

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #2

Do Not Mark In this Box

FILED
1992 AUG 10 AM 8:39
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

RULE TYPE: Legislative; CITE AUTHORITY West Virginia Code Secs. 33-2-10 and 33-15B-3

AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 16

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

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON September 11, 1992 AT 4:30 P.M.

ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS.

B. Keith Huffman, General Counsel
Office of the Insurance Commissioner
P. O. Box 50540
2019 Washington Street, East
Charleston, WV 25305-0540

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Stanley C. Clark
Hanley C. Clark
Insurance Commissioner

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

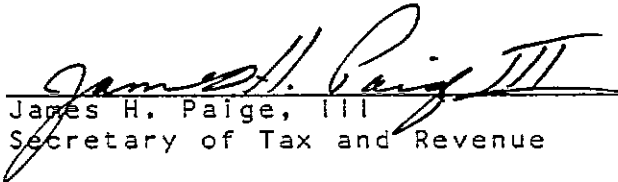
4-00

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 16, relating to Standards for Uniform Health Care Administration.

Dated this 30 day of July, 1992.


James H. Paige, III
Secretary of Tax and Revenue

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
2019 Washington Street, East,
Charleston, WV 25305-0540

	ANNUAL		FISCAL YEAR		
1. Effect of Proposed Rule	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	NONE				
Personal Services					
Current Expense					
Repairs & Alterations	NONE				
Equipment					
Other					

2. Explanation of above estimates:

The proposed rule will have no fiscal impact on state, local, or federal government.

3. Objectives of these rules:

The objective of this rule is to establish the acceptance and use throughout the health care system of standard administrative forms, terms, and procedures. It requires that all insurers, third-party administrators, and health care providers implement and use such standards in a uniform manner.

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.

Implementation of this rule should decrease health care costs by increasing administrative efficiency in the health care system.

Date: Aug. 7, 1992

Signature of Agency Head or Authorized Representative

Hanley C. Clark
Hanley C. Clark
Insurance Commissioner

Insurance Commissioner
Legislative Rule
Title 114, Series 16

FILED

1992 AUG 10 AM 8:40

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION

Title 114, Series 16

BRIEF SUMMARY OF RULE

This proposed rule implements 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. Requirements regarding standardized forms, coding and terminology, and practices regarding reimbursement of claims and explanation of benefits established in the rule apply to all health care providers, third-party payors, all applicable state agencies and departments, and all insurers in the State.

114CRS16

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

FILED

1992 AUG 10 AM 8:40

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

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.	Separability
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.	WMMIS-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.	WMMIS-111 Form for Dental Claims Submitted to Medicaid

114CRS16

TITLE 114
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. --

1.4. Effective Date. --

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

**Insurance Commission
Legislative Rule
Title 114, Series 16**

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; any 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 maintenance organization organized in accordance with the provisions of Article 25A, Chapter 33 of the West Virginia Code; any health care corporation organized in accordance with Article 25, 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 WVMMS-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.

**Insurance Commission
Legislative Rule
Title 114, Series 16**

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

3.4.c. 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.a. and 4.1.b. 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.a. The current International Classification of Diseases (ICD-9-CM) codes developed by the World Health Organization, or their successors; and

**Insurance Commission
Legislative Rule
Title 114, Series 16**

4.1.b. 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.a. and 4.1.b. 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.

§ 114-33-6. 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. Separability

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.

PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

PCA

Form sections 1-11: 1. MEDICARE/MEDICAID/CHAMPUS/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. EMPLOYMENT; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

Form sections 12-13: 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.

Form sections 14-16: 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK.

Form sections 17-18: 17. NAME OF REFERRING PHYSICIAN; 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.

Form sections 19-21: 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB CHARGES; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.

Form sections 22-23: 22. MEDICAID REDEMPTION CODE; 23. PRIOR AUTHORIZATION NUMBER.

Table with 11 columns (A-K) and multiple rows for detailing services, dates, charges, and diagnosis codes.

Form sections 24-26: 24. FEDERAL TAX ID NUMBER; 25. PATIENT'S ACCOUNT NO; 26. ACCEPT ASSIGNMENT?

Form sections 27-30: 27. TOTAL CHARGE; 28. AMOUNT PAID; 29. BALANCE DUE; 30. SIGNATURE OF PHYSICIAN OR SUPPLIER.

Form sections 31-33: 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. NAME AND ADDRESS OF FACILITY; 33. PHYSICIAN'S BILLER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #.

