ALASKA VA

TRIBAL HEALTH SHARING AND REIMBURSEMENT AGREEMENT

2016 GUIDEBOOK

SERVING AMERICA'S

VETERANS

http:// www.alaska.va.gov

(Click on **Partners** under **Resources** on right hand side of web page. Then click link under Vendor Resources)

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VA/Native Sharing and Reimbursement Agreement

The Sharing Agreements between Alaska VA Healthcare System (AVAHS) and the Alaska Tribal Health Programs set forth the terms and conditions under which AVAHS will authorize and reimburse the Native Health Program for direct care services provided to eligible Veterans.

This Guidebook outlines the process and procedures implemented to manage, maintain, and utilize the Agreement between partnering Native Health Programs and the Alaska VA Healthcare System. The goal of the Agreement is to increase access to healthcare for Alaska Veterans. Types of care provided under the Agreements include; outpatient medical and mental health, inpatient care, ambulatory surgery, and other services available in the VA benefits package.

Veteran Enrollment Process/Eligibility Verification

A Veteran must be enrolled in the VA healthcare system prior to services being rendered in order for the AVAHS to authorize and/or reimburse for healthcare services. The enrollment/application form (VA Form 10-10 EZ) can be obtained online, by visiting, calling or writing any VA health care facility or Veterans' benefits office. Depending on the method of application chosen by the Veteran, the following are ways the VA can receive and process the application:

(1) Applications being mailed to the facility should be sent to the following address:

Department of Veterans Affairs
Alaska VA Healthcare System
ATTN: Eligibility Department
1201 North Muldoon Road
Anchorage, AK 99504

(2) Applications with signature can be faxed to 907-257-6784.

(3) Forms can be accessed online by going to this website: https://www.1010ez.med.va.gov

Some Veterans are required to provide a financial assessment (Means Testing) as part of the enrollment process. Normally, Veterans that do not have a service connected condition are required to complete this as part of the enrollment process.

A DD 214 (Report of Separation) accompanying the request can help speed up the process of verification and enrollment; however the DD214 is NOT REQUIRED and should not hold up sending in the Veterans 1010EZ. If a Veteran has misplaced or lost their DD 214, then the application can still be processed, but may delay the notification process. A Veteran can request another copy to be sent to them by completing SF-180, which is accessible at the Alaska VA Website (address on cover of this document), in person at the Alaska VA, or also online at: http://www.archives.gov/veterans/military-service-records/. The Health Eligibility Center in Atlanta, Georgia is the final authority of Veteran enrollment or status.

Unless there is an urgent need, please give the VA Healthcare system at least two weeks to process a Veteran for enrollment. A Veteran may check the status of their enrollment by calling the Alaska VA at 907-257-4700 (Option 4 and then 1) which will be answered by one of the clerks if available. The

eligibility office will respond to messages within 24 hours. Another avenue of checking Veteran's enrollment/eligibility is to contact the Rural Health National Service helpline at 855-488-8441.

Note: Veterans enrolled and eligible for VA healthcare meet the minimum requirements under the Affordable Care Act.

AN/AI Direct Care Outpatient

Preauthorization is not required for AN/AI eligible Veterans receiving Direct care services from the partnering Native Health Program. A Veteran must be eligible for VA Healthcare services and the service must be included as part of the Veterans Benefits package.

AN/AI Referral Management to a Non Native Facility

When a Native health care facility needs to refer an AN/AI Veteran for services not available within the AK Native health care system, this care **Must Be Preauthorized.** A "Request for Authorization" form should be faxed to Integrated Care Service, fax 907-257-7418/4718. (See document on page **19** of this guidebook.

Clinical documentation must be attached to the "Request for Authorization" form. Clinical documentation should include at a minimum: a Diagnosis list, Medication list, progress notes from the visit requesting the referral, and any ancillary testing results that the receiving provider would need to care for the patient.

Once Integrated Care Service receives the "Request for Authorization" form and clinical documentation, and it has been determined the Veteran is eligible for VA healthcare services, they will determine whether the care can be provided within a federal facility or if Non VA care will be purchased. The Veteran will be called to coordinate the appointment time and/or to select a Non VA provider. The Veteran will be mailed a copy of the authorization and an Authorization Letter. The Non VA care provider will be faxed a copy of the authorization and the supporting clinical documentation.

Alaska Veterans Healthcare Clinics/Catchment Areas

The Alaska VA Healthcare System has clinics in the following areas:

- Anchorage VA Medical Center
- Fairbanks VA Community Based Outpatient Clinic (located on Ft. Wainwright in Bassett Army Community Hospital).
- Mat-Su VA Community Based Outpatient Clinic (Wasilla)
- Kenai VA Community Based Outpatient Clinic and Homer VA Outreach Clinic
- Juneau VA Outreach Clinic

If a Non AN/AI resides in a VA clinic catchment area and desires to utilize their VA benefits for their health care, s/he must go to one of the VA clinic's for primary care and/or any specialty care. **See Attached Catchment Area documents.**

Non AN/AI Pre-Authorization/Notification Process

In order for Non AN/AI Veterans to be eligible for VA coverage for hospitalization, emergency room care, or preauthorized outpatient care, the Veteran must be enrolled with the VA at the time service. **If enrollment has lapsed or if the Veteran has never applied for healthcare benefits, the care cannot be covered by the VA.** The Veteran may apply for enrollment at the time of admission, but it will go into effect after discharge.

Preauthorized Outpatient Care:

All non-emergent care must be **preauthorized**. VA encourages vendors to submit routine requests and supporting documentation in advance, and as early as possible.

