

**PROVIDER MANUAL SUPPLEMENT  
THIRD-PARTY LIABILITY**

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## THIRD-PARTY LIABILITY SUPPLEMENT

### INTRODUCTION

“Third-party liability” (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers’ compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

### HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid’s TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary’s eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

### ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient’s responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance.** You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid’s third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid

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patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Medicaid does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Medicaid all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

### Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

### Eligibility Verification

- **Medicaid Card:** Possession of a Partners for Health Medicaid Insurance card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **IVRS:** Instructions for using the Interactive Voice Response System (IVRS) are included in Section 1 of your provider manual. Information about third-party insurers comes after basic eligibility information, so be sure to listen all the way through the response message.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Medicaid Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

### REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.

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### Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in Section 5 of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

Medicaid Insurance Verification Services  
PO Box 101110  
Columbia, SC 29211-9804  
Fax: (803) 252-0870

### COORDINATION OF BENEFITS

Health insurers adhere to “coordination of benefits” provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the “primary” payer, the next is termed “secondary,” and the third is called “tertiary.” Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

### COST AVOIDANCE VS. PAY & CHASE

South Carolina Medicaid is required by the federal government to reject claims for which another party might be liable; this policy is known as “cost avoidance.” Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as “Pay & Chase.” Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in

## THIRD-PARTY LIABILITY SUPPLEMENT

this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

### Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children’s Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

### COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

**Remember, as a Medicaid provider you have agreed to accept Medicaid’s payment as payment in full.** You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary’s copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect

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the Medicaid beneficiary by limiting his or her liability for payment for medical services. Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

### DENIALS AND EOBs

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

### POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

**The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy.** The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call your SCDHHS program representative. He or she can look up more details of the plan in the TPL policy file.

### TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must resubmit the Edit Correction Form (ECF) within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.

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Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

### REASONABLE EFFORT

Providers occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. It is your responsibility as a provider to seek a solution to such problems.

“Reasonable effort” consists of taking logical, timely steps at each stage of the billing process. Such steps may include resubmitting claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. Your program representative can work with you to explore these options.

### Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

**A.** Send a claim to the insurance company.

If after **thirty days** you have received no response:

**B.** Call the company's customer service department to determine the status of the claim.

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.
  2. Confirm that all requested information has been submitted.

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3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.
  - **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
    1. Make a note in your files.
    2. Follow up with a written request for a response.

**C. If after two more weeks you have still received no response:**

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

### Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

### Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

Attach the form either to a claim filed as a denial or to an ECF. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance,

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notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in Section 5 of your provider manual, and examples appear at the end of this supplement.

### REPORTING TPL INFORMATION ON CLAIMS

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

### Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix DN (dental plans) or RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. The five-digit carrier codes for pharmacy claims submission may be found at <http://southcarolina.fhsc.com> or [www.scdhhs.gov](http://www.scdhhs.gov).

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, check the carrier code list on the SCDHHS Web site (From [www.scdhhs.gov](http://www.scdhhs.gov) click Resource Library, then Forms, and scroll to the bottom). If an ECF lists a code that you cannot find among the carrier codes either in your manual or online, contact your program area for assistance.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.

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### Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary's health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary's SSN. Edit codes and rejected claims are discussed in more detail below.

### PHARMACY CLAIMS

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists' billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Medicaid maintains separate carrier codes for pharmacy claims submission. The list of pharmacy carrier codes is available on the SCDHHS Web site (From [www.scdhhs.gov](http://www.scdhhs.gov) click Providers, then Pharmacy, then Carrier Code Lists). These unique codes may also be found at <http://southcarolina.fhsc.com>.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Medicaid edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor's Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

### NURSING FACILITY CLAIMS

Nursing facilities are required to follow Medicaid's TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or send the insurance EOB with an ECF.

If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

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To initiate Medicaid billing for a resident also covered by a third party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive an ECF for the claim, attach all EOBs and return the ECF to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. Your Nursing Facility program representatives will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call your Nursing Facility program representative. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

### PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500, UB-92, and ADA claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you may write in the carrier code, policy number, and amount paid in the third occurrences of fields 23, 24, and 25 of the ECF, and submit the ECF to MCCS. Claims submitted electronically will be processed automatically with up to ten primary payers. You may also submit the ECF and all the EOBs to the Division of Third-Party Liability; however, that is no longer required and may slightly delay claim payment.

