

## 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

## 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:
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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 for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

**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/fnal\_1500\_change\_log.pdf

**1500**

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA <span style="float: right;">PICA <input type="checkbox"/></span>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID #) (SSN or ID) (SSN) (ID)</small>					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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)		
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					9. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		10. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 8 a-d.		
11. IS PATIENT'S POLICY OR GROUP NUMBER:					12. IS THERE ANOTHER HEALTH BENEFIT PLAN?		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 _____ DATE _____		
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident OR PRE-EXISTING/LUMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>		
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Release items 1, 2, 3 or 4 or item 24E by line) 1. _____ 2. _____ 3. _____ 4. _____					21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____		22. PRIOR AUTHORIZATION NUMBER _____		
23. 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) MODIFIER E. DIAGNOSIS POINTER					24. \$ CHARGES		25. \$ CHARGES 26. \$ PAID (W/INS) 27. \$ PAID (P/R) 28. \$ UNL. 29. RENDERING PROVIDER ID #		
25. FEDERAL TAX I.D. NUMBER SSN EIN _____					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. TOTAL CHARGE \$					29. AMOUNT PAID \$		30. BALANCE DUE \$		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I certify that the information on this invoice 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](http://www.nucc.org)

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

### APPENDIX ITEM 4 – UB04

1		2		3a PAT CNTL #		4 TYPE OF BILL	
				3b UNIT REC #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM TO THRU	
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION	
						14 INPT 15 PRVE 16 ENCL 17 DMR	
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