The process to request preauthorized outpatient care for Non AN/AI Veterans is the same as requesting care for an AN/AI Veteran outside a Native facility. **See AN/AI Referral Management to a Non Native Facility above.** The **Alaska VA Outpatient Authorization Request** form should be submitted. The form can be located on **page 19** of this guidebook.

Upon approval the Non-AN/AI Veteran may be authorized for annual visits not to exceed 10, *prorated during the fiscal year*, (which could be used for primary care or behavioral health services), including simple labs and basic radiology.

If an office visit is for an emergent or urgent situation, notify the VA by utilizing the ER/Observation Alert Form, located on page **21**, in order for us to document the encounter within our system as a possible ER/urgent care visit. If coded as emergent care, it will be reviewed as an emergency room visit.

Please read the Authorization Document (VA Form 10-7079) carefully. VA will not be responsible for payment on any follow up appointments, diagnostic testing, or procedures that have not been pre-approved. The patient will be responsible for payment.

All VA rules and regulations pertaining to Veteran benefits, including healthcare, are established by Congress and administered by the Secretary of Veterans Affairs. These rules are subject to change.

Emergency Medical Services

- Emergency medical services are not pre-authorized. However, medical services that are necessary on a prompt or emergent basis should be reported within 72 hours in order to be reviewed under Alaska's expanded authority. Please submit notification of emergent medical care by letter, phone call, or facsimile. See **"VA ER/OBSERVATION ALERT"** on page **21** of this guidebook.

Telephone notifications:

Medical Administrative Assistants are available 24 hours a day @ 1-907-580-6421 or Toll Free: 877-817-3885.
Pager contact #: 907-580-7243, Ext. #0033

ICS (Mon – Fri, 08:00AM - 4:00PM)
@ 1-888-353-7574, ext. 6904 or
907- 257-6904

24 Hour FAX: 1-907-257-7418/4718

Claims for emergency services are reviewed and verified by the VA prior to payment by our medical review board. The claims and the **emergency room report** should contain sufficient information to enable the review board to:

- Properly identify the veteran;
- Determine the condition treated and amount of treatment already furnished;
- Confirm the need for the prompt or emergency treatment;
- Determine what further treatment, if any, is required.

If it is determined that the veteran is eligible for prompt or emergent treatment, an authorization will be completed and forwarded to our Fiscal Service for payment. If it is determined that the emergency room visit did not meet the criteria for emergent medical services, an explanation of benefit letter will be sent to both the vendor and the veteran stating the reason for denial.

Hospitalizations/Inpatient Admission

When veterans are emergently admitted to a non-VA hospital, the law requires VA be notified within **72 hours** from the time of admission. This allows us the opportunity to verify eligibility or assist you in obtaining the necessary documents.

To be eligible for VA coverage for inpatient care, veterans must be enrolled with the Alaska VA at the time of admission. ***If enrollment has lapsed or if the veteran has never applied for healthcare benefits, the admission will not be covered by the VA.*** The veteran may apply for enrollment at the time of admission, but it will go into effect until after discharge. We request admission notifications be done via fax at 1-907-257-6920.

See **"VA Inpatient ALERT"** on page **20** of this guidebook.

By accepting VA coverage, the veteran is subject to transfer to a Federal facility or to a contract facility if medically appropriate.
Considerations for each transfer:

- The patient's clinical stability
- Requests for surgical/invasive procedures
- Medical services needed
- Availability of such services at a Federal facility

Every effort will be made to respond to requests for authorization of medical services in an expeditious manner. VA will not transfer any patient who is assessed by the physician and documented as clinically unstable for transfer. Please see "**Transferring VA patients to another facility**" below for specific assistance with transfers.

Transferring VA patients to another facility

If you have a VA eligible patient that needs to be transferred to another facility (and the patient wishes to use his VA benefit), please call the **VA MAA** (***see Telephone notifications on page 14 of this document***). The MAA will verify the patient's eligibility for VA health care benefits and will facilitate transfer to the needed facility if eligible.

The VA is required by law to utilize federal facilities first, and then contract services. We may purchase from other sources only if federal or contract services are not available. Alaska VA has contracted with an air ambulance service to provide medivac services to Veteran patients. The MAA is the designated contact to arrange for transport. Medivac arrangements made outside MAA channels may result in the VA not authorizing payment for the medivac.

Many patients can be transferred to Joint Base Elmendorf Richardson (JBER) medical facility in Anchorage. In this case, the MAA will alert the on-call internist who will then speak with the referring provider. Upon acceptance by the JBER internist, the MAA will initiate medivac transportation of the patient from your facility to JBER or another appropriate federal facility as needed. This is the preferred method of patient referral, as federal law requires veterans to be cared for at federal facilities when possible.

There may be instances where the patient requires health care services that JBER cannot provide (i.e. interventional cardiology, neurosurgery), and the patient is **unstable**, transfer to Providence Alaska Medical Center (Anchorage) will be requested. If the patient is **stable**, transfer to Seattle VA will be requested.

Most Southeast Alaska patients will be transferred to Seattle VA, <u>not</u> Anchorage VA. Medivac distances are similar and the range of services available at Seattle VA is much greater than Anchorage VA. In both of the above cases, the VA MAA can assist you in facilitating the transfer.

In all cases an accepting physician and a bed for the patient need to be acquired before medivac transportation can be arranged.

Care with Special Eligibility

The VA provides a robust Medical Benefits Package of health services and needs, but some categories/specialties of care do have specific eligibility criteria that must be met in order to receive them. Normally, it is dependent on the enrollment priority group or service connected condition(s) assigned to a Veteran. Special reimbursement rates and eligibility criteria apply to the following services:

- Dental
- Certain Prosthetic items (hearing aids and eyeglasses)
- Long Term Care, to include nursing home care
- Transplant services

Maternity Benefits cover the Veteran's obstetric care, in addition, care for the newborn child is provided for the first seven (7) days.