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**Professional Paper Claims**

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

**CMS-1500 TPL Fields**

<p><b>9a Other Insured’s Policy or Group Number</b> Enter the policy number.</p>	<p><b>11 Insured’s Policy Group or FECA Number</b> Enter the policy number.</p>
<p><b>9c Employer’s Name or School Name</b> If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter “0.00” in this field.</p>	<p><b>11b Employer’s Name or School Name</b> If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter “0.00” in this field.</p>
<p><b>9d Insurance Plan Name or Program Name</b> Enter the three-digit carrier code.</p>	<p><b>11c Insurance Plan Name or Program Name</b> Enter the three-digit carrier code.</p>

<p><b>10d Reserved for Local Use</b> Enter the appropriate TPL indicator for this claim.</p>
--

The valid TPL indicators are:

- 1** Insurance denied
- 6** Crime victim
- 8** Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator “1” in field 10d. “6” is used to alert SCDHHS to potential criminal proceedings and restitution. “8” is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

<p><b>29 Amount Paid</b> Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.</p>
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Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

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### Institutional Paper Claims

Unlike other claim types, the UB-92 claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB-92 claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 32.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. The Medicaid provider number must appear on the same line as the Medicaid carrier code. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

### UB-92 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		\$33.01
B	401 (BCBS carrier code)		\$255.39
C	619 (Medicaid carrier code)	123456	

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB-92 claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-92 with TPL information appears at the end of this supplement.

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### Dental Paper Claims

The ADA 1999 (version 2000) claim form provides space for entering up to two insurers other than Medicaid.

### ADA Claim TPL Fields

<b>21</b> <b>Group #</b> Enter the three-digit carrier code of the private insurance.	<b>32</b> <b>Policy #</b> Enter the three-digit carrier code of the private insurance company or Medicare.
<b>22</b> <b>Subscriber/Employee Name</b> Enter the policy number of the insured.	<b>33</b> <b>Other Subscriber's Name</b> Enter the policy number of the insured.

<b>26</b> <b>State</b> Enter a "1" in this field if reporting a denial from a private insurance company or Medicare.
<b>Payment by other plan</b> Enter the total amount received from other insurance sources. If the private insurance or Medicare denies payment, put in \$0.00.
<b>Max Allowable</b> If you have an amount in the "Payment by other plan" field, then this field must be completed.

The Dental Services provider manual contains sample claims and complete instructions for filling out dental claim forms, and a sample ADA claim form appears at the end of this supplement.

### Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types using the Web Tool. The basic steps are the same as for paper claims.

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### REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Edit Correction Form will supply information you need to file with the third-party payer.

### Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed on the ECF, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information.

TPL information appears on the ECF to the right of the Medicaid claims receipt address under the heading “INSURANCE POLICY INFORMATION.” The insurance carrier code, the policy number, and the name of the policyholder are all listed on the ECF, while the carrier’s address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site.

Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the ECF, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the claim to what appears on the ECF. Enter the correct information on the ECF.

You can also refile a claim instead of returning an ECF. If you choose to refile a claim that was rejected for any reason, you must re-enter all TPL information.

Other TPL-related edit codes include:

- 316:** Third party code invalid
- 317:** Invalid injury code
- 390:** TPL payment amount not numeric
- 400:** TPL carrier and policy number must both be present
- 401:** Amount in other sources, but no TPL carrier code

## THIRD-PARTY LIABILITY SUPPLEMENT

- 555:** TPL payment is greater than payment due from Medicaid
- 557:** Carrier payments must equal payments from other sources
- 565:** Third-party payment, but no third-party ID
- 690:** Amount from other sources more than Medicaid amount
- 732:** Payer ID number not on file
- 733:** Insurance information coded, but payment or denial indicator missing
- 953:** Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual. Sample corrected ECFs appear at the end of this supplement.

### CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see Section 5 of your provider manual) and send it with the check to the following address:

SCDHHS  
Cash Receipts  
PO Box 8355  
Columbia, SC 29202

### RECOVERY

“Recovery” refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.

## THIRD-PARTY LIABILITY SUPPLEMENT

### Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each quarter for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited approximately six weeks later. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an “own reference number” to identify the debit(s).

You are expected to file the affected claims to Medicare within the quarter of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 509 for being more than two years after the date of service or six months after the Medicare remittance date, mail or fax the ECF to MIVS. If the patient is Part B-only and a UB-92 claim form has received edit 510, the ECF should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

### Retro Health and Pay & Chase

SCDHHS invoices institutional providers each quarter for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the quarter of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

Approximately four months after the recovery letter, providers are notified of any claims for which there has been no response. Again, six months after the initial invoice, providers are notified of non-response. At the end of nine months from the initial invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the one-year cycle.

#### Retro Health Example

January 2005	Initial invoice
May 2005	Second letter
July 2005	Third letter
September 2005	Notification: Automated debit on last check date of the month
December 2005	Deadline for reconsideration

## THIRD-PARTY LIABILITY SUPPLEMENT

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier's deadline, this is not an acceptable denial; however, when an insurer's timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer's denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

### CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims and ECFs.

## THIRD-PARTY LIABILITY SUPPLEMENT

### TPL RESOURCES

Your SCDHHS program representative is your first source for questions about third-party liability. Listed below are some other resources:

**SCDHHS Web site:** [www.scdhhs.gov](http://www.scdhhs.gov)

- Carrier codes
- Provider manuals
- Edit codes and resolutions

**Provider Outreach Web site:** [www.scmemoaidprovider.org](http://www.scmemoaidprovider.org)

- Web Tool User Guide and Addenda

### Medicaid Insurance Verification Services

PO Box 101110  
Columbia, SC 29211-9804  
(803) 252-7070 Main Number  
(803) 933-1752 Provider Recovery Specialists  
(803) 933-1825 Health Insurance Premium Payment Project  
(803) 252-0870 Fax

