# WEST VIRGINIA
# SECRETARY OF STATE
## KEN HECHLER
# ADMINISTRATIVE LAW DIVISION

Form #3

Do Not Mark In This Box

FILED

SEP 1 3 16 PM '00

OFFICE [illegible] VIRGINIA SECRETARY OF STATE

### NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE AND FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY: W. Va. Code § 33-2-10 and 33-15B-3

AMENDMENT TO AN EXISTING RULE: YES X NO ___

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 16

TITLE OF RULE BEING AMENDED: Standards for Uniform Health Care Administration

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ___

TITLE OF RULE BEING PROPOSED: ___

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Joseph M. Palmer

Authorized Signature

Acting Secretary of Tax & Revenue

$6.40

**STATE OF WEST VIRGINIA**

Offices of the Insurance Commissioner

Legal Division

**CECIL H. UNDERWOOD**
Governor

**HANLEY C. CLARK**
Insurance Commissioner

September 1, 2000

**HAND DELIVERED**

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Enclosed please find for filing one (1) copy of the following:

1) Notice of Agency Approval of a Proposed Rule and Consent of Acting Secretary of Tax and Revenue;

2) Fiscal Note for Proposed Rule;

3) Brief Summary of Rule;

4) Statement of Circumstances;

5) Legislative Rule-Making Review Committee Questionnaire;

6) Agency approved proposed rule entitled "Standards for Uniform Health Care Administration" (Title 114, Series 16).

Please contact me if further information is required.

Sincerely,

Donna S. Quesenberry
General Counsel

DSQ/jz
Enclosures

P.O. Box 50540
Charleston, West Virginia 25305-0540

"We are an Equal Opportunity Employer"

Telephone (304) 558-0401
Facsimile (304) 558-1362

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

**Rule Title:** Standards For Uniform Health Care Administration Title 114, Series 16

**Type of Rule:** XX Legislative ___Interpretive ____Procedural

**Agency:** Insurance Commissioner

**Address:** Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

==============================================================

**1. Effect of Proposed Rule**

| | ANNUAL | | FISCAL YEAR | | |
|---|---|---|---|---|---|
| | Increase | Decrease | Current | Next | Thereafter |
| ESTIMATED TOTAL COST | None | None | None | None | None |
| PERSONAL SERVICES | None | None | None | None | None |
| CURRENT EXPENSE | None | None | None | None | None |
| REPAIRS AND ALTERNATIONS | None | None | None | None | None |
| EQUIPMENT | None | None | None | None | None |
| OTHER | None | None | None | None | None |

**2. Explanation of above estimates:**

This rule will have no fiscal impact on State, local or Federal Government.

**3. Objectives of these rules:**

The objective of the amendment to the existing rule is to repeal the rule in its entirety without replacement.

**Rule Title:** Standards For Uniform Health Care Administration
Title 114, Series 16

**4. Explanation of Overall Economic Impact of Proposed Rule.**

**A. Economic Impact on State Government.**

None

**B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.**

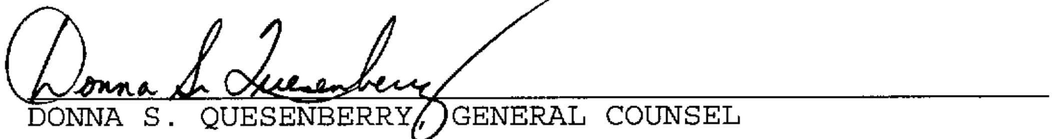
None

**C. Economic Impact on Citizens/Public at Large.**

None

**Date:** 9/1/00

**Signature of Agency Head or Authorized Representative**



DONNA S. QUESENBERRY, GENERAL COUNSEL

Insurance Commissioner
Legislative Rule
Title 114, Series 16

**STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION**

**TITLE 114, SERIES 16**

**BRIEF SUMMARY OF RULE**

The existing rule implemented the provisions of Article 15B, Chapter 33 of the West Virginia Code, which directed the Insurance Commissioner to establish guidelines regarding uniform health care administration.