WEST VIRGINIA
DEPARTMENT OF HEALTH & HUMAN RESOURCES
TITLE XVIII (MEDICARE)
DEDUCTIBLE AND
COINSURANCE INVOICE
SEE REVERSE FOR INSTRUCTIONS

1 TRANSMISSION CODE 091		2A PROVIDER ID NO. (7)		2B PROVIDER (GROUP) ID NO. (7)		5 PRIMARY CARRIER CODE 1-NO OTHER CARRIER 2-MEDICARE 3-OTHER (SPECIFY NAME)		STATE SELECT	
3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)			5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.			
6 TYPE OF COVERAGE CHECK ONE A B C D E		7 PATIENT ACCOUNT NO. (10 MAX)		8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD MO DAY YEAR MO DAY YEAR		10 MEDICARE PAID AMT	
11 DEDUCTIBLE AMOUNT		12 COINSURANCE AMT.		13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

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

GROUP NO. _____ CARDHOLDER ID NO. _____

CARDHOLDER NAME _____ OTHER MEDICAL COVERAGE YES NO

FOR OFFICE USE ONLY

PHARMACY INFORMATION

NAME	ADDRESS	CITY	STATE	ZIP	PHONE	DATE OF BIRTH		SEX		RELATIONSHIP TO CARDHOLDER				NCP COST	DISP. FEE	TAX	TOTAL PRICE	DED. AMT.	BAL.
						MO	DAY	MO	F	CARDHOLDER	SPOUSE	CHILD	OTHER						

AUTHORIZED REPRESENTATIVE
 AUTHORIZED REPRESENTATIVE

COPYRIGHT © 1977, 1979, 1987, 1988, 1989 By NCPCP

DO NOT WRITE
IN THIS SPACE**PHARMACY INVOICE**

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

WC-401 Rev. 7-85

1. CLAIMANT NAME (Last, First, and Middle Names)		2. CLAIMANT ADDRESS (Street or PO Box, City, State, and Zip Code)	
3. EMPLOYER BUSINESS NAME		4. EMPLOYER MAILING ADDRESS	
5. CLAIMANT SOCIAL SECURITY NO.		6. DATE OF INJURY	7. CLAIM NO.
8. DIAGNOSIS CODE (ICD-9-CM)		9. PROVIDER NO.	10. CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT <input type="checkbox"/>

PRESCRIPTION DETAIL

11. PRIOR AUTHORIZATION NO.	12. DATE WRITTEN	13. PRESCRIBING PHYSICIAN	14. PRESCRIBING PHYSICIAN'S PROVIDER NO.	15. PRESCRIPTION NO.
16. DATE FILLED	17. NATIONAL DRUG CODE	18. DRUG NAME		19. GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No
20. DRUG QUANTITY	21. EST. DAYS SUPPLY	22. REFILL <input type="checkbox"/> Yes <input type="checkbox"/> No	23. TOTAL CHARGE	24. AMOUNT PAID
25. BALANCE DUE				
26. BRAND NAME JUSTIFICATION				
27. CLAIMANT'S SIGNATURE		28. DATE	29. PHARMACIST'S SIGNATURE	
			DATE	

11a. PRIOR AUTHORIZATION NO.	12a. DATE WRITTEN	13a. PRESCRIBING PHYSICIAN	14a. PRESCRIBING PHYSICIAN'S PROVIDER NO.	15a. PRESCRIPTION NO.
16a. DATE FILLED	17a. NATIONAL DRUG CODE	18a. DRUG NAME		19a. GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No
20a. DRUG QUANTITY	21a. EST. DAYS SUPPLY	22a. REFILL <input type="checkbox"/> Yes <input type="checkbox"/> No	23a. TOTAL CHARGE	24a. AMOUNT PAID
25a. BALANCE DUE				
26. BRAND NAME JUSTIFICATION				
27. CLAIMANT'S SIGNATURE		28a. DATE	29a. PHARMACIST'S SIGNATURE	
			DATE	

11b. PRIOR AUTHORIZATION NO.	12b. DATE WRITTEN	13b. PRESCRIBING PHYSICIAN	14b. PRESCRIBING PHYSICIAN'S PROVIDER NO.	15b. PRESCRIPTION NO.
16b. DATE FILLED	17b. NATIONAL DRUG CODE	18b. DRUG NAME		19b. GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No
20b. DRUG QUANTITY	21b. EST. DAYS SUPPLY	22b. REFILL <input type="checkbox"/> Yes <input type="checkbox"/> No	23b. TOTAL CHARGE	24b. AMOUNT PAID
25b. BALANCE DUE				
26. BRAND NAME JUSTIFICATION				
27. CLAIMANT'S SIGNATURE		28b. DATE	29b. PHARMACIST'S SIGNATURE	
			DATE	

provided 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 be against any person, firm, or corporation.