### South Carolina Department of Insurance

300 Arbor Lake Drive, Suite 1200  
PO Box 100105  
Columbia, SC 29223  
[www.doi.state.sc.us](http://www.doi.state.sc.us)

### SCDHHS Division of Third-Party Liability

(803) 898-2630

### SCDHHS Casualty Department

(803) 898-2977

### SCDHHS Health Insurance Department

(803) 898-2907

### SCDHHS Estate Recovery Department

PO Box 100127  
Columbia, SC 29202  
(803) 898-2932

## THIRD-PARTY LIABILITY SUPPLEMENT

### SAMPLE FORMS

Form	Page
Health Insurance Information Referral Form: Carrier change	20
Health Insurance Information Referral Form: Unlisted policy	21
Reasonable Effort Documentation Form: Failure to respond – beneficiary	22
Reasonable Effort Documentation Form: Failure to respond – insurer	23
Reasonable Effort Flowchart	24
Adjustment Form 130: Won appeal to primary	25
Adjustment Form 130: Retroactive private coverage and subsequent private payment	26
UB-92: Medicare paid; private insurer denied	27
Dental: Two private insurers paid	28
CMS-1500: Two private insurers; one paid, one denied	29
CMS-1500: Medicare and private insurer paid	30
ECF: Correction to change carrier denial to carrier payment	31
ECF: Correction to add carrier denial and note about policy lapse	32

Medicaid Insurance Verification Services  
For  
**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**HEALTH INSURANCE INFORMATION REFERRAL FORM**

*This form is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid beneficiaries.*

Beneficiary Name: John Doe Date Referral Completed 11/02/05  
Medicaid ID#: 1234567890 SSN: 555-55-5555  
Insurance Company Name: National Dental Insurance  
Policy Number: 555555555 Group Number: LIC123456  
Insured's Name: Jane Doe  
Employer's Name: South Carolina State Library  
Employer's Address: 1500 Senate Street, Columbia, SC 29201

**REASON FOR REFERRAL: (PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE)**

1. The beneficiary's Medicaid Eligibility File does not list the policy above.
2. Insurance documentation gives information that should be used to update Medicaid's files, such as the following:
- a. beneficiary has never been covered by the policy
  - b. beneficiary's coverage ended (date) \_\_\_\_\_
  - c. policy lapsed (date) \_\_\_\_\_
  - d. carrier has changed; new carrier is Global Dental Ins.
  - e. other \_\_\_\_\_

**PLEASE ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Fax this information to Medicaid Insurance Verification Services at 803 252 0870 **OR**  
Please send this form to the following address: Medicaid Insurance Verification Services  
Post Office Box 101110  
Columbia, SC 29211-9804

Provider or Department Name: Acme Dental Clinic Provider ID# 111111  
Contact Person: Richard Roe Phone #: 803-555-5555

Medicaid Insurance Verification Services  
For  
**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**HEALTH INSURANCE INFORMATION REFERRAL FORM**

*This form is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid beneficiaries.*

Beneficiary Name: Jim Smith Date Referral Completed 08/22/05  
Medicaid ID#: 99999999999 SSN: 333-33-3333  
Insurance Company Name: Johnson Health  
Policy Number: 333333333 Group Number: JH11111  
Insured's Name: Jim Smith  
Employer's Name: N/A (Retired)  
Employer's Address: N/A

**REASON FOR REFERRAL: (PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE)**

- 1. The beneficiary's Medicaid Eligibility File does not list the policy above.
- 2. Insurance documentation gives information that should be used to update Medicaid's files, such as the following:
  - a. beneficiary has never been covered by the policy
  - b. beneficiary's coverage ended (date) \_\_\_\_\_
  - c. policy lapsed (date) \_\_\_\_\_
  - d. carrier has changed; new carrier is \_\_\_\_\_
  - e. other \_\_\_\_\_

**PLEASE ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Fax this information to Medicaid Insurance Verification Services at 803 252 0870 **OR**  
Please send this form to the following address: Medicaid Insurance Verification Services  
Post Office Box 101110  
Columbia, SC 29211-9804

Provider or Department Name: ABC Clinic Provider ID# PA0000  
Contact Person: Betty Medicine Phone #: 555-555-5555

March 2004 Note: We entered carrier code 199 on 08/20/05 claim.

**REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** Acme Orthopedic **DOS** 6/05/05

**MEDICAID BENEFICIARY NAME** Jane Doe

**MEDICAID BENEFICIARY ID#** 1111111111

**INSURANCE COMPANY NAME** Jones Health Insurance

**POLICYHOLDER** Jane Doe

**POLICY NUMBER** 987654321J

**ORIGINAL DATE FILED TO INSURANCE COMPANY** 6/15/05

**DATE OF FOLLOW UP ACTIVITY** 7/16/05

**RESULT:**

Called insurer to check claim status. Insurer needs bene to fill out subrogation forms.

