KAISER PERMANENTE®

# SECTION 17

## APPENDIX ITEM 1

### LANGUAGE ASSISTANCE FORM

***Interpreter Documentation Form for Contracted Providers***

In compliance with the Department of Managed Health Care (DMHC) Language Assistance Regulations, this form provides contracted providers a method to document that referred-limited English proficient (LEP) Kaiser Permanente members were offered interpreter services and whether those services were used or refused. Please note -- LEP members may require interpreter services anytime critical information is conveyed.

**Documentation Instructions**

1. Once interpreter services have been provided, please document the offer, use or refusal of interpreter services either through documentation in the patient care record or by completing **the bottom section** of this form.
2. In the event that it is required, we may request documentation from you regarding the provision of interpreter services for KP members.

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**Provision of Interpreter Services:** *This section is to be completed at the time patient care is initiated.*

***TO BE COMPLETED BY CONTRACTED PROVIDER OR STAFF ONLY AND RETAINED IN PATIENT CARE RECORD****

Member Name: _____
Member Record Number:_____
Provider Name:_____

Interpreter services offered: ☐ Yes ☐ No

1. If interpreter services were accepted, check the type of interpreter services utilized:
   ☐ Qualified bilingual staff ☐ Professional staff interpreter ☐ Outside contract interpreter service
   ☐ Phone interpreting ☐ Other: _____
   I don't understand the difference between "Qualified bilingual staff" and "Professional staff interpreter" and "Outside contract interpreter service" and "Phone interpreting". I would suggest "Language Line", "Language People" and "Qualified bilingual staff"
2. Name of interpreter: _____
3. Interpreter's unique identifying number: _____
4. If interpreter services were refused, check the appropriate reason for refusal:
   ☐ Patient preferred to use relative/friend (over 18 yrs)
   ☐ Patient preferred to use own English skills
   ☐ Patient preferred/received in-language care from bilingual provider (huh?) don't understand this
   ☐ Other: _____ what would be an "other"
   ☐ Patient declined to state reason

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## APPENDIX ITEM 2 – ADVANCED BENEFICIARY NOTICE

*(A)* **Notifier(s):**
*(B)* **Patient Name:** *(C)* **Identification Number:**

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

*NOTE:* If Medicare doesn't pay for *(D)*_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the *(D)*_____ below.

| *(D)*_____ | *(E)* Reason Medicare May Not Pay: | *(F)* Estimated Cost: |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the *(D)*_____ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**(G) OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the *(D)*_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the *(D)*_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the *(D)*_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

***(H)* Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

| *(I)* Signature: | *(J)* Date: |
|---|---|



Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

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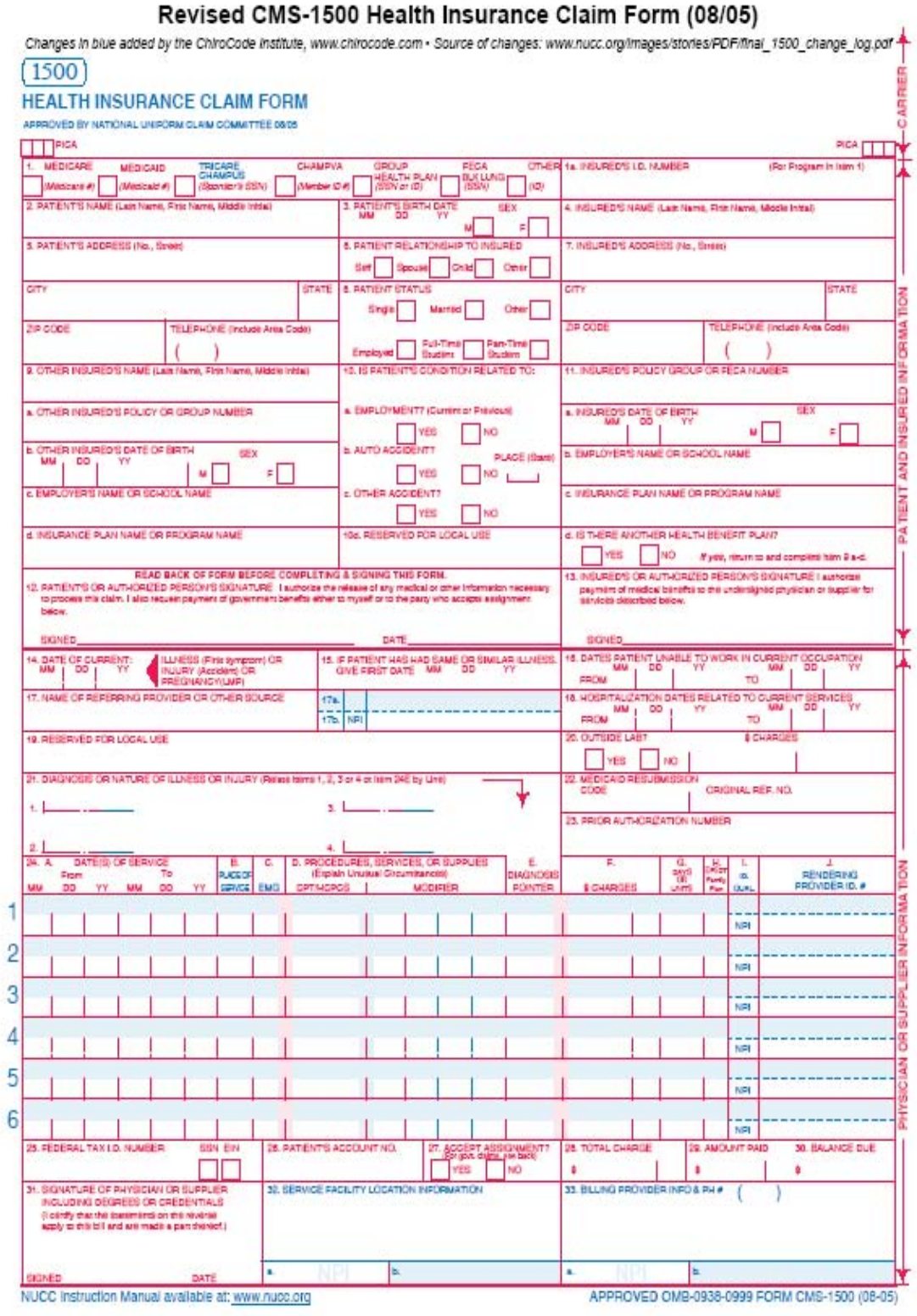
**APPENDIX ITEM 3 – CMS-1500 FORM** (see excel spreadsheet for instructions)



Revised CMS-1500 Health Insurance Claim Form (08/05)

Changes in blue added by the ChiroCode Institute, www.chirocode.com • Source of changes: www.nucc.org/images/stories/PDF/final_1500_change_log.pdf

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI |
| 2 | | | | | | | | | | NPI |
| 3 | | | | | | | | | | NPI |
| 4 | | | | | | | | | | NPI |
| 5 | | | | | | | | | | NPI |
| 6 | | | | | | | | | | NPI |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 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

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

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# APPENDIX ITEM 4 – UB04