H.B. 4776, effective June 8, 2000, amends Article 15B, Chapter 33 of the West Virginia Code by transferring authority and responsibility to promulgate rules, and develop standard forms and procedures regarding health care administration from the Insurance Commissioner to the West Virginia Health Care Authority.

This proposed amendment will repeal the rule in its entirety without replacement.

Insurance Commissioner
Legislative Rule
Title 114, Series 16

## STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION

## TITLE 114, SERIES 16

## STATEMENT OF CIRCUMSTANCES

This rule implemented the provisions of Article 15B, Chapter 33 of the West Virginia Code, which direct the Insurance Commissioner to establish guidelines regarding uniform health care administration. H.B. 4776, effective June 8, 2000, amends Article 15B, Chapter 33 of the West Virginia Code by transferring authority and responsibility to promulgate rules, and develop standard forms and procedures regarding health care administration from the Insurance Commissioner to the West Virginia Health Care Authority.

This proposed amendment will repeal the rule in its entirety without replacement.

# QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

**DATE:** SEPTEMBER 1, 2000

**TO:** LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

**FROM:** OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

**LEGISLATIVE RULE TITLE:** STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION (TITLE 114, SERIES 16)

1. **Authorizing statute(s) citation:**

   West Virginia Code §§ 33-2-10 and 33-15B-3

2. a. **Date filed in State Register with Notice of Hearing or Public Comment Period:**

      July 21, 2000

   b. **What other notice, including advertising, did you give of the hearing?**

      None

   c. **Date of Public Hearing(s) or Public Comment Period ended:**

      Public comment period ended August 21, 2000.

   d. **Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.**

      **Attached** ______ **No comments received** __X__

   e. **Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)**

      September 1, 2000

f. **Name, title, address and <u>phone/fax/e-mail numbers</u> of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)**

Esther T. Van Dall, Associate Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-0401
Fax: (304) 558-1362
E-mail: vandae@wvnvm.wvnet.edu

g. **<u>IF DIFFERENT</u> FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)**

Not applicable

3. **If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:**

a. **Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.**

Not applicable

b. **Date of hearing or comment period:**

Not applicable

c. **On what date did you file in the State Register the findings and determinations required together with the reasons therefor?**

Not applicable

d. **Attach findings and determinations and reasons:**

Not applicable

FILED
SEP 1 3 15 PM '00
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

**~~114CSR16~~**
**~~WEST VIRGINIA LEGISLATIVE RULE~~**
**~~INSURANCE COMMISSIONER~~**

**~~SERIES 16~~**
**~~STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION~~**

~~Section~~


| | |
|---|---|
| ~~114-16-1.~~ | ~~General~~ |
| ~~114-16-2.~~ | ~~Definitions~~ |
| ~~114-16-3.~~ | ~~Forms~~ |
| ~~114-16-4.~~ | ~~Coding and Terminology~~ |
| ~~114-16-5.~~ | ~~Practices Regarding Reimbursement of Claims and Explanation of Benefits~~ |
| ~~114-16-6.~~ | ~~Additional Information~~ |
| ~~114-16-7.~~ | ~~Severability~~ |
| ~~Appendix A.~~ | ~~Health Care Financing Administration Fifteen Hundred (HCFA 1500) Health Insurance Claim Form~~ |
| ~~Appendix B.~~ | ~~American Hospital Association (AHA) Universal Billing (UB-82) Form~~ |
| ~~Appendix C.~~ | ~~WVMMIS-091 Form for Certain Medical Equipment Claims Not Paid by Medicare~~ |
| ~~Appendix D.~~ | ~~National Council for Prescription Drug Programs (NCPDP) Universal Pharmacy Claim Form~~ |
| ~~Appendix E.~~ | ~~West Virginia Workers' Compensation Fund Pharmacy Invoice WV-401~~ |
| ~~Appendix F.~~ | ~~American Dental Association (ADA) Dental Claim Form~~ |
| ~~Appendix G.~~ | ~~West Virginia Workers' Compensation Fund Services Invoice WC-400~~ |
| ~~Appendix H.~~ | ~~WVMMIS-111 Form for Dental Claims Submitted to Medicaid~~ |