**FURTHER ACTION TAKEN:**

Called beneficiary on 7/16/05, 7/18/05, and 7/29/05. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

**DATE OF SECOND FOLLOW UP** 8/4/05

**RESULT:**

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/05; they will not act without forms.

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.**

*Mary Orthopod 08/20/05*

(SIGNATURE AND DATE)

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**

**REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** Dr. Betty Smith **DOS** 05/05/05

**MEDICAID BENEFICIARY NAME** John Jones

**MEDICAID BENEFICIARY ID#** 9999999999

**INSURANCE COMPANY NAME** Global Health

**POLICYHOLDER** John Jones

**POLICY NUMBER** 888888888

**ORIGINAL DATE FILED TO INSURANCE COMPANY** 05/20/05

**DATE OF FOLLOW UP ACTIVITY** 06/22/05

**RESULT:**

Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 06/24/05.

**FURTHER ACTION TAKEN:**

07/08/05: No reply from insurer. Called again; they could not find claim. Resubmitted claim on 07/16/05.

**DATE OF SECOND FOLLOW UP** 08/18/05

**RESULT:**

Called insurer; no action on claim. Wrote to Dept. of Insurance 08/25/05. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.**

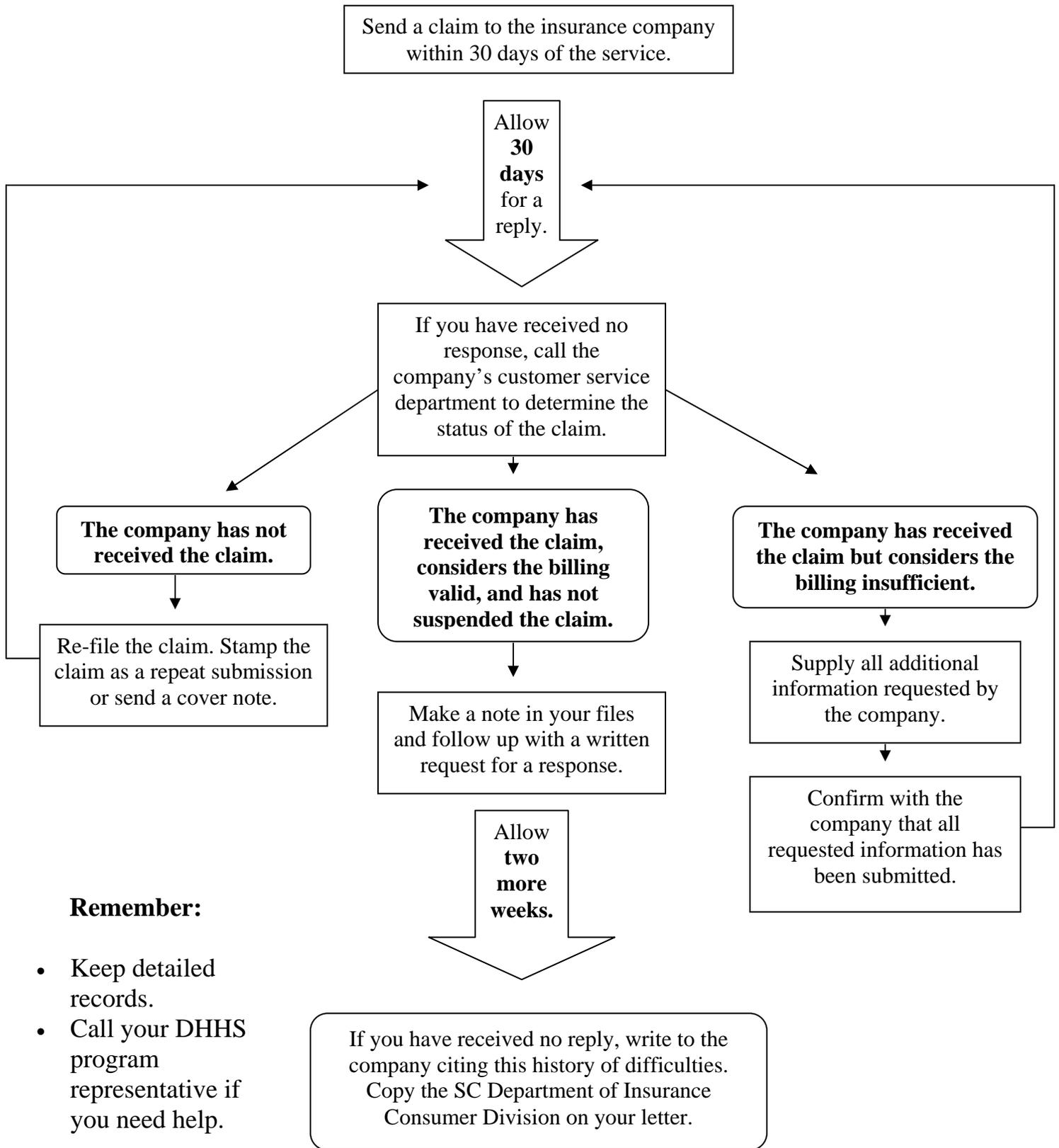
*Dr. Betty Smith 10/21/05*

(SIGNATURE AND DATE)