There are some services that are excluded from the VA Medical Benefits Package which include:

- Cosmetic surgery that is not medically necessary
- Abortions and abortion counseling
- In vitro fertilization
- Drugs, and biological/medical devices not approved by the Food and Drug Admin.
- Gender alterations
- Memberships in spas and health clubs

Should there be any questions concerning Veterans eligibility for any of these services then please contact the Integrated Care Service 1-888-353-7574, ext. 6904. Your referral may require a call to another service for verification as well.

Travel Eligibility

Veterans must meet established eligibility criteria for travel related benefits. In order for a Veteran to be eligible for travel benefits they must meet one of the following criteria:

- Veteran must have a service connected disability rating of 30 percent or greater
- Traveling for treatment of a service-connected condition
- Receive a VA pension or income that does not exceed the maximum annual pension rate. The rate is similar to Medicaid qualifications. Please Call VA beneficiary travel for income levels.
- Traveling for a scheduled compensation and pension examination

If an AN/AI travel eligible Veteran must drive into a VA or Native facility for treatment and the distance exceeds 27 miles from the facility – they can be reimbursed for their travel. The current mileage reimbursement is 41.5 cents per mile. The veteran must either present to the Alaska VA travel

department for reimbursement, mail in the VA Form 3542, or the form can be faxed to VA travel at 907-257-6982.

Veterans that require air travel for their appointment will need to have the travel request form (see page 23), faxed in to 907-257-6982; to include medical evidence from the facility generating the request for the appointment. The VA travel office will validate travel eligibility and notify the Veteran of their travel arrangements. It is requested that the facility be given as much notice as possible (prefer at least two weeks) in order to avoid any delays in arranging travel.

A Veteran may check the status of their travel arrangements by calling the Alaska VA at 907-257-4700, option 4 and then option 2, which will be answered by one of the clerks if available. The travel office will respond to messages within 24 hours.

Lodging and meals may also be reimbursable, depending on the treatment needed, and if an overnight stay is required.

Pharmacy Services

The VA pharmacy provides needed medications accurately, safely, and in a timely manner. They monitor therapeutic outcomes of prescribed medications to minimize potentially negative effects. Prescriptions may be brought in person to the VA Pharmacy window, at 1201 North Muldoon Road, or mailed to the VA Pharmacy at the following address:

AK VA Healthcare System
Attn: 119 (Pharmacy)
1201 North Muldoon Road
Anchorage, AK 99504
PH: 907-257-4805 or 1-888-353-7574, Extension 4805
FAX: 907-257-6755

To the extent pharmaceuticals are reimbursable under this Agreement, AVAHS shall reimburse the actual cost of the drugs dispensed by the tribal sharing agreement partner.

AVAHS will routinely reimburse ATHP only for drugs on the formulary used by AVAHS. Requests for reimbursement of non-formulary drugs will be submitted to VA Pharmacy and processed according to AVAHS policy on non-formulary drugs by mail to Alaska VA Healthcare System, Attn: 119 (Pharmacy), Chief, Pharmacy, 1201 North Muldoon Road, Anchorage, Alaska, 99504, telephone 1-800-907-257-4805, or fax 907-257-6755.

AVAHS will reimburse ATHP for drugs provided to an AN/AI Eligible Veteran during an outpatient visit, and for prescriptions filled by ATHP. Note: If the ATHP does not provide a particular medication needed by a Veteran please inquire of the CMOP to find out if it is available from the VA.

Non-AN/AI Eligible Veterans. AVAHS will reimburse ATHP for drugs provided to a non-AN/AI Eligible Veteran during an outpatient visit and for an initial supply that shall not exceed a period of 30 days of prescribed drugs. ATHP shall refer Non-AN/AI Eligible Veterans to a VA facility or CMOP to fill prescriptions other than for the initial 30 day supply. Fax prescription to the VA Pharmacy and the Pharmacist will enter the Veteran in to the CMOP system. The Veteran can bring in the

prescription if located in Anchorage and the Pharmacist will enter into the CMOP system for refills. The Veteran can request refills themselves from the CMOP if prescribed by their provider by calling the 1-800 number written on the medication bottle label. Most refills for chronic medications are for 90 days.

To obtain a copy of the VA formulary list of medications, please call: 907-257-4805 or 1-888-353-7574, ext. 4805. It is also available at
http://www.pbm.va.gov/nationalformulary.asp

The VA Pharmacy staff is available Monday – Friday, 8:00 am – 4:30 pm.

To file a claim for reimbursement of medications for eligible Native Veterans the information needs to include: Name of Veteran, social security number, date of fill, quantity, generic name, NDC#, tax ID number, and provider name. If the drug is a controlled substance, the DEA# must also be provided.

Billing/Reimbursement

The bill paying process for Alaska claims is pretty straight forward and follows standard billing practices. The only exception to this would be adding the code identified for whether a Veteran is either a native or a non-native beneficiary (see billing examples in this guide). Claims are processed at either of the two processing centers identified below; but again, is dependent on the type of claim - whether the Veteran is native or not. You can reach them by calling 855-331-5560 between the hours of 8:30 AM and 3:30 PM (PST), Monday thru Friday.

All claims for services must be submitted by mail. Please do not fax claims as our system utilizes OCR software and must read the claims to transfer the data appropriately for timely processing.