~~114CSR16~~

~~WEST VIRGINIA LEGISLATIVE RULE~~

~~INSURANCE COMMISSIONER~~

~~SERIES 16~~

~~STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION~~

## ~~§ 114-16-1. General~~

~~1.1. Scope. -- This legislative rule applies to all health care providers, applicable state agencies and departments, third-party administrators, and insuring entities in the State. It establishes the acceptance and use throughout the health care system of standard administrative forms, terms and procedures. The rule organizes and streamlines the claims process by establishing standard forms and procedures regarding health care claims. It requires that all insurers, third-party administrators, and health care providers implement and use such standards in a uniform manner.~~

~~1.2. Authority. -- West Virginia Code § 33-2-10 and § 33-15B-3.~~

~~1.3. Filing Date. -- June 18, 1993.~~

~~1.4. Effective Date. -- June 18, 1993.~~

~~1.5. This legislative rule repeals and replaces West Virginia 114CSR16 "Uniform Health Care Claim Forms" filed October 7, 1980 and effective on January 1, 1981.~~

## ~~§ 114-16-2. Definitions~~

~~2.1. "Health care facility" means any licensed hospital, nursing home, extended care facility, state health or mental institution, clinic, medical corporation, dental corporation, home health care agency, medical equipment vendor or other facility providing professional health care services, supplies, appliances, devices or equipment to an individual during that individual's health care, treatment or confinement.~~

~~2.2. "Health care practitioner" means any medical physician, osteopathic physician, podiatric physician, chiropractic physician, midwife, nurse practitioner, physical therapist, dentist, pharmacist, oral surgeon, or other practitioner who provides health care services, supplies, appliances, devices or equipment.~~

~~2.3. "Health care provider" means a person, partnership,~~

~~corporation, facility, institution, or other legal entity certified or authorized by law to provide professional health care services, supplies, appliances, devices or equipment to an individual during that individual's health care, treatment or confinement. "Health care provider" encompasses both "health care facility" and "health care practitioner," as those terms are defined herein.~~

~~2.4. "Insuring entity" means any insurer writing or issuing individual or group accident and sickness policies; and hospital service corporation, health service corporation, medical service corporation, or dental service corporation organized in accordance with the provisions of Article One, Chapter 31 or Chapter 33 of the West Virginia Code; any health care corporation organized in accordance with Article 25, Chapter 33 of the West Virginia Code; and health maintenance organization organized in accordance with the provisions of Article 25A, Chapter 33 of the West Virginia Code; any third-party administrator; all applicable state agencies and departments, including, but not limited to, the West Virginia Public Employees Insurance Agency and the West Virginia Workers' Compensation Fund; and Medicaid.~~

**~~§ 114-16-3. Forms~~**

~~3.1. All health care practitioners shall submit and all insuring entities shall accept third-party payor claims for services, supplies, appliances, devices or equipment on the form known as the current standard Health Care Financing Administration Fifteen Hundred (HCFA 1500) health insurance claim form, designated Appendix A to this rule, or its successor; Provided, That pharmacists and dentists shall submit third-party payor claims in the manner prescribed in Sections 3.3 and 3.4 below, respectively. If practitioners are presently using a HCFA 1500 form other than the most current HCFA 1500 form, they must use and insuring entities must accept the most current HCFA 1500 form by the date prescribed by HCFA.~~

~~3.2. All health care facilities shall submit and all insuring entities shall accept third-party payor claims for services, supplies, appliances, devices or equipment on either the current HCFA 1500 form or its successor or the American Hospital Association's current Uniform Billing form, designated Appendix B hereto, or its successor, as required by the insuring entity; Provided, however, That when Medicare is the primary payor, secondary claims submitted to Medicaid for medical equipment shall~~

~~be submitted on the current WVMMIS-091 form, designated Appendix C, or its successor.~~

~~3.3. All pharmacists shall submit and all appropriate insuring entities shall accept third-party payor claims for prescription drugs on the current universal pharmacy claim form most recently approved by the National Council for Prescription Drug Programs (NCPDP), designated Appendix D hereto, or its successor, with the exception of prescription drug claims to be submitted to the West Virginia Workers' Compensation Fund and Medicaid, or prescription drug claims to be submitted to an insuring entity which requires its participating pharmacists to submit claims exclusively by computerized electronic transmission, i.e., "point-of-sale" submission.~~

