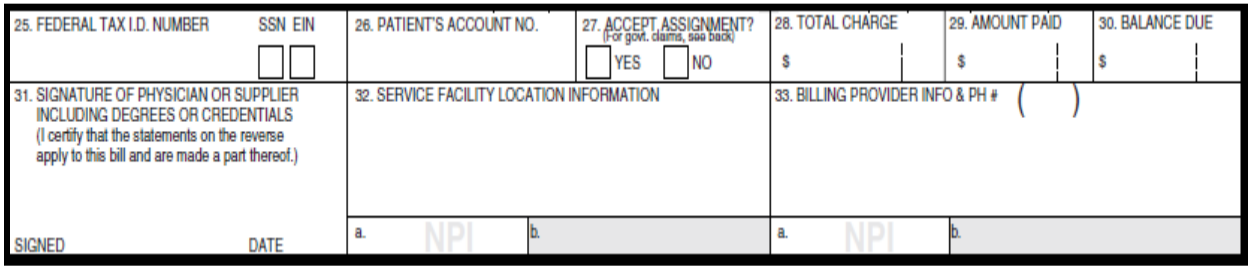
Box 28 - Enter the total amount of the services you are claiming.

Amount Paid

Box 29 - Enter any co-payment amounts paid to you by the Patient or their responsible party during the period covered by your claim.

Balance Due

Box 30 - Enter the amount due to you for this claim.



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.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

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Signature of Physician or Supplier

Box 31 - Sign and record the date you are submitting the claim. The signature represents the provider's certification that all information on the document is true and accurate.

Name and Address of Facility where services were rendered, if other than Practitioner's Office.

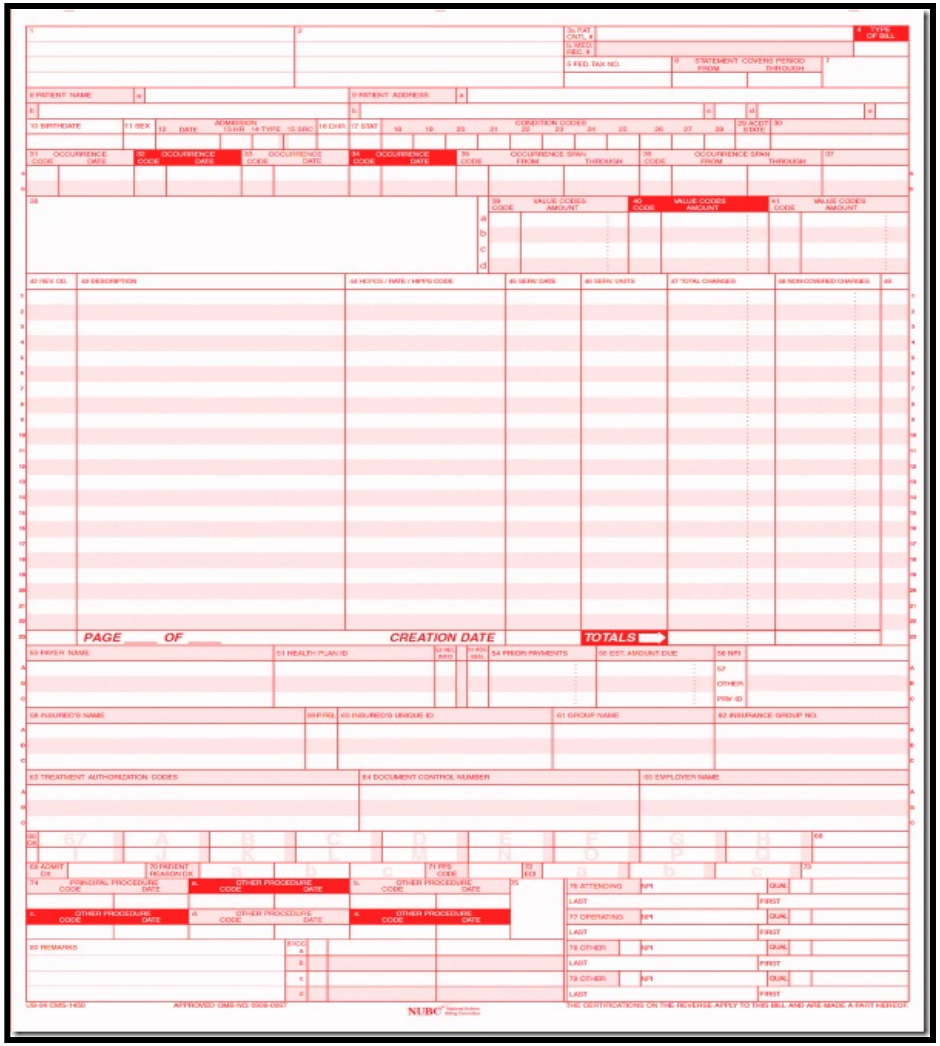
Box 32 - Name and address of the facility if the services were furnished in a hospital, clinic, patient's home, or facility other than the physicians' office. If the practitioner's address listed on block 33 and the place of service is the same, please write "SAME".
This block must be completed whether the provider performs the work at the office or at another location.