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**

# How to Obtain a Response from an Insurance Company

## A Suggested Third-Party Filing Process



South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Johnson DME Supply

Provider Address:

111 Oak Lane

Provider City, State, Zip:

Anywhere, SC 22222

Total paid amount on the original claim:

\$1244.00

Original CCN:

5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	A
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Provider ID:

1	1	1	1	1	1
---	---	---	---	---	---

Recipient ID:

2	2	2	2	2	2	2	2	2	2
---	---	---	---	---	---	---	---	---	---

Adjustment Type:

Void  Void/Replace

Originator:

DHHS  MCCS  Provider  MIVS

Reason For Adjustment: (Fill One Only)

- |  |   |
|--|---|
| <input checked="" type="radio"/> Insurance payment different than original claim | <input type="radio"/> Medicaid paid twice - void only |
| <input type="radio"/> Keying errors  | <input type="radio"/> Incorrect provider paid         |
| <input type="radio"/> Incorrect recipient billed                                 | <input type="radio"/> Incorrect dates of service paid |
| <input type="radio"/> Voluntary provider refund due to health insurance          | <input type="radio"/> Provider filing error           |
| <input type="radio"/> Voluntary provider refund due to casualty                  | <input type="radio"/> Medicare adjusted the claim     |
| <input type="radio"/> Voluntary provider refund due to Medicare                  | <input type="radio"/> Other                           |

For Agency Use Only

Analyst ID:

--	--	--	--	--	--

- |  |   |
|--|---|
| <input type="radio"/> Hospital/Office Visit included in Surgical Package | <input type="radio"/> Web Tool error          |
| <input type="radio"/> Independent lab should be paid for service         | <input type="radio"/> Reference File error    |
| <input type="radio"/> Assistant surgeon paid as primary surgeon          | <input type="radio"/> MCCS processing error   |
| <input type="radio"/> Multiple surgery claims submitted for the same DOS | <input type="radio"/> Claim review by Appeals |
| <input type="radio"/> MMIS claims processing error                       |   |
| <input type="radio"/> Rate change  |   |

Comments:

Insurer denied claim -- decided equipment wasn't medically necessary. We filed to Medicaid, but then appealed to primary insurer. We won the appeal.

Signature: Jane Doe

Date: 10/10/05

Phone: 999-999-9999

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Dr. Joe Jones

Provider Address:

22 Main Street

Provider City, State, Zip:

Somewhere, SC 22222

Total paid amount on the original claim:

\$230

Original CCN:

8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	A
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Provider ID:

9	9	9	9	9	9
---	---	---	---	---	---

Recipient ID:

7	7	7	7	7	7	7	7	7	7
---	---	---	---	---	---	---	---	---	---

Adjustment Type:

Void  Void/Replace

Originator:

DHHS  MCCS  Provider  MIVS

Reason For Adjustment: (Fill One Only)

- |  |   |
|--|---|
| <input type="radio"/> Insurance payment different than original claim              | <input type="radio"/> Medicaid paid twice - void only |
| <input type="radio"/> Keying errors  | <input type="radio"/> Incorrect provider paid         |
| <input type="radio"/> Incorrect recipient billed                                   | <input type="radio"/> Incorrect dates of service paid |
| <input checked="" type="radio"/> Voluntary provider refund due to health insurance | <input type="radio"/> Provider filing error           |
| <input type="radio"/> Voluntary provider refund due to casualty                    | <input type="radio"/> Medicare adjusted the claim     |
| <input type="radio"/> Voluntary provider refund due to Medicare                    | <input type="radio"/> Other                           |

For Agency Use Only

Analyst ID:

--	--	--	--	--	--

- |  |   |
|--|---|
| <input type="radio"/> Hospital/Office Visit included in Surgical Package | <input type="radio"/> Web Tool error          |
| <input type="radio"/> Independent lab should be paid for service         | <input type="radio"/> Reference File error    |
| <input type="radio"/> Assistant surgeon paid as primary surgeon          | <input type="radio"/> MCCS processing error   |
| <input type="radio"/> Multiple surgery claims submitted for the same DOS | <input type="radio"/> Claim review by Appeals |
| <input type="radio"/> MMIS claims processing error                       |   |
| <input type="radio"/> Rate change  |   |

Comments:

Beneficiary just learned that her new private insurance is retroactively effective. We filed with and were paid by the insurer.

