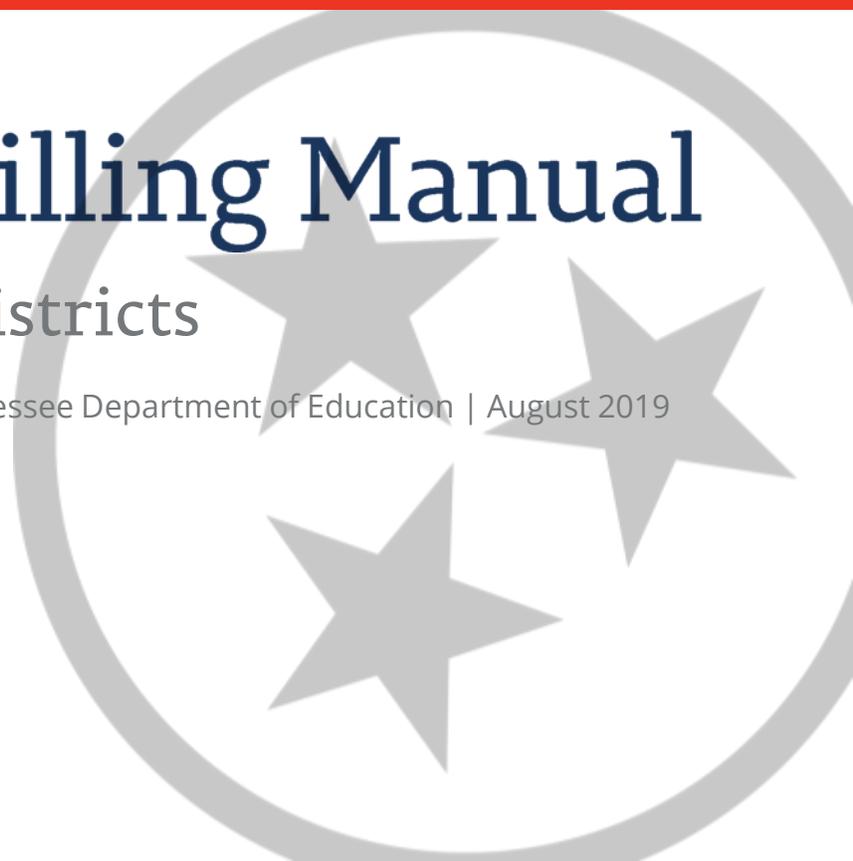




# TennCare Billing Manual

Tennessee School Districts

Tennessee Division of TennCare and Tennessee Department of Education | August 2019



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# Purpose

The purpose of this manual is to address the coverage by TennCare of medical services provided in a school setting. Some medical services provided to students while at school are covered by TennCare, Tennessee's Medicaid program. Under some circumstances, solely at the MCOs discretion, school districts may contract with MCOs to provide services not contained in a student's IEP. That process would be the same as treatment provided by any other contracted provider and is not addressed in this manual.

Covered services can be performed by a TennCare provider, or a school can contract with TennCare's managed care organizations (MCOs) to be reimbursed for providing these services.

This manual outlines how a school can become eligible to bill for services as a TennCare provider and the responsibilities in determining what services are appropriate and for which to seek reimbursement.

*Schools must contract with a TennCare Managed Care Organization to be reimbursed for services.*

## How to Become a TennCare Provider

A school district and any provider treating the student must be an "in-network" provider with a TennCare enrolled student's MCO to be eligible to bill the MCO for health care services delivered to that student. A school district and treating staff must complete the following steps, **in the order listed below**, to become a TennCare provider.

1. The school district must register to receive a National Provider Identifier (NPI).
2. The school district must register to receive a Medicaid Identification Number (Medicaid ID).
3. The school district must complete credentialing and contract with at least one TennCare MCO.

