WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION
Form #4

Do Not Mark In this Box

FILED

JAN 15 2 08 PM '93

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF RULE MODIFICATION OF A PROPOSED RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

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

AMENDMENT TO AN EXISTING RULE: YES____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ________

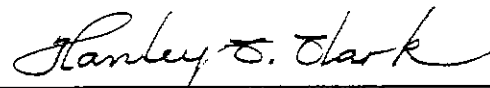
TITLE OF RULE BEING AMENDED: ________

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

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

---

THE ABOVE PROPOSED LEGISLATIVE RULE, FOLLOWING REVIEW BY THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE IS HEREBY MODIFIED AS A RESULT OF REVIEW AND COMMENT BY THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE. THE ATTACHED MODIFICATIONS ARE FILED WITH THE SECRETARY OF STATE.

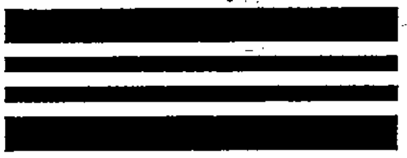


Hanley C. Clark
Insurance Commissioner

6.00

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA



PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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? PLACE (State) YES NO

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 ____

PHYSICIAN OR SUPPLIER 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
1										
2										
3										
4										
5										
6										

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. 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 #

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

APPROVED OMB NO. 0938-0279

1

2

3 PATIENT CONTROL NUMBER

4 TYPE OF BILL

5 BC/BS PROV NO

6 FEDERAL TAX NO

7 MEDICARE NO

8 MEDICAID NO.

9

10 PATIENT'S LAST NAME FIRST NAME INITIAL

11 PATIENT'S ADDRESS CITY STATE ZIP

12 BIRTH DATE | 13 SEX | 14 MS | ADMISSION 15 DATE 16 HR 17 TYPE 18 SRC | 19 A H | 20 D H | 21 STAT | 22 STATEMENT COVERS PERIOD FROM THROUGH | 23 COV D | 24 NC D | 25 CI D | 26 LR D | 27

28 OCCURRENCE CD DATE | 29 OCCURRENCE CD DATE | 30 OCCURRENCE CD DATE | 31 OCCURRENCE CD DATE | 32 OCCURRENCE CD DATE | 33 OCCURRENCE SPAN CD FROM THROUGH

34

CONDITION CODES 35 36 37 38 39

BLOOD RECORD (PINTS) 40 FURN 41 REPL 42 NOT RP 43 DED

44 SP PROG.

45

46 VALUE CD AMT | 47 VALUE CD AMT | 48 VALUE CD AMT | 49 VALUE CD AMT

50 DESCRIPTION | 51 R CODE | 52 UNITS | 53 TOTAL CHARGES | 54 | 55 | 56

57 PAYER | 58 REL INFO | 59 ASG BEN | 60 DEDUCTIBLE | 61 CO-INSURANCE | 62 EST RESPONSIBILITY | 63 PRIOR PAYMENTS | 64 EST AMOUNT DUE

DUE FROM PATIENT ▶

65 INSURED'S NAME | 66 SEX | 67 R REL | 68 CERT-SSN-HIC-ID NO | 69 GROUP NAME | 70 INSURANCE GROUP NO

71 E S | 72 ESC | 73 EMPLOYER NAME | 74 EMPLOYEE ID | 75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS | 77 PRIN. CODE | OTHER DIAGNOSES CODES 78 79 80 81

82 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS | 84 PRINCIPAL PROCEDURE CD DATE | 85 OTHER PROCEDURE CD DATE | 86 OTHER PROCEDURE CD DATE

PSRO-UR DATA 87 CD | 88 APP FROM | 89 APP THROUGH | 90 SRC | 91 TREATMENT AUTH | 92 ATTENDING PHYSICIAN ID | 93 OTHER PHYS ID