~~3.3.1. All pharmacists shall submit prescription drug claims to the Workers' Compensation Fund on the Pharmacy Invoice WC-401 form, designated Appendix E hereto, or its successor.~~

~~3.3.2. Pharmacists shall submit third-party payor claims for durable medical equipment and disposable medical supplies on the current HCFA 1500 form or its successor.~~

~~3.3.3. Prescription drug claims submitted to Medicaid shall be submitted at "point-of-sale," i.e., through electronic transmission, or, when required by Medicaid, on forms prescribed by Medicaid.~~

~~3.4. All dentists shall submit and all insuring entities shall accept third-party dental claims for services, supplies, appliances, devices or equipment to the appropriate insuring entity on the dental claim form most recently approved by the American Dental Association, designated Appendix F hereto, or its successor, with the exception of claims submitted to the Workers' Compensation Fund and Medicaid.~~

~~3.4.1. For Workers' Compensation claims, all dentists shall submit claims on the form known as Services Invoice WC-400, designated Appendix G hereto, or its successor.~~

~~3.4.2. For Medicaid, all dentists shall submit claims on the WVMMIS-111 form prescribed by Medicaid, designated Appendix H hereto, or its successor.~~

~~3.4.3. Oral surgeons or dentists who submit claims other than dental claims shall submit and all appropriate insuring entities shall accept the current HCFA 1500 form or its successor.~~

~~3.5. Nothing in this rule shall be construed to prohibit~~

~~voluntary arrangements between insuring entities and health care providers for the submission of claims by computerized electronic transmission.~~

**~~§ 114-16-4. Coding and Terminology~~**

~~4.1. If the coding systems in subsections 4.1.1. and 4.1.2. below apply to the services, supplies, appliances, devices or equipment provided by a health care provider, the provider shall use and all insuring entities shall accept the following coding systems:~~

~~4.1.1. The current International Classification of Diseases (ICD-9-CM) codes developed by the World Health Organization, or their successors; and~~

~~4.1.2. The current HCFA Common Procedural Coding System (HCPCS), which includes, but is not limited to, the Current Procedural Terminology (CPT) codes developed by the American Medical Association, or its successor.~~

~~4.2. All dentists shall use and all appropriate insuring entities shall accept the latest version of the American Dental Association's Code on Dental Procedures and Nomenclature; Provided, That oral surgeons and dentists who submit claims other than dental claims shall use and all appropriate insuring entities shall accept the coding systems set forth in Sections 4.1.1. and 4.1.2. above.~~

~~4.3. All pharmacists shall use and all insuring entities shall accept the current version of the United States Food and Drug Administration's National Drug Code (NDC), or its successor, for claims for prescription drugs for which NDC codes exist.~~

**~~§ 114-16-5. Practices Regarding Reimbursement of Claims and Explanation of Benefits~~**

~~Practices regarding reimbursement of claims and explanation of~~

~~benefits shall be left to the discretion of the insuring entity, depending upon the contractual agreements between the insurer and its insureds and/or participating provider network regarding deductibles, copayments, discounts and the like.~~

**~~§ 114-16-6. Additional Information~~**

~~Nothing in this rule shall be construed so as to prevent an insuring entity from requesting additional information directly from the insured or covered person, where such additional information is necessary for the determination of coverage or benefits applicable.~~

**~~§ 114-16-7. Severability~~**

~~If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall not be affected thereby.~~

APPROVED OMB-0938-0008

[...]ASE [...]O NOT [...]TAPLE [...] THIS [...]REA

CARRIER

PICA

# HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | 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 ____

PATIENT AND INSURED INFORMATION

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? — YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
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PHYSICIAN OR SUPPLIER INFORMATION

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.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #



SIGNED ____ DATE ____

PIN# — GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88)

*PLEASE PRINT OR TYPE*

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix B APPROVED OMB NO. 0938-0279