Provider Billing Information

Box 33 - Name, address, zip code and telephone number of the practitioner or provider group billing for the service.

Completing A UB04

UB04 Form



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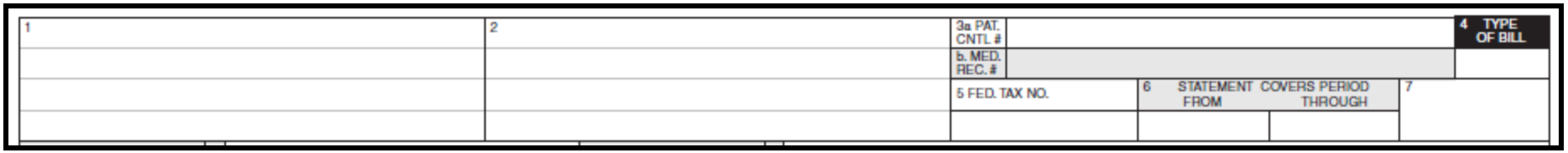
UB04 FORM FIELDS

Box 1 Billing provider name, street address, city, state, zip, telephone, fax, and country code
Box 2 Billing provider's pay-to name, address, city, state, zip, and ID
Box 3 Patient control number and medical record number
Box 4 Type of bill (TOB)
Box 5 Federal tax number
Box 6 Statement from and through dates

NOTE: Box 7 *Not in use*



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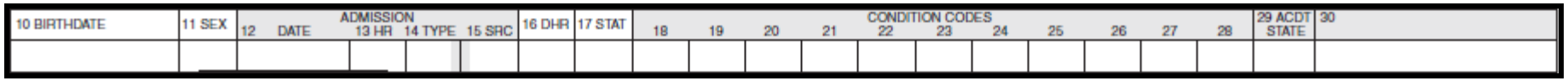
Box 8 Patient name
Box 9 Patient street address, city, state, zip, and country code

Box 10 Patient birthdate
Box 11 Patient sex
Box 12 Admission date
Box 13 Admission hour
Box 14 Type of visit
Box 15 Point of origin
Box 16 Discharge hour
Box 17 Discharge status
Box 18-28 Condition codes
Box 29 Accident state

NOTE: Box 30 *Not in use*



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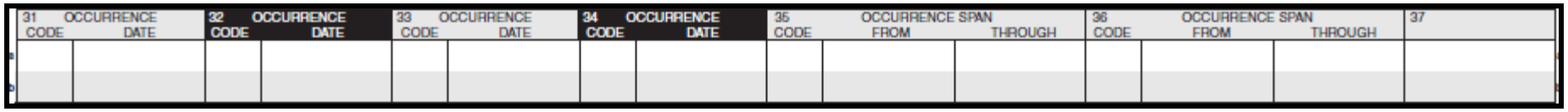
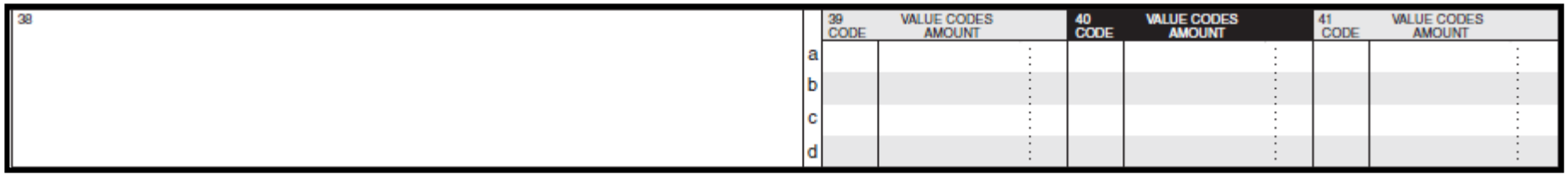
Box 31-34 Occurrence codes and dates
Box 35-36 Occurrence span codes and dates