94 REMARKS

FOR INTERMEDIARY USE ONLY

VERIFIED FROM THROUGH | PR PSO ID

AMT REIMBURSED | APPR CD | APPROV BY | DATE APPROV

Signature X Date

UB-92 HCFA-1450 PAYER COPY

PROVIDER
NAME AND ADDRESS HERE

WEST VIRGINIA

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

SEE REVERSE FOR INSTRUCTIONS

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

1 TRANSMISSION CODE 091
2A PROVIDER I.D. NO. (7)
2B PROVIDER (GROUP) I.D. NO. (7)

0
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE.
6 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
11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT
13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)
14 BLOOD DEDUCTIBLE AMT
CARRIER CODE

1
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE
6 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
11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT.
13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)
14 BLOOD DEDUCTIBLE AMT
CARRIER CODE

2
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE
6 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
11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT
13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)
14 BLOOD DEDUCTIBLE AMT
CARRIER CODE

3
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE
6 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
11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT
13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)
14 BLOOD DEDUCTIBLE AMT
CARRIER CODE

4
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE
6 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
11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT
13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)
14 BLOOD DEDUCTIBLE AMT
CARRIER CODE

5
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE
6 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
11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT
13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)
14 BLOOD DEDUCTIBLE AMT.
CARRIER CODE

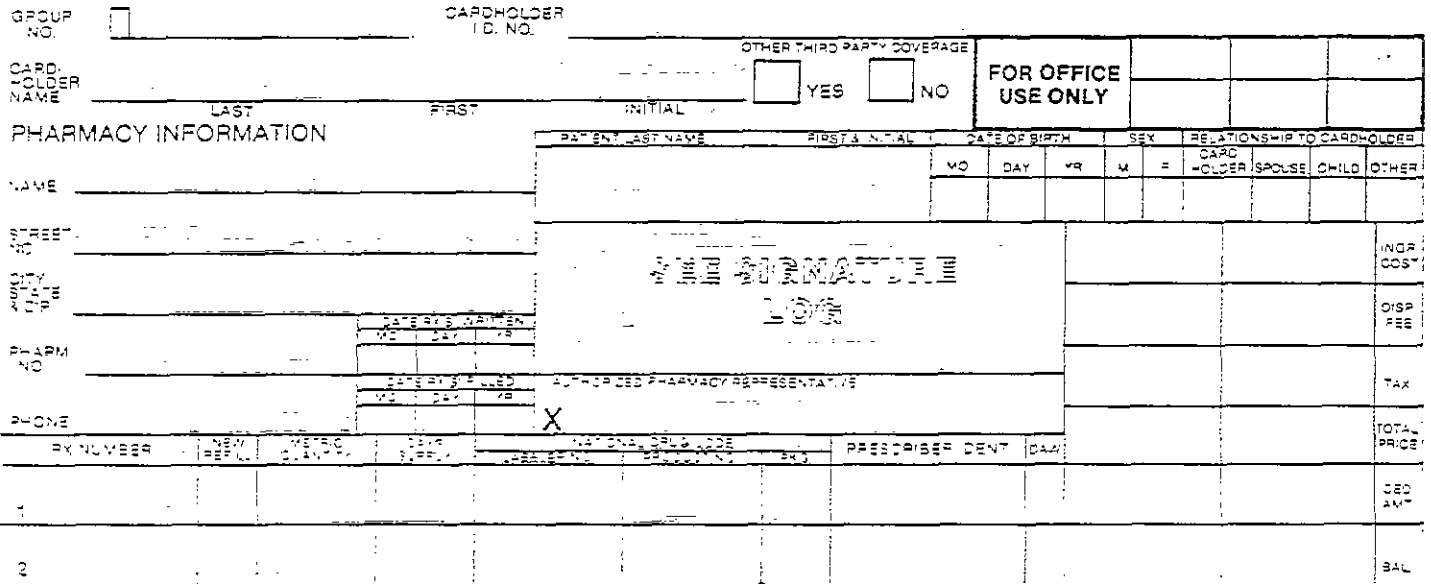
6
3 RECIPIENT'S LAST NAME FIRST
4 RECIPIENT'S I.D. NO. (11)
5 PRIMARY CARRIER INFORMATION. ENTER CODE, IF OTHER SPECIFY NAME HERE
6 TYPE OF COVERAGE CHECK ONE A B
7 PATIENT ACCOUNT NO. (10 MAX)
8 RECIPIENT'S H.I.B. NUMBER (MEDICARE)
9 STATEMENT COVERS PERIOD FROM (6) MO DAY YEAR THRU (6) MO DAY YEAR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