NON-Native Claims Address:

Department of Veteran Affairs
Alaska VA Healthcare System
1201 North Muldoon
Anchorage, AK 99504
ATTN: 136F

Native Beneficiary Claims Address:

Department of Veterans Affairs
V20 NPC-IHS
PO Box 1035, Mail Stop 10N20
Portland, OR 97207

Incomplete claims or claims missing information will delay processing, and could result in either claim denials or rejects. We process all claims off invoices, not statements. In order to process an invoice in a timely manner, the VA is requesting that each invoice (original not photocopy) UB-04 or CMS 1500 contain the following:

Claims must contain:

- Name, Address, and SSN of the Veteran
- Name, Address, and Tax ID of the Vendor
- Name, Address, or facility where services were rendered
- Date of Service
- Detailed itemization, appropriate CPT and/or HCPC codes for each service provided, and ICD-9-CM (diagnosis) code(s). Payment will be made based on the approved Encounter rate for outpatient visit or inpatient hospitalization as published in the Federal Register. Community Health Aide services will be reimbursed at 85% of the Encounter rate.

Claims should be filed within one year of the date of service. The VA will make payment on electronic claims within 30 days and 45 days for paper claims.

If a Native Health Program seeks reimbursement under the Sharing Agreement, such payment shall be considered payment in full and the Native Health Program may not seek reimbursement for such care from entities or individuals other than the VA.

Reimbursement for pharmaceuticals will be made for Native Veterans receiving care by Native Health Organizations. Pharmaceuticals for Veterans in an inpatient status are included in the per diem encounter rate.

Copayment/Third Party Billing

The Co-Payment requirement has been waived for Native Veterans. The Co-payment required for Non-Native Veterans will be determined by the VA, and the Veteran will be billed by the VA.

Co-payment amounts are normally $15.00 for primary care visits, and $50.00 for a specialty visit. Pharmacy co-payments are also required for certain Veterans.

VA will pursue third party billing when appropriate for services reimbursed to the Native Health Program.

Common VA Departments and Extensions:

The 1-888 phone numbers below can also be reached by dialing
1-907-257-xxxx (xxxx = extension)
Normal VA Duty Hours: Monday – Friday 8:00 a.m. to 4:30 p.m.

Dental Service	1-888-353-7574, ext. 4940
Diabetes Coordinator	1-888-353-7574, ext. 4828
Inpatient Notification	1-888-353-7574, ext. 4976
Laboratory	1-888-353-7574, ext. 4870
Military Sexual Trauma Coordinator	1-888-353-7574, ext. 4908
My HealtheVet Coordinator	1-888-353-7574, ext. 7496
Outpatient Authorizations for Purchased Care	1-888-353-7574, ext. 6904
Pharmacy	1-888-353-7574, ext. 4805
Prosthetics	1-888-353-7574, ext. 4930
Rural Health Program Office	1-888-353-7574, ext. 5460
Rural Health Nurse	1-888-353-7574, ext. 5481
Rural Health Eligibility National Service Helpline	**1-855-488-8441**
Social & Behavioral Health Service	1-888-353-7574, ext. 4854
Suicide Prevention Coordinator	1-888-353-7574, ext. 4846
Telehealth/Triage	1-888-353-7574, Option #3
Veteran Eligibility and Enrollment	1-888-353-7574, ext. 3323
Veteran Travel	1-888-353-7574, ext. 4738
Veterans Benefits (For non-healthcare benefits such as Disability and Pension)	1-800-827-1000

Other Alaska Veterans Healthcare Clinics/Offices:

Fairbanks VA Medical Clinic on Ft. Wainwright	1-907-361-6370, ext. #1
Fairbanks RN Care Manager	1-907-361-6370, ext. #1
Fairbanks VA Toll-Free	1-888-353-5242
Fairbanks Fax	1-907-361-5260
Kenai VA Clinic	1-907-395-4100
Kenai VA Toll-Free	1-877-797-8924
Kenai Fax	1-907-283-4236
Mat-Su VA Clinic	1-907-631-3100
Mat-Su VA Toll Free	1-866-323-8648
Mat-Su VA Fax	1-907-631-3101
Juneau VA Outreach Clinic	1-907-796-4300
Juneau Outreach Toll Free	1-888-308-7890
Juneau Outreach Fax	1-907-796-4301

Phone Numbers for Integrated Care Service

The 1-888 phone numbers below can also be reached by dialing
1-907-257-xxxx (xxxx = extension)
Normal VA Duty Hours: Monday – Friday 8:00 am to 4:30 pm

Authorizations/Outpatient Patient Services Asst. (PSA)	1-888-353-7574, ext. 6904
Fax Anchorage Team authorization requests	1-907-257-7418/4718
Fax Rural Team authorization requests	1-907-257-7418/4718
DeLynn James, Chief, Integrated Care Service	1-888-353-7574, ext. 6922
David Marsett, Supervisory Program Specialist	1-888-353-7574, ext. 4943
Peggy Balster, UM Nurse Manager	1-888-353-7574, ext. 4819
Cindy Massey, Nurse Manager	1-888-353-7574, ext. 3740
Inpatient/UM Program Support Asst.	1-907-257-4976
Utilization Management Fax	1-907-257-6920
Sharing Agreement Authorization Nurse	1-888-353-7574, ext. 5424
Glenda Stratton, ICS Lead PSA	1-888-353-7574, ext. 5408
Ann Brown, ICS Lead PSA	1-888-353-7574, ext. 5448

******Integrated Care Service/Authorizations Message Line 1-888-353-7574, ext. 3202

Messages left on the Message Line are checked daily and returned with 24 hours.