3 PATIENT CONTROL NUMBER

4 TYPE OF BILL

5 BC-BS PROV NO.

6 FEDERAL TAX NO

7 MEDICARE NO

8 MEDICAID NO.

FIRST NAME

11 PATIENT'S ADDRESS

CITY

STATE

ADMISSION

15 DATE

22 STATEMENT COVERS PERIOD

FROM

THROUGH

23 COV D.

OCCURRENCE

DATE

CONDITION CODES

BLOOD RECORD (PINTS)

44 SP PROG.

VALUE

CD

AMT

53 TOTAL CHARGES

DUE FROM PATIENT ▶

73 EMPLOYER NAME

OTHER DIAGNOSES CODES

PRINCIPAL PROCEDURE

OTHER PROCEDURE

DATE

FOR INTERMEDIARY USE ONLY



PAYER COPY

X

PROVIDER
NAME AND ADDRESS HERE

# WEST VIRGINIA

## DEPARTMENT OF HEALTH & HUMAN RESOURCES
## TITLE XVIII (MEDICARE)
## DEDUCTIBLE AND
## COINSURANCE INVOICE

## SEE REVERSE FOR INSTRUCTIONS

TRANSMISSION CODE 091

2A PROVIDER I.D. NO. (7)

2B PROVIDER (GROUP) I.D. NO. (7)

5 PRIMARY CARRIER CODE
1-NO OTHER CARRIER
2-MEDICARE
3-OTHER (SPECIFY NAME)

RECIPIENT'S LAST NAME | FIRST | 4 RECIPIENT'S I.D. NO. (11) | 5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE.

TYPE OF COVERAGE CHECK ONE A / B | 7 PATIENT ACCOUNT NO. (10 MAX) | 8 RECIPIENT'S H I B NUMBER (MEDICARE) | 9 STATEMENT COVERS PERIOD FROM (6) MO DAY YEAR THRU (6) MO DAY YEAR | 10 MEDICARE PAID AMT.

DEDUCTIBLE AMOUNT | 12 COINSURANCE AMT. | 13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE) | 14 BLOOD DEDUCTIBLE AMT. | CARRIER CODE

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I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

AUTHORIZED SIGNATURE | DATE

STATE COPY



WVMMIS-091
REV 7/91

GROUP NO. CARDHOLDER I.D. NO.

CARD-HOLDER NAME LAST FIRST INITIAL

OTHER THIRD PARTY COVERAGE YES NO

FOR OFFICE USE ONLY

PHARMACY INFORMATION

NAME

STREET NO.

CITY STATE & ZIP

PHARM NO

PHONE

| PATIENT LAST NAME | FIRST & INITIAL | DATE OF BIRTH MO | DAY | YR | SEX M | F | RELATIONSHIP TO CARDHOLDER CARD HOLDER | SPOUSE | CHILD | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| RX NUMBER | NEW REF | METRIC QUANTITY | DAYS SUPPLY | NATIONAL DRUG | | | PRESCRIBER IDENT | DAW | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | INGR. COST / DISP FEE / TAX / TOTAL PRICE / DED AMT / BAL |
| 2 | | | | | | | | | |

AUTHORIZED PHARMACY REPRESENTATIVE X

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DO NOT WRITE IN THIS SPACE

Appendix E

# PHARMACY INVOICE

Workers' Compensation Fund
P.O. Box 3151, Charleston, WV 25332

WC-401 Rev. 7-89

| CLAIMANT NAME (Last, First, and Middle Names) | 2. CLAIMANT ADDRESS (Street or PO Box, City, State, and Zip Code) | |
|---|---|---|
| EMPLOYER BUSINESS NAME | 4. EMPLOYER MAILING ADDRESS | |
| CLAIMANT SOCIAL SECURITY NO. | 6. DATE OF INJURY | 7. CLAIM NO. |
| DIAGNOSIS CODE (ICD-9-CM) | 9. PROVIDER NO. | 10. CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT ☐ |