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

STATE COPY

AUTHORIZED SIGNATURE DATE

WVMMIS-091
REV. 1/91



GROUP NO.
CARDHOLDER I.D. NO.
CARD-HOLDER NAME — LAST — FIRST — INITIAL
OTHER THIRD PARTY COVERAGE — YES — NO
FOR OFFICE USE ONLY
PHARMACY INFORMATION
PATIENT LAST NAME — FIRST & INITIAL — DATE OF BIRTH (MO, DAY, YR) — SEX (M, F) — RELATIONSHIP TO CARDHOLDER (CARD HOLDER, SPOUSE, CHILD, OTHER)
NAME
STREET NO.
CITY STATE & ZIP
PHARM NO.
PHONE
DATE RX WRITTEN (MO, DAY, YR)
DATE RX FILLED (MO, DAY, YR)
AUTHORIZED PHARMACY REPRESENTATIVE
X
INGR COST
DISP FEE
TAX
TOTAL PRICE
DED AMT
BAL

RX NUMBER	NEW REFILL	METRIC QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE			PRESCRIBER IDENT	DAW
1								
2								

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

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

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 ☐

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 ☐ Yes ☐ No
20. DRUG QUANTITY	21. EST. DAYS SUPPLY	22. REFILL ☐ Yes ☐ No	23. TOTAL CHARGE	24. AMOUNT PAID / 25. BALANCE DUE
26. BRAND NAME JUSTIFICATION				
27. CLAIMANT'S SIGNATURE	DATE	28. 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 ☐ Yes ☐ No
20a. DRUG QUANTITY	21a. EST. DAYS SUPPLY	22a. REFILL ☐ Yes ☐ No	23a. TOTAL CHARGE	24a. AMOUNT PAID / 25a. BALANCE DUE
26a. BRAND NAME JUSTIFICATION				
27a. CLAIMANT'S SIGNATURE	DATE	28a. 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 ☐ Yes ☐ No
20b. DRUG QUANTITY	21b. EST. DAYS SUPPLY	22b. REFILL ☐ Yes ☐ No	23b. TOTAL CHARGE	24b. AMOUNT PAID / 25b. BALANCE DUE
26b. BRAND NAME JUSTIFICATION				
27b. CLAIMANT'S SIGNATURE	DATE	28b. PHARMACIST'S SIGNATURE	DATE	

As 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 made against any person, firm, or corporation.

29. REMARKS	30. PROVIDER NAME AND ADDRESS

Dental Claim Form

Check one:
☐ **Dentist's pre-treatment estimate**
☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

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

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

▶
Signed (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

BILLING DENTIST

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

Identify missing teeth with "x"

FACIAL — LINGUAL — RIGHT — LEFT — UPPER — LOWER — PRIMARY — PERMANENT — LINGUAL — FACIAL
(Teeth 1–32, A–T)

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

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

▶
Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

©American Dental Association, 1990

J510

SERVICES INVOICE

Workers' Compensation Fund
P.O. Box 3151, 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

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

11. DIAGNOSIS CODE (ICD-9-CM)/DESCRIPTION
1.
2.
3.

12. PRIOR AUTHORIZATION NO.	13. IF EMERGENCY CHECK HERE ☐	14. PATIENT ACCOUNT NO.	15. PROVIDER NO.
16. CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT ☐	17. PAYEE NO.	18. PAYEE NAME AND ADDRESS	