**Note: All TennCare members are enrolled in one of four MCOs, each of which operates on a statewide basis. This means that school districts will likely have students enrolled in each of the four MCOs and would need to contract with all four if the goal is to maximize the ability to bill for eligible health care services.**

### STEP 1: Obtain a National Provider Identifier (NPI)

To apply for an NPI, visit the Centers for Medicare & Medicaid Services (CMS) website ([here](#)). An NPI is required for all covered health service providers by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). There are two types of NPIs:

- Type 1 will be necessary for each individual health care provider who is associated with the school district and who will provide/render the health care services for which the district intends to bill.
- Type 2 is required for the school district itself.

**Note: The billing and rendering providers on the claim form must complete this process for all applicable NPIs before the MCOs can pay the claims.**

**STEP 2: Register for a Medicaid Identification Number**

The Medicaid Identification Number is assigned to a provider by the Division of TennCare. There are certain Medicaid provider screenings and enrollment requirements, which are pursuant to federal regulations set forth by the CMS. For more information, please visit the Centers for Medicaid and CHIP Services Informational Bulletin ([here](#)).

Information on how to apply for a TennCare Medicaid Identification Number is located on the Division of TennCare’s website ([here](#)).

TennCare utilizes the Council for Affordable Quality Healthcare (CAQH) ProView application process for individual providers using a Type 1 NPI (see above). Individual providers will enter key pieces of data into the TennCare system ([here](#)). TennCare then submits the individual provider’s information to CAQH. If CAQH has the individual provider’s data on file, it will be returned to TennCare for processing and assignment of a Medicaid ID. If CAQH does not have the individual provider’s information on file, CAQH will send instructions on how to complete the CAQH ProView application to the email address entered on the TennCare website. Once the provider completes the CAQH ProView application, CAQH will return the provider’s data to TennCare for processing and assignment of Medicaid ID.

Organizational providers (i.e., school districts) will create an account and enter all data for the organization on TennCare’s website ([here](#)). Once the provider submits a completed electronic application, TennCare will process and assign a Medicaid ID.

**For questions, schools and providers should call (800) 852-2683, and select option 5.**

**STEP 3: Contract with an MCO**

Providers must contract with an MCO before payments for school-based services can be made. The MCO processes and pays claims for medically necessary, covered services provided to TennCare members. Services in an individualized education program (IEP) that could be covered include, but are not limited to, speech therapy, physical therapy, occupational therapy, behavioral counseling, and audiology services. Providers may include physicians, nurse practitioners, occupational therapists, physical therapists, speech pathologists, and therapists. Covered services are defined in [TennCare Rule 1200-13-13-.04](#). Prior to contracting, the MCO will request additional information as part of their credentialing process.

*For a service to be considered medically necessary, it must meet five criteria:*

1. *Be ordered by a treating licensed physician or other treating licensed health care provider.*
2. *Required to diagnose or treat a medical condition.*
3. *Be safe and effective.*
4. *Not be experimental or investigational.*
5. *Be the least costly alternative.*

For more information on how to contract with an MCO, contact the individuals listed below for each of TennCare’s four MCOs by region.

**Note: MCOs are not required to contract with school districts. If an MCO chooses not to contract with a school district, that MCO must make arrangements for the district students to receive medically necessary services included in an IEP through other contracted providers and must assure that the service is initiated as soon as possible and information concerning the successful delivery of such services is communicated to the school district.**