## PRESCRIPTION DETAIL

| PRIOR AUTHORIZATION NO. | 12. DATE WRITTEN | 13. PRESCRIBING PHYSICIAN | 14. PRESCRIBING PHYSICIAN'S PROVIDER NO. | 15. PRESCRIPTION NO. |
|---|---|---|---|---|
| DATE FILLED | 17. NATIONAL DRUG CODE | 18. DRUG NAME | | 19. GENERIC ☐ Yes ☐ No |
| DRUG QUANTITY | 21. EST. DAYS SUPPLY | 22. REFILL ☐ Yes ☐ No | 23. TOTAL CHARGE | 24. AMOUNT PAID / 25. BALANCE DUE |
| BRAND NAME JUSTIFICATION | | | | |
| CLAIMANT'S SIGNATURE | DATE | 28. PHARMACIST'S SIGNATURE | | DATE |

| PRIOR AUTHORIZATION NO. | 12a. DATE WRITTEN | 13a. PRESCRIBING PHYSICIAN | 14a. PRESCRIBING PHYSICIAN'S PROVIDER NO. | 15a. PRESCRIPTION NO. |
|---|---|---|---|---|
| DATE FILLED | 17a. NATIONAL DRUG CODE | 18a. DRUG NAME | | 19a. GENERIC ☐ Yes ☐ No |
| DRUG QUANTITY | 21a. EST. DAYS SUPPLY | 22a. REFILL ☐ Yes ☐ No | 23a. TOTAL CHARGE | 24a. AMOUNT PAID / 25a. BALANCE DUE |
| BRAND NAME JUSTIFICATION | | | | |
| CLAIMANT'S SIGNATURE | DATE | 28a. PHARMACIST'S SIGNATURE | | DATE |

| PRIOR AUTHORIZATION NO. | 12b. DATE WRITTEN | 13b. PRESCRIBING PHYSICIAN | 14b. PRESCRIBING PHYSICIAN'S PROVIDER NO. | 15b. PRESCRIPTION NO. |
|---|---|---|---|---|
| DATE FILLED | 17b. NATIONAL DRUG CODE | 18b. DRUG NAME | | 19b. GENERIC ☐ Yes ☐ No |
| DRUG QUANTITY | 21b. EST. DAYS SUPPLY | 22b. REFILL ☐ Yes ☐ No | 23b. TOTAL CHARGE | 24b. AMOUNT PAID / 25b. BALANCE DUE |
| BRAND NAME JUSTIFICATION | | | | |
| CLAIMANT'S SIGNATURE | DATE | 28b. PHARMACIST'S SIGNATURE | | DATE |

...ded by statute, this is to certify that the medication(s) was provided as outlined above and that no other or additional charge for such medication(s) has been or will b... ...ainst any person, firm, or corporation.

| REMARKS | 30. PROVIDER NAME AND ADDRESS |
|---|---|

# ntal Claim Form

k one:
entist's pre-treatment estimate
entist's statement of actual services

Carrier name and address

1. Patient name first m.i. last
2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other
3. Sex m f
4. Patient birthdate MM DD YYYY
5. If full time student school city

6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate MM DD YYYY
9. Employer (company) name and address
10. Group number

11. Is patient covered by another dental plan? ☐ yes ☐ no If yes, complete 12-a.
Is patient covered by a medical plan? ☐ yes ☐ no
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber soc. sec. or I.D. number
14-c. Employee/subscriber birthdate MM DD YYYY
15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other

e reviewed the following treatment plan. I authorize release of any information ing to this claim. I understand that I am responsible for all costs of dental treatment.

d (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Insured person) Date

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How many?

24. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates.
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? (If no, reason for replacement) 28. Date of prior placement
29. Is treatment for orthodontics? If services already commenced enter: Date appliances placed Mos. treatment remaining

y missing teeth with "x"

FACIAL
LINGUAL
RIGHT PRIMARY LEFT PERMANENT
LINGUAL
FACIAL

30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Use charting system shown.

| Tooth # or letter | Surface | Description of service (including x-rays, prophylaxis, materials used, etc.) | Date service performed Mo. Day Year | Procedure number | Fee |
|---|---|---|---|---|---|

For administrative use only

31. Remarks for unusual services

y certify that the procedures as indicated by date have been completed and that the fees submitted actual fees I have charged and intend to collect for those procedures.