NOTE: Box 37 *Not in use*



Box 38 Responsible party name and address
Box 39-41 Value codes and amounts



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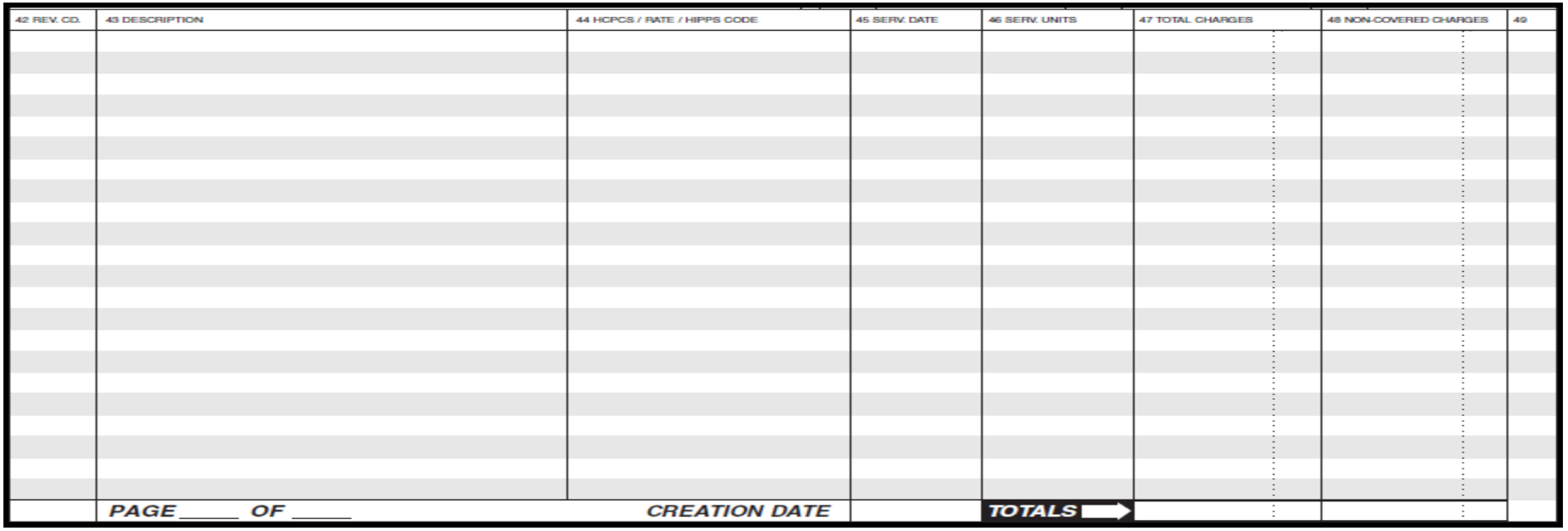
Box 42 Revenue codes
Box 43 Revenue code description, investigational device exemption (IDE) number, or Medicaid drug rebate NDC (national drug code)
Box 44 HCPCS (Healthcare Common Procedure Coding System), accommodation rates, HIPPS (Health Insurance Prospective Payment System) rate codes
Box 45 Service dates
Box 46 Service units
Box 47 Total charges
Box 48 Non-covered charges
Box 49 Page of_ and Creation date



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	PAGE _____ OF _____	CREATION DATE		TOTALS			

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Box 50 Payer Identification (a) Primary, (b) Secondary, and (c) Tertiary
Box 51 Health plan ID (a) Primary, (b) Secondary, and (c) Tertiary
Box 52 Release of information (a) Primary, (b) Secondary, and (c) Tertiary
Box 53 Assignment of benefits (a) Primary, (b) Secondary, and (c) Tertiary
Box 54 Prior payments (a) Primary, (b) Secondary, and (c) Tertiary
Box 55 Estimated amount due (a) Primary, (b) Secondary, and (c) Tertiary
Box 56 Billing provider national provider identifier (NPI)

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO		53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A								57	
B								OTHER	
C								PRV ID	

Box 57 Other provider ID (a) Primary, (b) Secondary, and (c) Tertiary
Box 58 Insured's name (a) Primary, (b) Secondary, and (c) Tertiary
Box 59 Patient's relationship (a) Primary, (b) Secondary, and (c) Tertiary
Box 60 Insured's unique ID (a) Primary, (b) Secondary, and (c) Tertiary
Box 61 Insurance group name (a) Primary, (b) Secondary, and (c) Tertiary
Box 62 Insurance group number (a) Primary, (b) Secondary, and (c) Tertiary

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

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Box 63 Treatment authorization code (a) Primary, (b) Secondary, and (c) Tertiary
Box 64 Document control number also referred to as Internal control number (a) Primary, (b) Secondary, and (c) Tertiary
Box 65 Insured's employer name (a) Primary, (b) Secondary, and (c) Tertiary