## MCO Provider Services Contact Information

Amerigroup	BlueCare	UnitedHealthcare Community Plan	TennCareSelect
Evelyn Fatokun (West Region) (615) 316-2400 ext. 106-126- <a href="mailto:Evelyn.Fatokun@amerigroup.com">Evelyn.Fatokun@amerigroup.com</a>	Duane Wilson (West Region) (901) 544-2112 <a href="mailto:Duane_wilson@bcbst.com">Duane_wilson@bcbst.com</a>	Greta Murphy (Statewide) (615) 493-8971 <a href="mailto:Greta_murphy@uhc.com">Greta_murphy@uhc.com</a>	Duane Wilson (West Region) (901) 544-2112 <a href="mailto:Duane_wilson@bcbst.com">Duane_wilson@bcbst.com</a>
Evelyn Fatokun (Middle Region) (615) 316-2400 ext. 106-126- <a href="mailto:Evelyn.Fatokun@amerigroup.com">Evelyn.Fatokun@amerigroup.com</a>  Dedra Robison (Middle Region) (615) 316-2400 ext. 106-126- <a href="mailto:Dedra.Robison@amerigroup.com">Dedra.Robison@amerigroup.com</a>	Lisa Pirozzolo (Middle Region) (615) 565-1972 <a href="mailto:Lisa_Pirozzolo@bcbst.com">Lisa_Pirozzolo@bcbst.com</a>	Melissa Fookes (Statewide Back up) (612) 383-4522  <a href="mailto:melissa_fookes@uhc.com">melissa_fookes@uhc.com</a>	Lisa Pirozzolo (Middle Region) (615) 565-1972 <a href="mailto:Lisa_Pirozzolo@bcbst.com">Lisa_Pirozzolo@bcbst.com</a>
Dedra Robison (East Region) (615) 316-2400 ext. 106-126- <a href="mailto:Dedra.Robison@amerigroup.com">Dedra.Robison@amerigroup.com</a>	Jennifer Allen (East Region-Chattanooga) (901) 308-3625 <a href="mailto:Jeni_Allen@bcbst.com">Jeni_Allen@bcbst.com</a>		Jennifer Allen (East Region- Chattanooga) (901) 308-3625 <a href="mailto:Jeni_Allen@bcbst.com">Jeni_Allen@bcbst.com</a>
	Audrey Wilkinson (East Region – Knoxville*) (865) 588-4635 <a href="mailto:Audrey_Wilkinson@BCBST.com">Audrey_Wilkinson@BCBST.com</a>		Audrey Wilkinson (East Region – Knoxville*) (865) 588-4635 <a href="mailto:Audrey_Wilkinson@BCBST.com">Audrey_Wilkinson@BCBST.com</a>

Amerigroup	BlueCare	United Healthcare Community Plan	TennCareSelect
	Joey Turner (Behavioral Health - Statewide) (615) 386- 8631 <a href="mailto:Joey_Turner@bcbst.com">Joey_Turner@bcbst.com</a>		Joey Turner (Behavioral Health - Statewide) (615) 386- 8631 <a href="mailto:Joey_Turner@bcbst.com">Joey_Turner@bcbst.com</a>
	Jeff Leyman (East Region – Tri Cities) (865) 588-4677 <a href="mailto:Jeffrey_leyman@bcbst.com">Jeffrey_leyman@bcbst.com</a>		Jeff Leyman (East Region – Tri Cities) (865) 588-4677 <a href="mailto:Jeffrey_leyman@bcbst.com">Jeffrey_leyman@bcbst.com</a>

\*East Region (any of these can help and direct internally)

### ***Important Note Regarding Contracting with TennCare MCOs***

This document addresses the process for a school district to bill TennCare for medically necessary services (i.e., the school district is the Billing Entity) that are included in an IEP and provided in a school setting. In some situations, a school district may invite a medical provider (e.g., physical therapy, speech therapy, occupational therapy) to deliver services in the school setting with the understanding that the provider would bill the TennCare MCO directly. In these situations, the provider must contract with the MCO in the same manner as they would if the service was being delivered in another setting (e.g., provider office or member home). All requirements in this manual would apply in such a situation, except that the school district would not need to become a TennCare provider and would not be the billing provider.

MCOs may choose not to contract with a provider if they have an adequate network to facilitate access to the service. If this occurs in the case of school-based services, the school should contact the MCO to advise them of their need for service and to discuss with the MCO options for obtaining those services. MCOs may then choose to contract with the requested provider or may facilitate access to the service through an alternative in-network provider. If a school or family feels that the services provided outside of the school setting are not adequate, the school or family can file an appeal with the MCO. Appeal processes are outlined in member handbooks and provider manuals that are sent to enrollees annually. Providers can also request the member handbook and provider manuals by contacting the MCOs.