Treating Dentist) License Number Date

Total Fee Charged
Max. Allowable
Deductible
Carrier %
Carrier pays


erican Dental Association, 1990

# ERVICES INVOICE

Vorkers' Compensation Fund
.O. Box [illegible]151, Charleston, WV 25332

DO NOT WRITE IN THIS SPACE

WC-400 Rev. 6-87

- (K) ☐ Dental
- (N) ☐ Nursing Home
- (P) ☐ Practitioner
- (R) ☐ Vocational Rehabilitation
- (V) ☐ Other Medical Vendor

CLAIMANT NAME (Last, First, and Middle Names)

2. CLAIMANT ADDRESS (Street or PO Box, City, State, and Zip Code)

EMPLOYER BUSINESS NAME

4. EMPLOYER MAILING ADDRESS

CLAIMANT SOCIAL SECURITY NO.

6. DATE OF INJURY

7. CLAIM NO.

REFERRING PHYSICIAN'S PROVIDER NO.

9. REFERRING PHYSICIAN'S NAME

10. DATE CLAIMANT FIRST CONSULTED PROVIDER FOR THIS CONDITION

DIAGNOSIS CODE (ICD-9-CM)/DESCRIPTION

1.
2.
3.

PRIOR AUTHORIZATION NO.

13. IF EMERGENCY CHECK HERE ☐

14. PATIENT ACCOUNT NO.

15. PROVIDER NO.

CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT ☐

17. PAYEE NO.

18. PAYEE NAME AND ADDRESS

| SERVICE DATE | 20. PROCEDURE CODE | 21. MOD CODE | 22. DESCRIPTION | 23. CHARGES | 24. UNITS | 25. T.O.S. | 26. DENTAL TOOTH NO. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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| | | | | | | | |

PROVIDER OR CLAIMANT SIGNATURE

DATE

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

REMARKS

32. PROVIDER NAME, ADDRESS AND TELEPHONE NO.

VIDER
D ADDRESS HERE

# WEST VIRGINIA

## DEPARTMENT OF HUMAN SERVICES

## DENTIST INVOICE

## SEE REVERSE FOR INSTRUCTIONS

| TRANSMISSION CODE | 2A PROVIDER I.D. NO. (7) | 2B PROVIDER (GROUP) I.D. NO. (7) | 3 RECIPIENT I.D. NO. (1) | 4 RECIPIENT'S LAST NAME FIRST |
|---|---|---|---|---|
| 1 1 1 | | | | |

TREATMENT DUE ACCIDENT? YES ☐ NO ☐ | PATIENT ACCOUNT NO. (10 MAX) | 7 EMERGENCY TREATMENT? YES ☐ NO ☐ | 8 SCREENING RELATED? (EPSDT) YES ☐ NO ☐

TOOTH IDENTIFICATION NUMBER OR LETTER. USE UNIVERSAL TOOTH IDENTIFICATION SYSTEM.

12 SURFACE CODE LETTERS
M—MESIAL F—FACIAL
O—OCCLUSAL L—LINGUAL
D—DISTAL

| DATE OF SERVICE MO DAY YEAR | 10 PRIOR AUTHORIZATION NUMBER | 11 TOOTH CODE | 12 SURFACE CODE M | O | D | F | L | 13 QUADRANTS 1 | 2 | 3 | 4 | 14 PROCEDURE CODE (5) | 15 | 16 CHARGE | 17 PAYMENT FROM PRIMARY CARRIER | 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |
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TOTAL

Q-1 FACIAL Q-2
UPPER RIGHT LINGUAL PRIMARY PERMANENT LEFT LOWER LINGUAL
Q-4 FACIAL Q-3

18 * INDIVIDUAL CONSIDERATION (REMARKS)
LINE NO. ____
LINE NO. ____
LINE NO. ____
LINE NO. ____
LINE NO. ____

19 IS TREATMENT COMPLETE? YES ☐ NO ☐

20 PRIMARY CARRIER INFORMATION (CHECK ONE)
1-☐ NO OTHER CARRIER 2-☐ MEDICARE
3-☐ OTHER (SPECIFY INS. CO. NAME)

I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.