Signature: Mary Smith

Date: 10/05/05

Phone: 555-5555

ST11843 IFLYUB-92

ABC MEDICAL CENTER 111 OAK LANE ANYWHERE, SC 00000-0000		2	3 PATIENT CONTROL NO. DOB-1234567890				4 TYPE OF BILL 111
5 FED. TAX NO. 00-0000000	6 STATEMENT COVERS PERIOD FROM 080905	7 COVD	8 N-C D	9 C-I D	10 L-R D	11	

12 PATIENT NAME JANE DOE	13 PATIENT ADDRESS 222 MAPLE ST, COLUMBIA, SC, 00000
-----------------------------	---

14 BIRTHDATE 01011960	15 SEX F	16 MS	17 DATE 080905	18 HR	19 TYPE 2	20 SRC 7	21 D HR 01	22 STAT 01	23 MEDICAL RECORD NO. JD000000000	24	25 80	26 C5	27	28	29	30	31
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32 OCCURRENCE CODE 24	33 OCCURRENCE DATE 083105	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE CODE	39 OCCURRENCE DATE	40 OCCURRENCE CODE	41 OCCURRENCE DATE	42 OCCURRENCE CODE	43 OCCURRENCE DATE	44 OCCURRENCE CODE	45 OCCURRENCE DATE	46 OCCURRENCE CODE	47 OCCURRENCE DATE	48 OCCURRENCE CODE	49 OCCURRENCE DATE
--------------------------	------------------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------	--------------------

MEDICAID PO BOX 1458 COLUMBIA, SC 29202-1458				39 CODE a 02	40 VALUE CODES AMOUNT 00.00	41 CODE	42 VALUE CODES AMOUNT	43 CODE	44 VALUE CODES AMOUNT
				b				c	
				c				d	
				d					

42 REV. CD	43 DESCRIPTION	44 HC PCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 206	ICU/INTERMEDIATE	975.00	081005	5	4875.00	.	1
2 270	MED/SURG SUPPLY		081005	104	1636.23	.	2
3 350	CT SCAN		080905	2	1821.00	.	3
4 450	EMERG ROOM		080905	1	591.00	.	4
5 001	TOTAL CHARGE				8923.23	0.	5
6					.	.	6
7					.	.	7
8					.	.	8
9					.	.	9
10					.	.	10
11					.	.	11
12					.	.	12
13					.	.	13
14					.	.	14
15					.	.	15
16					.	.	16
17					.	.	17
18					.	.	18
19					.	.	19
20					.	.	20
21					.	.	21
22					.	.	22
23					.	.	23

50 PAYER 618	51 PROVIDER NO. 123456	52 REL INFO	53 A/B/C BEN	54 PRIOR P. PAYMENTS 6000.00	55 EST. AMOUNT DUE	56
B 199				0.00		
C 619						
57 <b>DUE FROM PATIENT</b>						

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC - ID NO. 12345678999 999111111AZX 11111111111	61 GR. OUP NAME	62 INSURANCE GR. OUP NO.
-------------------	-----------	---	-----------------	--------------------------

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
----------------------------------	--------	------------------	----------------------

67 PRIN. DIAG. CD 2888	68 CODE 07051	69 CODE 4928	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD	77 E-CODE	78 32
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79 P.C.	80 PRINCIPAL PROCEDURE CODE 4131	81 OTHER PROCEDURE CODE A	82 ATTENDING PHYS. ID 555-55-5555
	80 PRINCIPAL PROCEDURE DATE 081005	81 OTHER PROCEDURE DATE A	82 ATTENDING PHYS. ID ABC123 JONES, MARY MD
	80 PRINCIPAL PROCEDURE DATE C	81 OTHER PROCEDURE DATE D	82 ATTENDING PHYS. ID A
	80 PRINCIPAL PROCEDURE DATE E	81 OTHER PROCEDURE DATE E	82 ATTENDING PHYS. ID B

84 REMARKS	85 PROVIDER REPRESENTATIVE X RICHARD ROE	86 DATE 090505
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**Dental Claim Form**

© American Dental Association, 1999 version 2000

Example of Completed Dental Claim Form Reporting a Private Insurance Payment(s)

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual service Specialty _____	3. Carrier Name _____ 4. Carrier Address _____ 5. City _____ 6. State _____ 7. Zip _____
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # _____	

<b>P A T I E N T</b> 8. Patient Name (Last, First, Middle) <b>JONES, MARY (OPTIONAL)</b> 12. Date of Birth (MM/DD/YYYY) / / 13. Patient ID # <b>0123456789</b> 14. Sex <input type="checkbox"/> M <input type="checkbox"/> F 15. Phone Number ( ) _____ 16. Zip Code _____ 17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	9. Address _____ 10. City _____ 11. State _____ 18. Employer/ School Name _____ Address _____
--	---

<b>S U B S C R I B E R / E M P L O Y E E</b> 19. Subs./Emp. ID#/SS# _____ 20. Employer Name _____ 21. Group # <b>467</b> 22. Subscriber/Employee Name (Last, First, Middle) <b>012986065 (policy # of insured)</b> 23. Address _____ 24. Phone Number ( ) _____ 25. City _____ 26. State _____ 27. Zip Code _____ 28. Date of Birth (MM/DD/YYYY) / / 29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other 30. Sex <input type="checkbox"/> M <input type="checkbox"/> F 31. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. X _____ Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____	<b>O T H E R P O L I C I E S</b> 31. Is patient covered by another plan <input type="checkbox"/> No. (Skip 32-37) <input type="checkbox"/> Yes <input type="checkbox"/> Dental or <input type="checkbox"/> Medical 32. Policy # <b>401</b> 33. Other Subscriber's Name <b>012986065 (policy # of insured)</b> 34. Date of Birth (MM/DD/YYYY) / / 35. Sex <input type="checkbox"/> M <input type="checkbox"/> F 36. Plan/Program Name _____ 37. Employer/ School Name _____ Address _____ 38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student 40. Employer/School Name _____ Address _____ 41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X _____ Signed (Employee/Subscriber) _____ Date (MM/DD/YYYY) _____
---	---