Other Important Numbers to keep handy

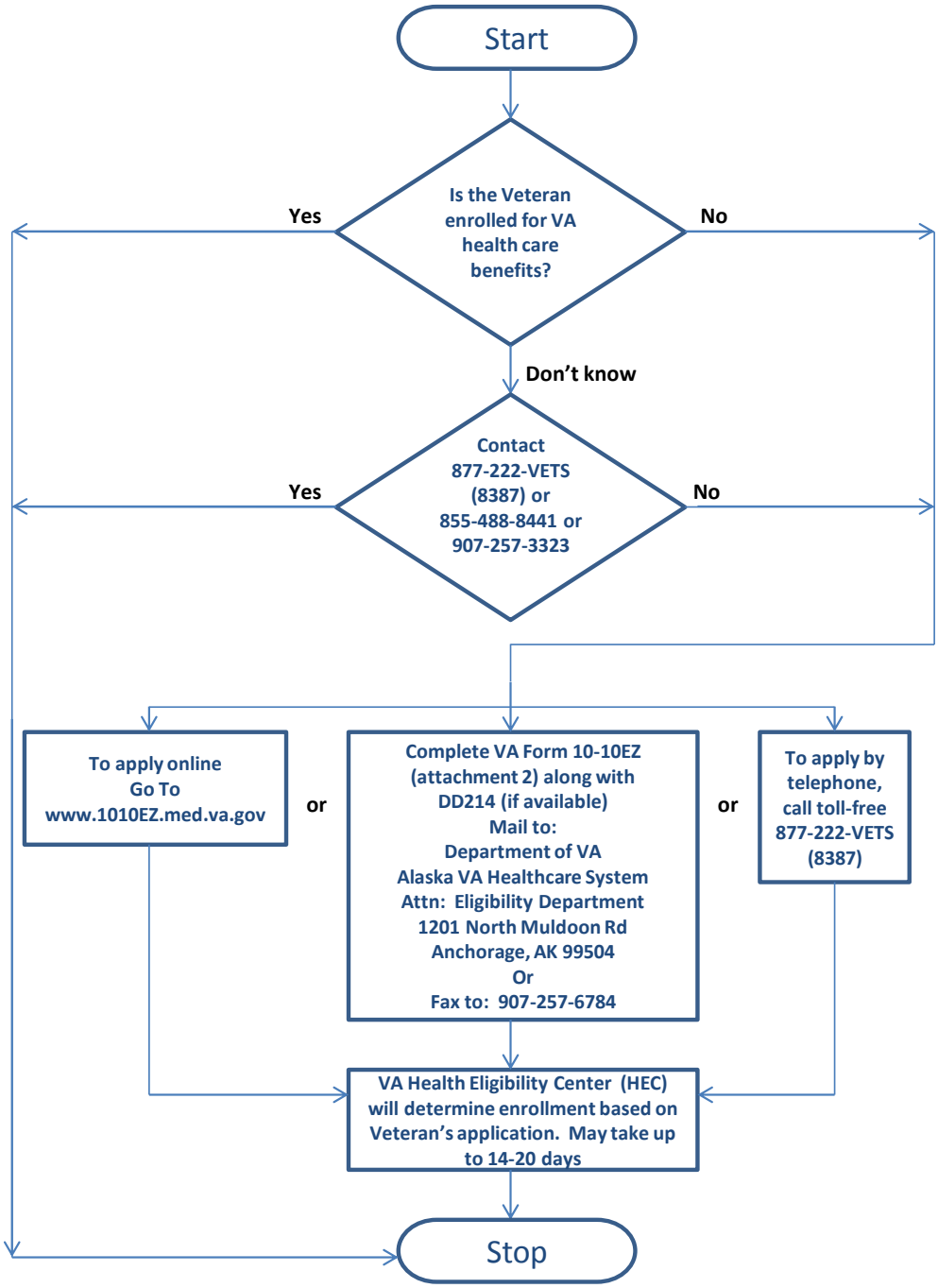
Telehealth/Triage (8:00 am–4:00 pm) Veterans' health concerns:
1-888-353-7574, ext. 4710

Telehealth/Triage during non-duty hour's 24 hr. off-site nurses to answer Veterans' health concerns/questions:
1-888-353-7574, option 3

MAAs – "24/7" for emergencies, inpatient admissions, VA transfers, after hour questions

Direct Dial:	**1-907-580-6421**
Toll Free #:	**1-877-817-3885**
MAA Pager:	**907-580-7243, ext. #0033**

VETERANS CRISIS LINE: 1-800-273-8255, Press 1


Start
Is the Veteran enrolled for VA health care benefits?
Yes
No
Don't know
Contact 877-222-VETS (8387) or 855-488-8441 or 907-257-3323
Yes
No
To apply online Go To www.1010EZ.med.va.gov
or
Complete VA Form 10-10EZ (attachment 2) along with DD214 (if available) Mail to: Department of VA Alaska VA Healthcare System Attn: Eligibility Department 1201 North Muldoon Rd Anchorage, AK 99504 Or Fax to: 907-257-6784
or
To apply by telephone, call toll-free 877-222-VETS (8387)
VA Health Eligibility Center (HEC) will determine enrollment based on Veteran's application. May take up to 14-20 days
Stop

OMB Approved No. 2900-0091
Estimated Burden Avg. 30 min.