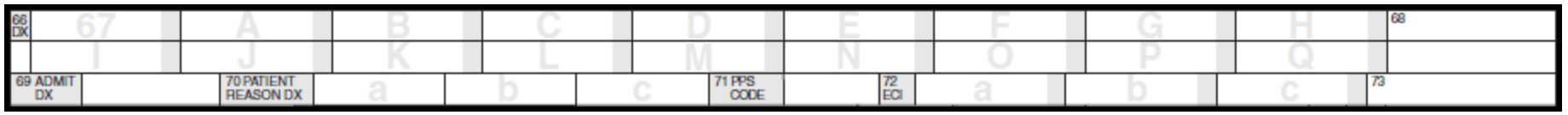
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

Box 66 Diagnosis codes (ICD)
Box 67 Principle diagnosis code, other diagnosis and present on admission (POA) indicators

NOTE: Box 68 *Not in use*

Box 69 Admitting diagnosis codes
Box 70 Patient reason for visit codes
Box 71 Prospective payment system (PPS) code
Box 72 External cause of injury code and POA indicator

NOTE: Box 73 *Not in use*



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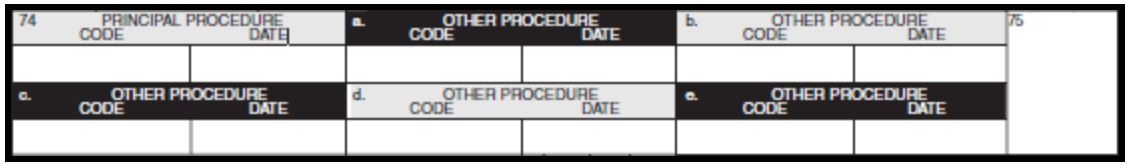
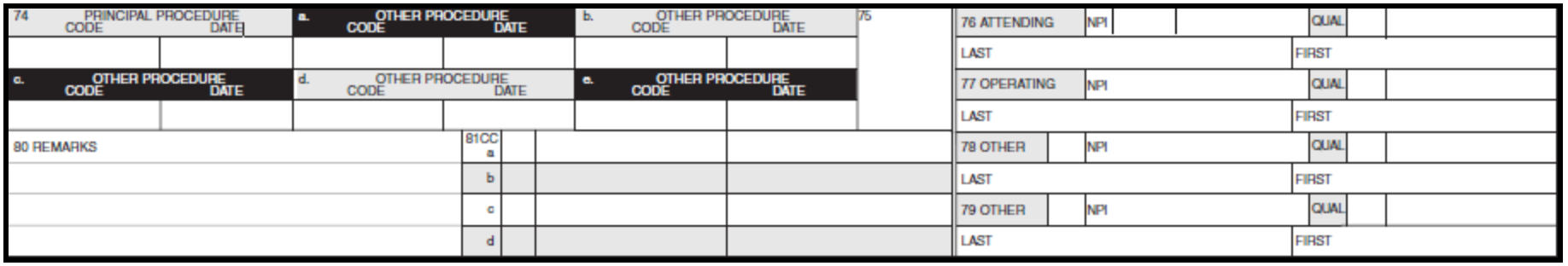
Box 74 Other procedure code and date



NOTE: Box 75 *Not in use*

Box 76 Attending provider NPI, ID, qualifiers, and last and first name
Box 77 Operating physician NPI, ID, qualifiers, and last and first name
Box 78 Other provider NPI, ID, qualifiers, and last and first name
Box 79 Other provider NPI, ID, qualifiers, and last and first name
Box 80 Remarks
Box 81 Taxonomy code and qualifier



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Contact Information

- **Availability of interpreter, auxiliary aides, and services for their patients**

- Interpreter and sign language services are available at no charge

- Call the regional Customer Service Center at **808-432-5955 (Oahu) or toll-free 1-800-966-5955.**

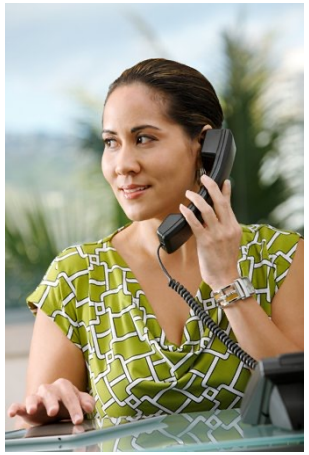
A Customer Service representative will provide an interpreter over the phone.

Members who are deaf, hard of hearing, or speech impaired may call:

TTY phones:
MOA HOC and MOA and HON 1st Floor lobbies. Check with Supervisor at other facilities. If unable to connect through **711:**

- **1-877-447-5990** (from a text telephone)
- **1-877-447-5991** (no text telephone)

TRS: Patient needs TTY phone.



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