<b>B I L L I N G D E N T I S T</b> 42. Name of Billing Dentist or Dental Entity <b>JOHN SMITH DMD (OPTIONAL)</b> 46. Address _____ 50. City _____ 51. State _____ 52. Zip Code _____ 55. If prosthesis (crown, bridge, denture), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No 56. Is treatment result of occupational illness or injury? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____	43. Phone Number ( ) _____ 44. Provider ID # <b>ZA0000</b> 45. Dentist Soc. Sec. or T.I.N. _____ 47. Dentist Licence # _____ 48. First visit date of current series: _____ 49. Place of treatment <input checked="" type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other 53. Radiographs or models enclosed? <input type="checkbox"/> Yes, how many? <input type="checkbox"/> No 54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: _____ Date appliance placed _____ Total mos. treatment remaining _____ 57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input checked="" type="checkbox"/> neither Brief description and dates _____
--	---

58. Diagnosis Code Index (optional)

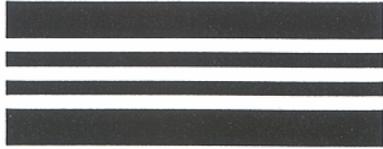
1. _____	2. _____	3. _____	4. _____	5. _____	6. _____	7. _____	8. _____
----------	----------	----------	----------	----------	----------	----------	----------

59. Examination and treatment plans - List teeth in order								Admin. Use Only	
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee		
11 19 03				D0120			\$ 50.00	ZZ1111	
11 19 03				D0220			\$ 18.00	ZZ1111	
11 19 03	1			D0230			\$ 10.00	ZZ1111	
11 19 03	2			D0230			\$ 10.00	ZZ1111	
11 19 03	14	M		D2140			\$ 60.00	ZZ1111	
11 19 03	18			D7140			\$ 75.00	ZZ1111	
11 19 03	68			D7140			\$ 60.00	ZZ1111	

60. Identify all missing teeth with X										Total Fee		\$ 283.00															
Permanent					Primary					Payment by other plan		100.00															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	Max. Allowable	\$ 183.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Deductible	
61. Remarks for unusual services										Carrier %																	
<b>JONESMARY</b> OPTIONAL, BUT RECOMMENDED. YOUR CHART # OR BENEFICIARY NAME CAN BE ENTERED IN THIS BLOCK. HOLDS UP TO 9 DIGITS OR CHARACTERS										Carrier pays																	
										Patient pays																	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. X _____ Signed (Treating Dentist) _____ Licence# _____ Date (MM/DD/YYYY) _____	63. Address where treatment was preformed _____ 64. City _____ 65. State _____ 66. Zip Code _____
--	--

PLEASE  
DO NOT  
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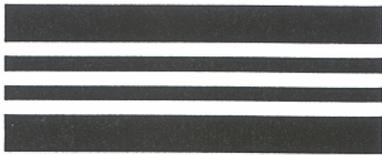
# Two Private Insurers; One Paid, One Denied

**HEALTH INSURANCE CLAIM FORM**

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Smith, John</b>				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)															
5. PATIENT'S ADDRESS (No., Street) <b>12 Main St.</b>				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 <b>Anytown</b>		STATE <b>SC</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE													
ZIP CODE <b>29000</b>		TELEPHONE (Include Area Code) <b>(803) 111-1111</b>		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		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 <b>012345678</b>															
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>012345678</b>				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		SEX													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME <b>10.00</b>															
c. EMPLOYER'S NAME OR SCHOOL NAME <b>0.00</b>				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>400</b>															
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>134</b>				10d. RESERVED FOR LOCAL USE <b>1</b>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.															
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.						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 _____						SIGNED _____															
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 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 PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.															
23. PRIOR AUTHORIZATION NUMBER																					
24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
8   1   01   8   1   01   11						99999				20 00 1											
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>20 00</b>		29. AMOUNT PAID \$ <b>10 00</b>		30. BALANCE DUE \$ <b>10 00</b>									
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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #									
SIGNED _____ DATE _____						PIN# _____ GRP# _____															

PLEASE  
DO NOT  
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AREA



# Medicare Paid; Private Insurer Paid

CARRIED

## HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG SN <input type="checkbox"/> OTHER <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Smith, John</b>		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) <b>12 Main St.</b>		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 <b>Anytown</b>		STATE <b>5.L.</b>		CITY			
ZIP CODE <b>29000</b>		TELEPHONE (Include Area Code) <b>(803) 111-1111</b>		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 <b>111222333A</b>			
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>012345678</b>		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME <b>10.00</b>			
c. EMPLOYER'S NAME OR SCHOOL NAME <b>5.00</b>		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>620</b>			
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>400</b>		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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 _____			