## **Billing Requirements**

In order for a school district to bill and be reimbursed by a TennCare MCO, the

following criteria must be met:

<sup>1</sup>*Inclusion in the IEP:* The medical service must be included in the student's IEP, including information regarding the medical service type, amount, and frequency. The services recorded in the IEP must be consistent with services that would be included in the IEP for any student with similar needs, regardless of TennCare eligibility. Medical services that are not in an IEP are not covered by the process outlined in this document. For example, medical services appearing in an Individual Health Plan (IHP) are not covered by this process. An IHP is a separate document. A child may have both an IEP and an IHP. TennCare MCOs no longer require that either the IEP or the parental consent form be submitted to the MCO before a school may bill for services; however, those documents must be made available by the school district upon request.

- *Physician's order:* The health care service must have been ordered by the student's primary care provider (PCP) or other treating licensed healthcare provider in the student's MCO network. IEPs are not physician's orders on their own. According to the CMS, TennCare's federal oversight agency, an IEP does not constitute an ordering, referring, or prescribing document and thus is not sufficient to fulfill federal requirements.
- *Documentation of medical necessity and service delivery:* The health care service must be medically necessary. Documentation of medical necessity would include records indicating that appropriate diagnostic screening was performed to determine the need for treatment. This is information that supports a physician's order for treatment. TennCare MCOs may require that some services be authorized prior to being eligible for reimbursement. Prior authorization means the MCO may require that they approve coverage of the services before it is performed. If a service requires prior authorization, it will be indicated in the MCOs' provider manuals. In these cases, the MCO will determine the medical necessity during the prior authorization process. Medical necessity is determined by evaluating the case using clinical guidelines. Providers can request these guidelines from the MCO. As part of the prior authorization process, the MCO may require that additional documentation be provided before the service is approved. Additional documentation may be medical records describing screenings or test results. Documentation may include assessments, test results, and progress notes. If a request is denied, the criteria for the denial will be provided in writing. Services provided without proper prior authorization, when required by the MCO, will not be reimbursed. In all cases, records maintained by the school district must clearly and specifically describe the need for the health care service and document each instance of delivery of the health care service in accordance with generally accepted medical documentation standards. This includes doctor's orders, any evaluations or tests conducted to determine the service was necessary to begin the service or continue it, as well as a description of the treatment performed for each billing and any progress notes or other standards for the provider's profession. If guidance is needed regarding documentation requirements, schools should contact the MCO contacts listed in this document.

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<sup>1</sup> When a school district invites a behavioral health provider (e.g., Community Mental Health Center) to deliver behavioral health services in the school setting, the MCO may process and pay claims for medically necessary, covered behavioral health services that are not included in the IEP.

· *Rendering providers:* While the school district may function as the billing provider, the individual delivering the health care service (i.e., the rendering provider) must be a health care professional with an active Tennessee health care license, working within the scope of their license, registered with TennCare, and under contract with an MCO. The rendering provider must be identified in the rendering provider field of the CMS 1500 claim form ([Appendix A](#)).

*Filing a claim:* To be reimbursed for medical services, a school district must file a claim with the member's (i.e., student) MCO. The school district must be contracted with a student's MCO to receive payment. Claims are submitted on a specific form (CMS Form 1500) and provide detailed information that allows the MCO to pay for services. Generally, claims must be filed electronically. The form in Appendix A is a hard copy representation of the data that is to be submitted. This includes information about the member/student, the billing provider (e.g., the school district), the rendering provider (i.e., the licensed health care provider), the service delivery location (e.g., the school), and the specific service that was provided. All TennCare medically necessary, covered services provided on school grounds shall be billed with the place of service code (03), defined by CMS as any facility whose primary purpose is education. The school district must be listed as the billing provider on the CMS Form 1500 in order to receive payment directly from the MCO. Specific information/requirements regarding claim submission protocols, provider reimbursement, and procedures for resolution of any disputes regarding payment of claims can be found in the MCOs' provider manuals at the links listed below:

- [Amerigroup Community Care of Tennessee](#)
- [BlueCare of Tennessee/TennCare Select](#)
- [UnitedHealthcare Community Plan of Tennessee](#)

All MCOs require compliance with the National Correct Coding Initiative ([here](#)). This initiative provides guidance on the appropriate way to code for all types of patient encounters.

**Note: Schools may find it beneficial to obtain assistance with coding and billing for services. This is permissible. If a school district does decide to employ a vendor, school districts remain liable for ensuring billing practices are in accordance with both their MCO provider agreements and all applicable state and federal laws. School districts should ensure vendors meet those requirements. A list of school-based Medicaid billing companies can be found on the department's website [here](#).**

## Audits and Other Record Review Requirements

TennCare requires that MCO provider contracts address access to records. Those contracts generally stipulate that TennCare or its authorized representative, the MCO, the Office of the Comptroller of the Treasury, and any health oversight agency—such as the Tennessee Office of the Inspector General, the Department of Health and Human Services Office of Inspector General, the Department of Justice, and any other authorized state or federal agency—have the right to review records related to billings to MCOs. They can elect to request copies of records or access records on site.

Records requests can occur from routine sampling of claims by any of the entities listed here, as part of quality reviews, or as part of an investigation of fraud, waste, or abuse. If a school has records selected for review or audit by an MCO, the MCO will generally send a letter requesting a copy of records supporting reimbursement of the services provided. MCOs can request to review records on site if they choose. Those records generally would include a copy of the IEP, doctor's orders, medical records documenting the need for and delivery of the billed service, and the IEP parental consent form. Records requests from other entities may follow this same process but can vary. Failure to provide requested records or comply with the requirements outlined in this manual may result in action including but not limited to: recoupment, imposition of prior authorization requirements, and/or disenrollment from the MCO network and/or loss of Medicaid ID number.

## Record Retention Requirements

TennCare requires that the MCO provider agreements contain a record retention policy that includes an adequate record system where all records be maintained for ten years from the termination of the provider agreement or retained until all evaluations, audits, reviews, investigations, or prosecutions are completed for recording enrollee services, servicing providers, charges, dates, and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil, or criminal investigations and prosecutions).

## Understanding FERPA and HIPAA Regulations

There are several key aspects in the interplay between the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to the use and disclosure of information about students. The following table highlights the key points of the requirements imposed by the two regulatory structures governing education records and health records.

**Understanding FERPA and HIPAA**

	<b>Applicability*</b>	<b>Restriction</b>	<b>Types of Information</b>	<b>Disclosure without Consent</b>	<b>Interplay</b>
<b>HIPAA</b>	Applies to covered entities (e.g., health plans, health transaction clearinghouses, and healthcare providers) regardless of source for funding or	A covered entity may not use or disclose protected health information (PHI) except either: 1. as the Privacy Rule permits or requires; or 2. as the	PHI is individually identifiable health information held or transmitted by a covered entity or its business associate, in	Permitted for treatment, payment and healthcare operations, public health activities, research, and law enforcement purposes.	The HIPAA Privacy Rule generally does not apply to elementary or secondary school because: 1. it is not a HIPAA covered entity; or 2. it is a HIPAA

	<b>Applicability*</b>	<b>Restriction</b>	<b>Types of Information</b>	<b>Disclosure without Consent</b>	<b>Interplay</b>
	administration model	individual (or their representative) authorizes in writing.	any form or medium.		covered entity but maintains health information only in records that are defined as education records, and the HIPAA Privacy Rule excludes such information from coverage.
<b>FERPA</b>	All educational agencies and institutions (and non-school entities) that receive funds under any program administered by the U.S. Department of Education	Entity is prohibited from disclosing education records or personally identifiable information (PII) without a parent or eligible student's (at least 18) written consent.	PII includes name, address, personal identifiers, like social security number or date of birth that can be used to identify a student (with an exception to directory information).  Education records are 1. directly related to a student, and 2. maintained by an educational agency or by a party acting for the agency.	Permitted for health and safety of the individual, some research purposes, to other school officials for normal operations, and law enforcement purposes	

\*Applicability of regulations is fact specific.