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME *(Last, First, Middle Name)*

2. MOTHER'S MAIDEN NAME

3. GENDER ☐ MALE ☐ FEMALE

4. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE AMERICAN OR OTHER PACIFIC ISLANDER

6. SOCIAL SECURITY NUMBER

7. DATE OF BIRTH *(mm/dd/yyyy)*

7A. PLACE OF BIRTH *(City and State)*

8. PERMANENT ADDRESS *(Street)*

8A. CITY

8B. STATE

8C. ZIP CODE

8D. COUNTY

8E. HOME TELEPHONE NUMBER *(Include area code)*

8F. MOBILE TELEPHONE NUMBER *(Include area code)*

8G. E-MAIL ADDRESS

9. CURRENT MARTIAL STATUS ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

10. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT ☐ YES ☐ NO

11. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*

12. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE

1A. LAST ENTRY DATE

1B. LAST DISCHARGE DATE

1C. DISCHARGE TYPE

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
			I. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM JANUARY 1, 1957 THROUGH DECEMBER 31, 1987?	☐	☐

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER

3. POLICY NUMBER

4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO

6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO

6A. EFFECTIVE DATE *(mm/dd/yyyy)*

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NUMBER
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	
1C. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER	
1D. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP - if different from Veteran's)*	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO	
	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*	

SECTION V - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VI - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION VII - PREVIOUS CALENDAR YEAR NETWORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS *(e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second home and non-incoming producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

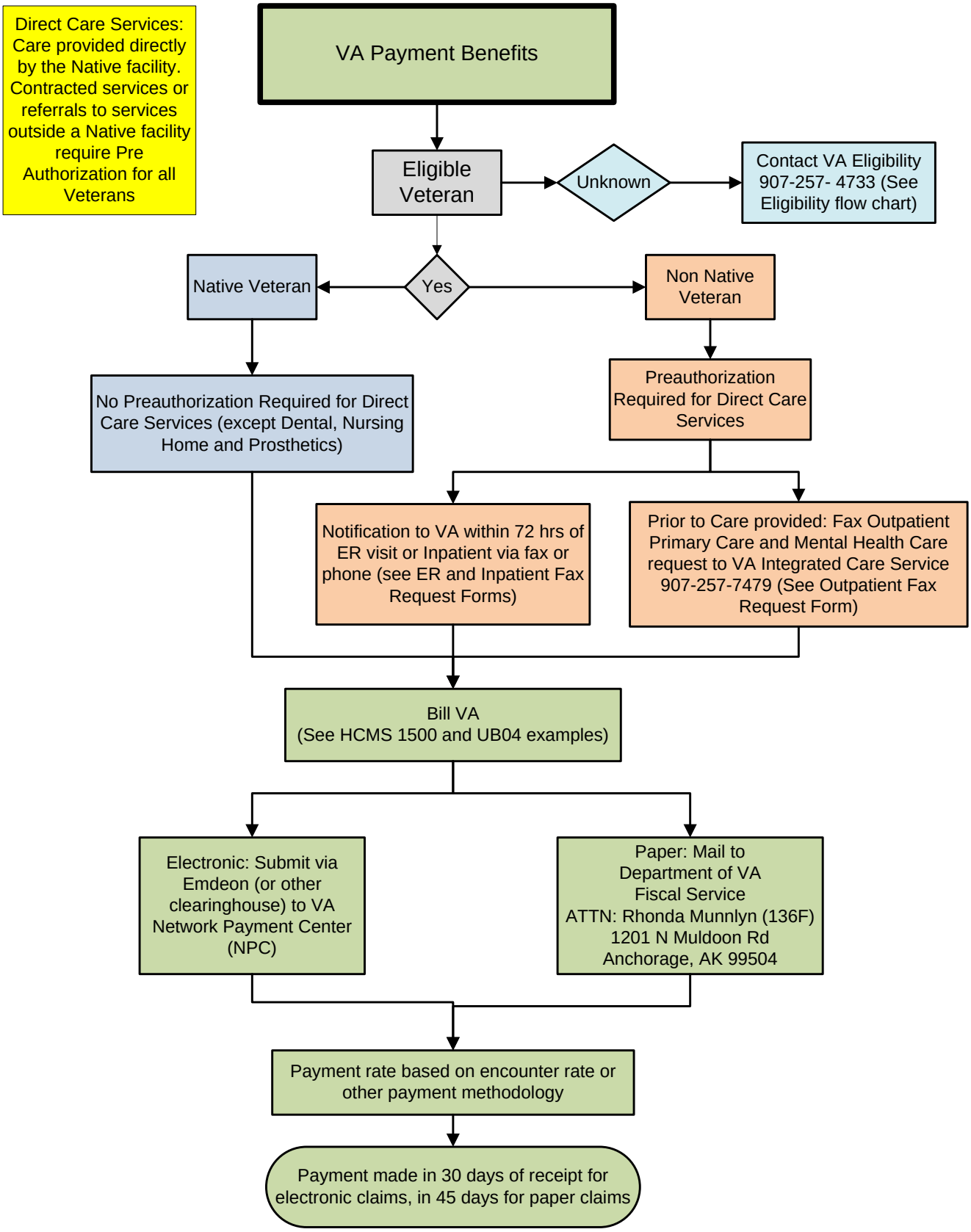
By submitting this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law. You also agree to receive communications from VA to your supplied email or mobile number.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT _____ DATE _____