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 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 PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER		24. A B C D E F G H I J K DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE	

A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
8   1   01   8   1   01	11		99999		20 00					

25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>20 00</b>		29. AMOUNT PAID \$ <b>15 00</b>		30. BALANCE DUE \$ <b>5 00</b>	
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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			
SIGNED _____ DATE _____				PIN# _____				GRP# _____			

REPORT NUMBER CLM3500

EDIT CORRECTION FORM

PAGE 37267 ECF 37249 PAGE 1 OF 1

ANALYST ID

HIC - 21 PRAC SPEC - 12

EMC

SIGNON ID

CLAIM RESTART DATE / / DOC IND Y

EDITS

1	2	3	4	5	6	7	8	9
PROVIDER	RECIPIENT	P AUTH	TPL	INJURY	EMERG	PC COORD	DIAGNOSIS	
ID	ID	NUMBER		CODE			PRIMARY	SECONDARY
123456	0123456789		1				485	787.91

INSURANCE EDITS

00- 150

00- 733

CLAIM EDITS

LINE EDITS

10 RECIPIENT NAME - Jane Doe 11 DATE OF BIRTH 11/23/1998 12 SEX F

13	14	15	16	17	18	19	20	21	22
RES	ALLOWED	LN	DATE OF	PLACE	PROC	MOD MD2 MD3 MD4	INDIVIDUAL	CHARGE	PAY
		NO	SERVICE		CODE		PROVIDER	IND	UNITS
	.00	1	07/13/05	81	85025	000	ABC123	29.50	1.000
		2	/ /						**
		3	/ /						**
		4	/ /						**
		5	/ /						**
		6	/ /						**
		7	/ /						**
		8	/ /						**

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\*\* AGENCY USE ONLY \*\*

\*\* APPROVED EDITS \*\*

\*\* REJECTED LINE EDITS \*\*

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! CLAIMS/LINE PAYMENT INFO !

! !

! EDIT PAYMENT DATE !

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23	24	25	26	27	28	29
INS CARR	POLICY	INS CARR	TOTAL CHARGE	AMT REC'D INS	BALANCE DUE	OWN REF #
NUMBER	NUMBER	PAID				
01 401	111224444	5.00	29.50	<del>.00</del> 5.00	<del>29.50</del> 24.50	012345
02						
03						

RESOLUTION DECISION \_\_\_\_

RETURN TO:  
 MEDICAID CLAIMS RECEIPT  
 P. O. BOX 1412  
 COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

401 111224444  
 DOE JOHN

PROVIDER:  
 Dr. I.U. Mend  
 PO BOX 00000  
 ANYWHERE XO 0000-0000

REPORT NUMBER CLM3500

EDIT CORRECTION FORM

PAGE 37267 ECF 37249 PAGE 1 OF 1

ANALYST ID

HIC - 21 PRAC SPEC - 12

EMC

SIGNON ID

CLAIM RESTART DATE / / DOC IND Y

EDITS

1	2	3	4	5	6	7	8	9
PROVIDER	RECIPIENT	P AUTH	TPL	INJURY	EMERG	PC COORD	DIAGNOSIS	
ID	ID	NUMBER		CODE			PRIMARY	SECONDARY
123456	0123456789		1				485	787.91

INSURANCE EDITS

00- 150

00-733

CLAIM EDITS

LINE EDITS

10 RECIPIENT NAME - Jane Doe 11 DATE OF BIRTH 11/23/1998 12 SEX F

13	14	15	16	17	18	19	20	21	22
RES	ALLOWED	LN	DATE OF	PLACE	PROC	MOD MD2 MD3 MD4	INDIVIDUAL	CHARGE	PAY
		NO	SERVICE		CODE		PROVIDER	IND	UNITS
	.00	1	07/13/05	81	85025	000	ABC123	29.50	1.000
		2	/ /						**
		3	/ /						**
		4	/ /						**
		5	/ /						**
		6	/ /						**
		7	/ /						**
		8	/ /						**

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\*\* AGENCY USE ONLY \*\*

\*\* APPROVED EDITS \*\*

\*\* REJECTED LINE EDITS \*\*

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! CLAIMS/LINE PAYMENT INFO !

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! EDIT PAYMENT DATE !

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23	24	25	26	27	28	29
INS CARR	POLICY	INS CARR	TOTAL CHARGE	AMT REC'D INS	BALANCE DUE	OWN REF #
NUMBER	NUMBER	PAID				
01 401	11122444	00.00	29.50	.00	29.50	012345

RESOLUTION DECISION \_\_\_\_

RETURN TO:  
 MEDICAID CLAIMS RECEIPT  
 P. O. BOX 1412  
 COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION  
 401 11122444  
 DOE JOHN

PROVIDER:  
 Dr. I.U. Mend  
 PO BOX 00000  
 ANYWHERE

*No longer covered  
 by this insurance.*

XO 0000-0000