It should be noted that this is a limited snapshot of the two frameworks. The applicability of either set of regulations to a facility for use or disclosure depends on the facts specific to the situation. For example, a school may be considered a health care provider under HIPAA if it provides health care to students in the normal course of business. If in connection with that health care, it conducts any covered transactions electronically, it is considered a covered entity under HIPAA and would have compliance obligations with respect to transactions. However, if the health records maintained by the school are considered education records under FERPA, these are excluded under HIPAA Privacy Rule, and the school would have to comply with FERPA's privacy requirements. The U.S. Departments of Health and Human Services and Education, as well as other entities, prepared and provided a variety of guidance documents on the relationship between HIPAA and FERPA. Some of those are listed below:

- ✓ [U.S. Department of Health and Human Services and U.S. Department of Education Joint Guidance on the Application of the Family Educational Rights and Privacy Act \(FERPA\) And the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) To Student Health Records](#)
- ✓ [U.S. Department of Health and Human Services FAQ on FERPA and HIPAA](#)
- ✓ [The Association of State and Territorial Health Official Comparison of FERPA and HIPAA Privacy for Accessing Student Health Data](#)
- ✓ [National Association of School Nurses](#)

# Glossary

- ✓ Amerigroup Community Care of Tennessee – One of four managed care organizations serving TennCare eligible Tennesseans.
- ✓ BlueCare of Tennessee – One of four managed care organizations serving TennCare eligible Tennesseans.
- ✓ Center for Medicare and Medicaid Services (CMS) – Federal organization that manages Medicare and Medicaid rules and regulations including funding for TennCare.
- ✓ Council for Affordable Quality Healthcare (CAQH) – A vendor utilized by TennCare to assist in the registration of each individual provider of medical services.
- ✓ Individuals with Disabilities Education Act (IDEA) – Also called IDEIA; this is a special education federal law with rules and regulations that guide public school districts.
- ✓ Managed Care Organization (MCO) – Refers to the four companies in Tennessee who manage the healthcare for TennCare enrollees (i.e., Amerigroup, BlueCare of Tennessee, UnitedHealthcare Community Plan, and TennCare Select).
- ✓ Medicaid Identification Number – Number assigned to school districts as part of the registration and contracting process to receive reimbursement for medically necessary services.
- ✓ Medical Necessity – For a service to be considered medically necessary, it must meet five criteria:
  1. Must be ordered by a treating licensed physician or other treating licensed health care provider
  2. Must diagnose or treat a medical condition
  3. Must be safe and effective
  4. Must not be experimental or investigational
  5. Must be the least costly alternative
- ✓ National Correct Coding Initiative – Program designed to prevent improper payment of procedures that should not be submitted together.
- ✓ National Provider Identifier (NPI) – National provider number assigned to each approved provider of Medicaid services. Speech and language pathologists, occupational therapists, and

physical therapists are a few providers that must apply for these numbers. A separate NPI is required for the school district.