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

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

31. 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	2A PROVIDER I.D. NO. (7)	2B PROVIDER (GROUP) I.D. NO. (7)	3 RECIPIENT I.D. NO. (11)	4 RECIPIENT'S LAST NAME FIRST
1 1 1				

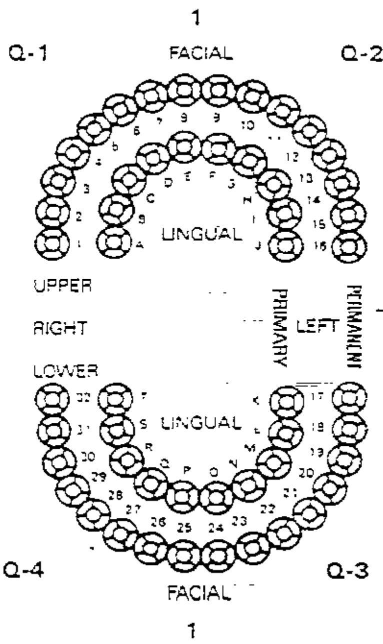
5 IS TREATMENT DUE TO ACCIDENT?	6 PATIENT ACCOUNT NO. (10 MAX)	7 EMERGENCY TREATMENT?	8 SCREENING RELATED? (EPSDT)
YES ☐ NO ☐		YES ☐ NO ☐	YES ☐ NO ☐

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

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

	9 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 NO. OF PROC	16 CHARGE	17 PAYMENT FROM PRIMARY CARRIER	18 I.C.
0																			
1																			
2																			
3																			
4																			
5																			
6																			

TOTAL ______



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.

AUTHORIZED SIGNATURE ______ DATE ______

WVMMIS-111 REV. 9-87

STATE COPY

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

January 15, 1993

FILED

JAN 15 2 08 PM '93

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

<u>HAND DELIVERED</u>

Ms. Judy Cooper, Director
Administrative Law Division
Office of the 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 Rule Modification of a Proposed Rule; and

(2) The proposed rule entitled "Standards for Uniform Health Care Administration" (Series 16).

Please contact me if further information is needed.

Very truly yours,

Linda Gay
Associate Counsel

LG/sar
Enclosures

2019 WASHINGTON STREET, EAST • CHARLESTON, WEST VIRGINIA 25305
Telephone (304) 348-0401 • Facsimile (304) 348-0412
"We are an Equal Opportunity Employer"

WEST VIRGINIA LEGISLATURE

LEGISLATIVE RULE-MAKING REVIEW COMMITTEE
Room M-152, State Capitol
Charleston, West Virginia 25305
(304) 340-3286

FILED

JAN 20 2 05 PM '93

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

Senator William R. Wooton, Co-Chair
Delegate David Grubb, Co-Chair

Debra A. Graham, Counsel
~~Michael McThomas, Associate Counsel~~
Marie Nickerson, Admr. Assistant

NOTICE OF ACTION TAKEN BY LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

January 12, 1993

TO: Ken Hechler, Secretary of State, State Register

TO: Mr. Hanley C. Clark
Insurance Commissioner
2019 Washington Street, East
Charleston, WV 25305

FROM: Legislative Rule-Making Review Committee

PROPOSED RULE: Standards for Uniform Health Care Administration

The Legislative Rule-Making Review Committee recommends that the West Virginia Legislature:

1. Authorize the agency to promulgate the Legislative Rule
   (a) as originally filed ______
   (b) as modified by the agency __X__

2. Authorize the agency to promulgate part of the Legislative rule; a statement of reasons for such recommendation is attached. ______

3. Authorize the agency to promulgate the Legislative rule with certain amendments; amendments and a statement of reasons for such recommendation is attached. ______

4. Authorize the agency to promulgate the Legislative rule as modified with certain amendments; amendments and a statement of reasons for such recommendation is attached. ______

5. Recommends that the rule be withdrawn; a statement of reasons for such recommendation is attached. ______

Pursuant to Code 29A-3-11(c), this notice has been filed in the State Register and with the agency proposing the rule.

cc: Linda Gay, Associate Counsel