REMARKS	30. PROVIDER NAME AND ADDRESS
Page 9	

SERVICES INVOICE

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



DO NOT WRITE
 IN THIS SPACE

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

WC-400 Rev. 6-97

1. CLAIMANT NAME (Last, First, and Middle Names)		2. CLAIMANT ADDRESS (Street or PO Box, City, State, and Zip Code)	
3. EMPLOYER BUSINESS NAME		4. EMPLOYER MAILING ADDRESS	
5. CLAIMANT SOCIAL SECURITY NO.		6. DATE OF INJURY	7. CLAIM NO.
8. REFERRING PHYSICIAN'S PROVIDER NO.	9. REFERRING PHYSICIAN'S NAME		10. DATE CLAIMANT FIRST CONSULTED PROVIDER FOR THIS CONDITION

1. DIAGNOSIS CODE (ICD-9-CM) DESCRIPTION

1. _____

2. _____

3. _____

2. PRIOR AUTHORIZATION NO.	13. IF EMERGENCY CHECK HERE <input type="checkbox"/>	14. PATIENT ACCOUNT NO.	15. PROVIDER NO.
6. CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT <input type="checkbox"/>		17. PAYEE NO.	
18. PAYEE NAME AND ADDRESS			

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

7. PROVIDER OR CLAIMANT SIGNATURE	DATE	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
-----------------------------------	------	------------------	-----------------	-----------------

11. REMARKS	32. PROVIDER NAME, ADDRESS AND TELEPHONE NO.
-------------	--

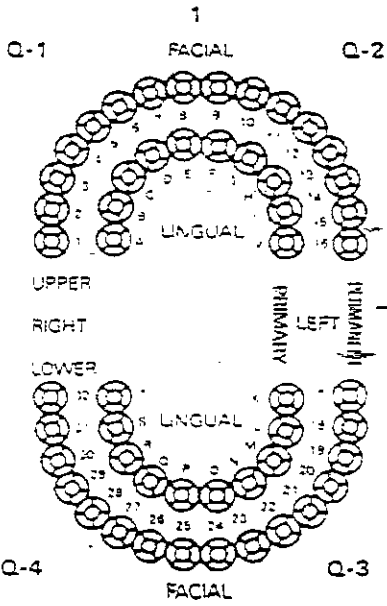
PROVIDER
NAME AND ADDRESS HERE

WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
DENTIST INVOICE
SEE REVERSE FOR INSTRUCTIONS

1 TRANSMISSION CODE: 111
 2A PROVIDER I.D. NO. (7)
 2B PROVIDER GROUP I.D. NO. (7)
 3 RECIPIENT'S ID NO.
 4 RECIPIENT'S LAST NAME
 5 IS TREATMENT DUE TO ACCIDENT? YES NO
 6 PATIENT ACCOUNT NO. (10 MAX.)
 7 EMERGENCY TREATMENT? YES NO
 8 SCREENING RELATED? (EPSDT) YES NO
 11 TOOTH IDENTIFICATION NUMBER OR LETTER (USE UNIVERSAL TOOTH IDENTIFICATION SYSTEM)
 12 SURFACE CODE LETTERS (M, D, P, L, B, S, R)

9	10	11	12	13	14	15	16	17	18
DATE OF SERVICE MO DAY YEAR	PRIOR AUTHORIZATION NUMBER	TOOTH CODE	SURFACE CODE	QUADRANT	PROCEDURE CODE (5)	CHARGE	PAYMENT BY PRIVATE CARRIER		
0									
1									
2									
3									
4									
5									
6									
7									
8									
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									

TOTAL _____



19 INDIVIDUAL DENTATION REMARKS:
 LINE NO _____
 LINE NO _____
 LINE NO _____
 LINE NO _____
 LINE NO _____

20 IS TREATMENT COMPLETE? YES NO

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

IF ANY OF THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL, CHECK APPROPRIATE BOX



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

August 10, 1992

HAND DELIVERED

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

Dear Ms. Cooper:

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

- (1) Notice of a Comment Period on a Proposed Rule;
- (2) Fiscal Note;
- (3) Consent to Proposed Rule;
- (4) Brief Summary of Rule; and
- (5) The Insurance Commissioner's proposed legislative rule entitled "Standards for Uniform Health Care Administration" (Series 16).

Please contact me if further information is needed.

Very truly yours,

Linda Gay
Linda Gay
Staff Counsel

LG/fs
Enclosures