Direct Care Services: Care provided directly by the Native facility. Contracted services or referrals to services outside a Native facility require Pre Authorization for all Veterans
VA Payment Benefits
Eligible Veteran
Unknown
Contact VA Eligibility 907-257- 4733 (See Eligibility flow chart)
Yes
Native Veteran
Non Native Veteran
No Preauthorization Required for Direct Care Services (except Dental, Nursing Home and Prosthetics)
Preauthorization Required for Direct Care Services
Notification to VA within 72 hrs of ER visit or Inpatient via fax or phone (see ER and Inpatient Fax Request Forms)
Prior to Care provided: Fax Outpatient Primary Care and Mental Health Care request to VA Integrated Care Service 907-257-7479 (See Outpatient Fax Request Form)
Bill VA (See HCMS 1500 and UB04 examples)
Electronic: Submit via Emdeon (or other clearinghouse) to VA Network Payment Center (NPC)
Paper: Mail to Department of VA Fiscal Service ATTN: Rhonda Munnlyn (136F) 1201 N Muldoon Rd Anchorage, AK 99504
Payment rate based on encounter rate or other payment methodology
Payment made in 30 days of receipt for electronic claims, in 45 days for paper claims

ALASKA VA OUTPATIENT

SHARING AGREEMENT

AUTHORIZATION REQUEST

Phone: 907-257-6904 or 1-888-353-7574 ext. 6904

*****NOTES MUST ACCOMPANY THIS REQUEST*****

Fax: 907-257-4718 or 7418

Today's Date: _____

Vendor's Name: _____

Ordering Provider's Name: _____

Vendor's Address: _____

Vendor's Phone: _____ Fax: _____ Tax Id: _____

Veteran's Name: _____ Last 4 SSN: _____ **AK Native/Non:** _____

Diagnosis: _____

_____

Desired treatment, procedure, or referral: _____

_____

Lab _____ X-ray _____ Rx _____ Other _____

Date and **Time** of desired treatment, procedure, or referral: Date: _____ Time: _____

Location of treatment if different from doctor's office: _____

Period of Care: Yes _____ No _____ (Indicate length of time and number of visits)

_____

Surgical Procedure: Yes _____ No _____(If yes, list CPT codes with cost estimates & ancillaries)

_____

Comments: _____

ALASKA VA INPATIENT ALERT

Please attach a copy of **Admission Face Sheet** with this Alert.

(VA INPATIENT FAX: 1-907-257-6920)

Today's Date: _____

Hospital Name: _____

Hospital FAX: _____

Admitting Physician: _____

Admission Type: ER_____ Direct_____ Scheduled_____

Date Patient in ER if different than admit date: _____

Patient Unstable for Transfer: _____ (Initials Please)

Date Of Admission: _____ Date of Discharge: _____

Veteran's Name: _____ SSN: _____

Diagnosis: _____

Specialty: Med___ Surg ___ Psych____ Rehab____ OB_____

Additional Insurance Information: _____

***** VETERAN'S STATEMENT: I request VA coverage for this episode of care. In accordance with the law, I understand I am subject to transfer to a federal facility.**

Signature of veteran or family member: _____

(Please, do not write below this line, for VA use only)

AUTHORIZED: _____**NOT AUTHORIZED:** _____

ALASKA VA
EMERGENCY ROOM/OBSERVATION ALERT

(VA ER FAX: 1-907-257-7418/4718)