- ✓ TennCare Select – A MCO operated by BlueCross/Blue Shield of Tennessee that manages the care of specific populations in TennCare.
- ✓ Treating (Rendering) Provider – A licensed TennCare provider acting within the scope of their practice that has a treatment relationship with the patient. This does not include providers who have not examined the patient and have reviewed records to order services.
- ✓ UnitedHealthcare Community Plan – One of four managed care organizations serving TennCare eligible Tennesseans

# Appendix A: CMS Form 1500



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA												PICA <input type="checkbox"/>																																																																																			
1. MEDICARE <input type="checkbox"/> (Medicare#)												MEDICAID <input type="checkbox"/> (Medicaid#)												TRICARE <input type="checkbox"/> (ID#/DoD#)												CHAMPVA <input type="checkbox"/> (Member ID#)												GROUP HEALTH PLAN <input type="checkbox"/> (ID#)												FECA BUK LUNG <input type="checkbox"/> (ID#)												OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>												4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																															
5. PATIENT'S ADDRESS (No., Street)																								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												8. RESERVED FOR NUCC USE												CITY												STATE																																															
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 FEE NUMBER																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO												a. INSURED'S DATE OF BIRTH MM DD YY												SEX <input type="checkbox"/>																																																											
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO												b. OTHER CLAIM IS (Designated by NUCC)												c. INSURANCE PLAN NAME OR PROGRAM NAME																																																											
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.</i>												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																											
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 payment on my behalf.																																																																																															
SIGNED _____												DATE _____												SIGNED _____												DATE _____																																																											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY												15. OTHER DATE QUAL. DD YY												16. PATIENT UNDER CURRENT OCCUPATION FROM MM DD TO MM DD												17. HOSPITALIZATION DATE FROM MM DD TO MM DD																																																											
17a. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17b. NPI												18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO												\$ CHARGES																																																											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to ICD-9-CM code below (24E))																																																																																															
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____																																																																																															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE EMG												C. PROCEDURES (Express Unusual) CPT/HCPCS												D. SUPPLIER (L. CENTER)												E. \$ CHARGES												F. DAYS OR UNITS												G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.																							
25. FEDERAL TAX I.D. NUMBER												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$												29. AMOUNT PAID \$												30. Rsvd for NUCC Use																																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the above information reverse apply to this bill and no part thereof.)																																																																																															
32. SERVICE FACILITY LOCATION INFORMATION																																																																																															
33. BILLING PROVIDER INFO & PH # ( )																																																																																															
SIGNED _____												DATE _____												# NPI												# NPI																																																											

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND TRICARE PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate, and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)**

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate, and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license#, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties' payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR TRICARE CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment

claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

# Appendix B: Parental Consent Form



Student Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

School District: \_\_\_\_\_

By signing this Release form, you allow your child's school, along with the Bureau of TennCare, your child's health care providers, and your child's TennCare managed care organization to release documents to each other containing educational records about your child. The following records may be disclosed:

1. Your child's Individualized Education Program (IEP);
2. Medical and psychology records, including this type of information that is contained in your child's educational records; and
3. Education reports, records, or relevant test results contained in your child's educational records.

The purpose for allowing these records to be shared is so that the people providing health care related services can talk with your child's school about your child and those services. In addition, allowing these records to be shared also makes it so that your child's school can verify whether your child is on TennCare so that the school can ask TennCare to pay for eligible school-based health services under the Individuals with Disabilities Education Act. If you sign this release form, you will be giving consent for the records listed above to be released to the Department of Education, school district, their billing agent(s), the insured's physician(s), and TennCare representatives as needed.

Note: You are not required to sign this Release form for your child to receive services in their IEP. Those services will still be provided to your child at no cost to you. If you do sign the release form, you have the right to later withdraw or revoke your consent at any time by sending a letter to the Director of Special Education.

By signing this form, I am stating that:

- ✓ I have received a copy of the Notice of Access to Information.
- ✓ I understand and agree that \_\_\_\_\_ (name of school district) may access my child's public benefits or insurance information to seek reimbursement for services rendered as listed on the IEP or Individualized Family Service Plan (IFSP).
- ✓ I understand and agree that the records and information listed above may be released for the purposes described in this release to the people or organizations identified above.

DATE: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

TC-1087 July 2017



RDA2046