TODAY'S DATE: _____

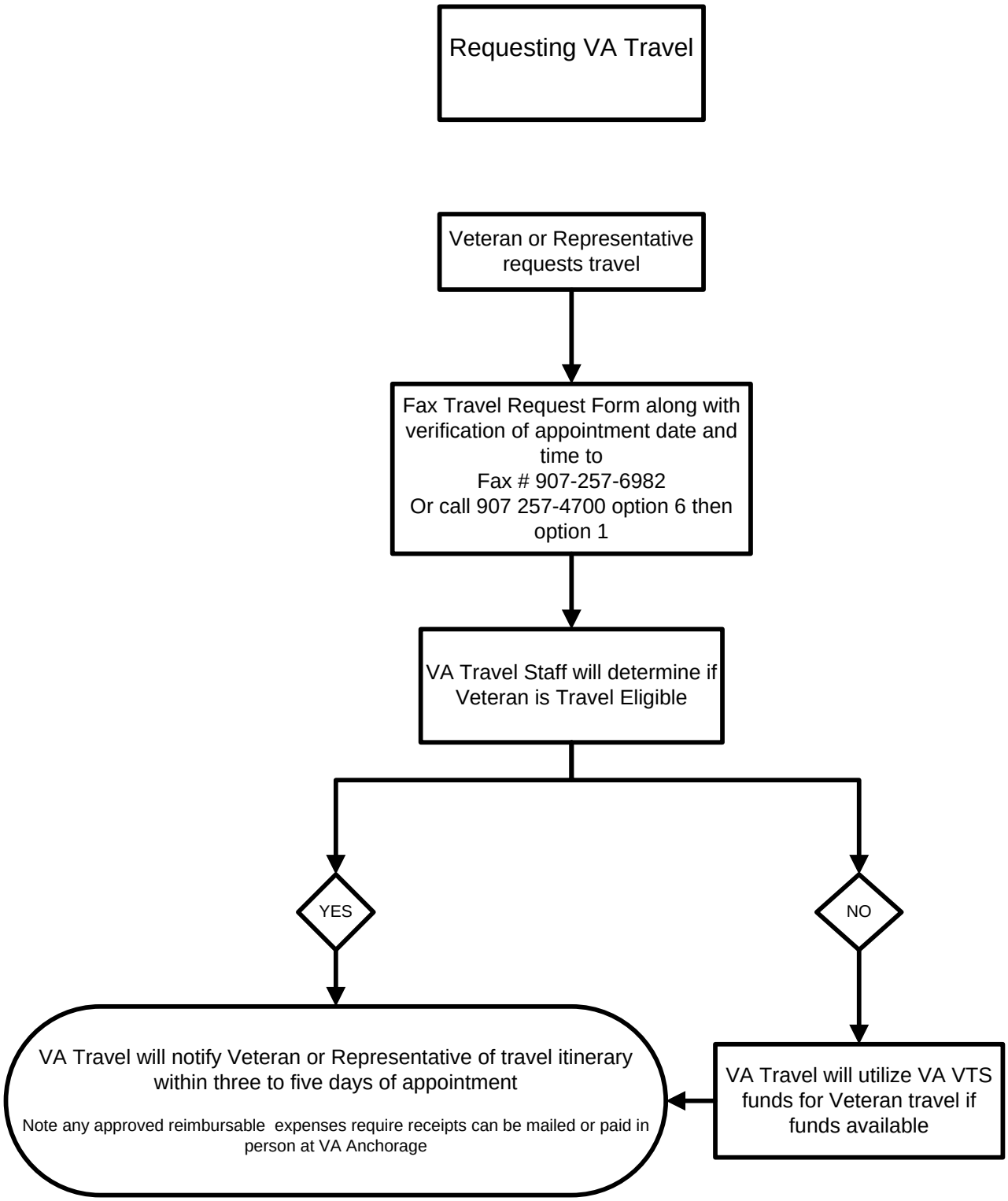
HOSPITAL NAME: _____

HOSPITAL FAX: _____

DATE OF SERVICE:_____

VETERAN'S NAME: _____SSN:_____

DIAGNOSIS: _____


Requesting VA Travel
Veteran or Representative requests travel
Fax Travel Request Form along with verification of appointment date and time to
Fax # 907-257-6982
Or call 907 257-4700 option 6 then option 1
VA Travel Staff will determine if Veteran is Travel Eligible
YES
NO
VA Travel will notify Veteran or Representative of travel itinerary within three to five days of appointment
Note any approved reimbursable expenses require receipts can be mailed or paid in person at VA Anchorage
VA Travel will utilize VA VTS funds for Veteran travel if funds available

VA TRAVEL REQUEST FORM

Requesting Facility Information

Name of Facility: _____ Request Date: _____
Name of Requesting Official: _____
Contact Phone: (_____) _____ - _____
Email Address: _____

Patient Information

Veteran's Last Name: ______ Veteran's First Name: _____
Last 4 of Veteran's Social Security Number: _____
Permanent Address: _____
Temporary Address (if applicable): _____
Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Select Specialty: MED _____ SURG _____ PSYCH _____
Appointment Date and Time: _____
Facility of Appointment: _____ City: _____
Will patient need an escort? Yes or No Name of escort: _____

Please complete escort request form.

Travel Information

Date of Travel (mm/dd/yyyy)	FROM (Departure Location)	TO (Arrival Location)	Mode of Travel A = Air S = Sea T = Train G = Ground Transport

FOR BENEFICIARY TRAVEL CLERK ONLY

Received Date: _____		Is veteran eligible for travel benefits? (circle one): Yes No Is veteran eligible for VTS? (circle one): Yes No
Date contacted veteran	Contacted by	Comments

Travel Office: 888-353-7574 Option 6, Option 1 Fax: 907-257-6982

Special Travel Request

TO: BENEFICIARY TRAVEL OFFICE

PATIENT: _____

NEEDS A NON-MEDICAL ESCORT DUE TO THE FOLLOWING:

_____ DEMENTIA/MEMORY LOSS

_____ BLIND

_____ UNABLE TO TRANSFER SELF FROM WHEELCHAIR

_____ NEED FIR OIST-OP ATTENDANCE

NEEDS A FLIGHT INSTEAD OF DRIVING DUE TO THE FOLLOWING:

_____DOCUMENTED CHRONIC BACK PAIN

_____UNABLE TO DRIVE DUE TO THE FOLLOWING MEDICATIONS:

_____

_____ SEVERE ANXIETY/PTSD

_____INSOMNIA (HIGH RISK DRIVER)

_____KNEES/LEG DISABILITY – (SPECIFIC PROBLEM) _____

_____VISION/HEARING DIFFICULTIES

_____TRAUMATIC ARTHRITIS

_____CANNOT SIT FOR EXTENDED PERIODS OF TIME due to: _____

_____OTHER:_____

THIS IS AUTHORIZED BY THE MEDICAL PROVIDER LISTED BELOW:
And subject to review by Chief of Staff

EFFECTIVE DATE: _____
(THIS REQUEST IS VALID FOR 1 YEAR FROM THE DATE SIGNED)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23 NATIVE

23. PRIOR AUTHORIZATION NUMBER

THP 463-AIAN

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

THP 463

23 NON NATIVE

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

OB04 AIAN

1 | 2 | 3a PAT. CNTL # | b. MED REC. # | 4 TYPE OF BILL

5 FED TAX NO | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a | 9 PATIENT ADDRESS a

b | b | c | d | e

10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | CONDITION CODES 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 ACCT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a b c d

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

PAGE ___ OF ___ CREATION DATE | TOTALS

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

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

63 Native

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

THP 463-AIAN

66 DX | 67

68 ADMIT DX | 69 PATIENT REASON DX | 70 | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB04 Non-Native

1 | 2 | 3a PAT CNTL # | 4 TYPE OF BILL
5 MED REC #
6 STATEMENT COVERS PERIOD FROM THROUGH
7 FED TAX NO

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e

10 BIRTH-DATE | 11 SEX | 12 DATE | ADMISSION 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | 18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28 | 29 ACCT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a b c d

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

PAGE ____ OF ____ CREATION DATE TOTALS

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

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

63 Non Native

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

THP 463

66 DX

67 | 68 ADMIT DX | 69 PATIENT REASON DX | 70 PPS CODE | 71 ECI | 72

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF