

PRIMARY CARE SERVICES
APPENDIX

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

DENTAL SERVICES

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

FAMILY PLANNING SERVICES

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorized basis. Coverage for home health services is not limited by age.

HOSPITAL SERVICES

INPATIENT SERVICES

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

OUTPATIENT SERVICES

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medical Assistance Program (KMAP) participating independent laboratories includes KMAP reimbursable procedures for which the laboratory is certified by the Department of Health and Human Services to perform.

LONG-TERM CARE FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES

The KMAP can make payment to skilled nursing facilities for:

- A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*
- B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.

-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

INTERMEDIATE CARE FACILITY SERVICES

The KMAP can make payment to intermediate care facilities for:

- A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*
- B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.*

*Need for the intermediate level of care and the ICF/MR/DD level of care must be certified by a PRO.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

MENTAL HOSPITAL SERVICES

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

- Outpatient Services
- Psychosocial Rehabilitation
- Emergency Services
- Inpatient Services
- Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

NURSE MIDWIFE SERVICES

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHYSICIAN SERVICES (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

Ova and Parasites (feces)	Bone Marrow spear and/or cell block; aspiration only
Smear for Bacteria, stained	Smear; interpretation only
Throat Cultures (Screening)	Aspiration; staining and interpretation
Red Blood Count	Aspiration and staining only
Hemoglobin	Bone Marrow needle biopsy
White Blood Count	Staining and interpretation
Differential Count	Interpretation only
Bleeding Time	Fine needle aspiration with or without preparation of smear; superficial tissue
Electrolytes	Deep tissue with radiological guidance
Glucose Tolerance	Evaluation of fine needle aspirate with or without preparation of smears
Skin Tests for:	Duodenal intubation and aspiration: single specimen
Histoplasmosis	Multiple specimens
Tuberculosis	Gastric intubation and aspiration: diagnostic
Coccidioidomycosis	Nasal smears for eosinophils
Mumps	Sputum, obtaining specimen, aerosol induced technique
Brucella	
Complete Blood Count	
Hematocrit	
Prothrombin Time	
Sedimentation Rate	
Glucose (Blood)	
Blood Urea Nitrogen (BUN)	
Uric Acid	
Thyroid Profile	
Platelet count	
Urine Analysis	
Creatinine	

PODIATRY SERVICES

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

SCREENING SERVICES

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

Medical History	Tuberculin Skin Test
Physical Assessment	Dental Screening
Growth and Developmental Assessment	Screening for Venereal Disease, As Indicated
Screening for Urinary Problems	Assessment and/or Updating of Immunizations
Screening for Hearing and Vision Problems	

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

TRANSPORTATION SERVICES

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

****SPECIAL PROGRAMS****

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were statewide July 1, 1987. These services are arranged for and provided by home health agencies.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

- AFDC (Aid to Families with Dependent Children)
- AFDC Related Medical Assistance
- State Supplementation of the Aged, Blind, or Disabled
- Aged, Blind, or Disabled Medical Assistance
- Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE**

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Eligibility Period is the month, day and year of KMAP eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Medical Insurance Code indicates type of insurance coverage.-

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		MEMBERS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS	MEDICAL ASSISTANCE IDENTIFICATION NUMBER	SEX	DATE OF BIRTH MO - YE	REL.
ELIGIBILITY PERIOD		CASE NUMBER				
FROM	TO					
06-01-85	07-01-85	037 C 000123456				
CASE NAME AND ADDRESS						
Jane Smith 400 Block Ave. Frankfort, KY 40601		Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS						
SEE OTHER SIDE FOR SIGNATURE			MAP-226 REV. 12/83			

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Names of members eligible for Medical Assistance Benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE**

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers.
Insurance Identification
codes indicate type of
insurance coverage as
shown on the front of
the card in "Ins." block.

<p style="text-align: center;">PROVIDERS OF SERVICE</p> <p>This card certifies that the services listed herein to/are eligible during the period indicated on the reverse side, for covered benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement properly as contained on this card to cover the payment to be made.</p> <p>Questions regarding provider participation, fees, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p style="text-align: center;">Cabinet for Human Resources Department for Social Insurance Division of Medical Assistance Frankfort, KY 40620</p> <p style="text-align: center;">Insurance Identification</p> <table border="0"> <tr> <td>A-Part A, Medicare Only</td> <td>G-Charitas</td> </tr> <tr> <td>B-Part B, Medicare Only</td> <td>H-Health Maintenance Organization</td> </tr> <tr> <td>C-Both Parts A & B Medicare</td> <td>I-Other and/or Unknown</td> </tr> <tr> <td>D-Blue Cross/Blue Shield</td> <td>J-Adopted Parent's Insurance</td> </tr> <tr> <td>E-Blue Cross/Blue Shield Major Account</td> <td>K-None</td> </tr> <tr> <td>F-Private Medical Insurance</td> <td>N-United Life Working</td> </tr> <tr> <td></td> <td>P-Other Long</td> </tr> </table>	A-Part A, Medicare Only	G-Charitas	B-Part B, Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	I-Other and/or Unknown	D-Blue Cross/Blue Shield	J-Adopted Parent's Insurance	E-Blue Cross/Blue Shield Major Account	K-None	F-Private Medical Insurance	N-United Life Working		P-Other Long	<p style="text-align: center;">RECIPIENT OF SERVICES</p> <ol style="list-style-type: none"> 1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, ambulatory medical centers, and participating providers of hearing, vision, orthodontic, non-emergency transportation, counseling, and family planning services. 2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you. 3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign or the new card, and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card. 4. If you have questions, contact your eligibility worker at the county office. 5. Absentees temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. <p style="text-align: right;">Signature _____</p>
A-Part A, Medicare Only	G-Charitas														
B-Part B, Medicare Only	H-Health Maintenance Organization														
C-Both Parts A & B Medicare	I-Other and/or Unknown														
D-Blue Cross/Blue Shield	J-Adopted Parent's Insurance														
E-Blue Cross/Blue Shield Major Account	K-None														
F-Private Medical Insurance	N-United Life Working														
	P-Other Long														
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 206.004, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of this card by an ineligible person.</p>															

Notification to recipient
of assignment to the Cabinet
for Human Resources of third
party payments.

Recipient's signature
is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Eligibility Period, month, day, and year. "From" date is first day of eligibility certified by this card. "To" date is the day that eligibility ends, and is not included in the eligibility period represented by this card.

Name and license number of lock-in physician. Once the designated providers have been selected, KMAP payments will be limited to those providers, unless otherwise authorized by the KMAP (with the exception of emergency services and physician referrals).

M.A.I.D. Number for medical service billing on provider invoices. This is a 10 digit number.

Record of visits to be recorded on the lock-in card by the physician's office at the time service was rendered.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		
ELIGIBLE RECIPIENT & ADDRESS		
<p>Public, John Q. 1791 Kentucky Street Frankfort, KY 40601</p> <p>SEE OTHER SIDE FOR SIGNATURE</p>	<p>ELIGIBILITY PERIOD</p> <p>FROM 050185 TO 060185</p> <p>MEDICAL ASSISTANCE IDENTIFICATION NUMBER 1234567890</p> <p>SEX CODE</p> <p>INSURANCE D</p> <p>DATE OF BIRTH MONTH / YEAR</p> <p>CASE NUMBER 0037</p>	<p>PHYSICIAN NAME E. Smith, M.D. 12345</p> <p>LICENSE NO.</p> <p>RECORD OF VISITS</p> <p>1 _____ 3</p> <p>2 _____ 4</p> <p>Capital Drugs 23451</p> <p>PHARMACY NAME Elkhorn Avenue Frankfort, Ky. 40601</p>

Currently Left Blank

Medical Insurance Code

Identifies type of case and county of residence.

Name and address of member eligible for Medical Assistance benefits. All eligible individuals within a given household will receive a separate card.

Name, license number and address of lock-in pharmacy. Payment for pharmacy services is limited to the named pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

CABINET FOR HUMAN RESOURCES
 DEPARTMENT FOR SOCIAL INSURANCE
 DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers.
 Insurance Identification
 codes indicate type of
 insurance coverage as
 shown on the front of
 the card in "Ins." block.

ATTENTION:															
<p>This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.</p> <p>In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person, if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Questions regarding scope of services should be directed to the Lock-In Coordinator, by calling toll free 1-800-373-2786.</p> <p>You are hereby notified that under State Law, KRS 205.624, your right to third party payments has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p>															
<p>Insurance Identification</p> <table border="0"> <tr> <td>A - Part A, Medicare Only</td> <td>G - Champus</td> </tr> <tr> <td>B - Part B, Medicare Only</td> <td>H - Health Maintenance Organization</td> </tr> <tr> <td>C - Both Part A & B Medicare</td> <td>I - Other and/or Unknown</td> </tr> <tr> <td>D - Blue Cross/Blue Shield</td> <td>L - Absent Parent's Insurance</td> </tr> <tr> <td>E - Blue Cross/Blue Shield Major Medical</td> <td>M - None</td> </tr> <tr> <td>F - Private Medical Insurance</td> <td>N - United Mine Workers</td> </tr> <tr> <td></td> <td>P - Black Lung</td> </tr> </table>	A - Part A, Medicare Only	G - Champus	B - Part B, Medicare Only	H - Health Maintenance Organization	C - Both Part A & B Medicare	I - Other and/or Unknown	D - Blue Cross/Blue Shield	L - Absent Parent's Insurance	E - Blue Cross/Blue Shield Major Medical	M - None	F - Private Medical Insurance	N - United Mine Workers		P - Black Lung	<p>I have read the above information and agree with the procedures as outlined and explained to me.</p> <p>_____ Signature of Recipient or Representative</p> <p>_____ Date</p>
A - Part A, Medicare Only	G - Champus														
B - Part B, Medicare Only	H - Health Maintenance Organization														
C - Both Part A & B Medicare	I - Other and/or Unknown														
D - Blue Cross/Blue Shield	L - Absent Parent's Insurance														
E - Blue Cross/Blue Shield Major Medical	M - None														
F - Private Medical Insurance	N - United Mine Workers														
	P - Black Lung														
RECIPIENT OF SERVICES															
<p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>															

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

- (a) name;
- (b) ownership;
- (c) licensure/certification/regulation status; or
- (d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19____, with conditional termination on _____, 19____, and shall automatically terminate on _____, 19____, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

BY: _____
Signature of Authorized Official

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____
2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)
3. _____
City State Zip Code
4. _____
Area Code Telephone Number
5. _____
Pay to, In Care of, Attention, etc. (If different from above)
6. _____
Pay to Address (If different from above)
7. Federal Employer ID Number: _____
8. Social Security Number: _____
9. License Number: _____
10. Licensing Board (If Applicable): _____
11. Original License Date: _____
12. KMAP Provider Number (If Known): _____
13. Medicare Provider Number (If Applicable): _____
14. Provider Type of Practice Organization:
 - Corporation (Public) Individual Practice Hospital-Based Physician
 - Corporation (Private) Partnership Group Practice
 - Health Maintenance Profit Non-Profit
Organization
15. If group practice, Number of Providers in Group (specify provider type):

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

Telephone Number: _____

Name and Address of Officers:

17. If Partnership, name and address of Partners:

18. National Pharmacy Number (If Applicable): _____

(Seven-Digit Number Assigned by
National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

21. Physician/Professional Specialty Certification Board:

1st _____ Date: _____
 2nd _____ Date: _____
 3rd _____ Date: _____

22. Name of Clinic(s) in Which Provider is a Member:

1st _____
 2nd _____
 3rd _____
 4th _____

23. Control of Medical Facility:

Federal State County City Charitable or Religious
 Proprietary (Privately owned) Other _____

24. Fiscal Year End: _____

25. Administrator: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

28. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprietorship, name, address, and telephone number of owner:

Name: _____
 Address: _____
 Telephone No. _____

30. If facility is government owned, list names and addresses of board members:

	<u>Name</u>	<u>Address</u>
President or Chairman of Board:	_____	
Member:	_____	

31. Management Firm (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

	<u>Total Licensed Beds</u>	<u>Total Title XIX Certified Beds</u>
Hospital Acute Care	_____	_____
Hospital Psychiatric	_____	_____
Hospital TB/Upper Respiratory Disease	_____	_____
Skilled Nursing Facility	_____	_____
Intermediate Care Facility	_____	_____
ICF/MR/DD	_____	_____
Personal Care Facility	_____	_____

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

<u>Name</u>	<u>Address</u>	<u>Percent of Ownership</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

35. Institutional Review Committee Members (If Applicable):

36. Providers of Transportation Services:

No. of Ambulances in Operation: _____ No. of Wheelchair Vans in Operation: _____
 Total No. of Employees: _____ (Enclose list of names, ages, experience & Training.)

Current Rates:

- A. Basic Rate \$ _____ (Includes up to _____ miles.)
- B. Per Mile \$ _____
- C. Oxygen \$ _____
- D. Extra Patient \$ _____
- E. Other _____ \$ _____

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medical Assistance Program.

Signature: _____

Name: _____

Title: _____ Date: _____

INTER-OFFICE USE ONLY	
License Number Verified through _____	(Enter Code)
Comments: _____	

Date: _____	Staff: _____

KMAP
STATEMENT OF ON-SITE SERVICES
AND REFERRAL ARRANGEMENTS

This is to certify that _____
(Facility Name)

(Address, City, State and Zip Code)

in applying for participation in the Kentucky Medical Assistance Program to provide medical services to eligible Title XIX recipients, agrees to provide the following basic and supplemental services at the facility site in accordance with the requirements of State Regulations.

List all services that will be provided (i.e. Medical, Dental, Optometric, Pharmacy, Laboratory, etc.):

<u>SERVICE</u>	<u>STAFF MEMBER</u>	<u>LICENSE NUMBER/DEGREE</u>
----------------	---------------------	------------------------------

I further certify that the _____
(Facility Name)
has entered into written arrangements with the following institutions/professionals
for the provision of services unavailable at the facility:

<u>FACILITY/PROFESSIONAL</u>	<u>LICENSE #</u>	<u>SERVICE TO BE PROVIDED</u>	<u>TYPE OF ARRANGEMENT</u>
------------------------------	------------------	-------------------------------	----------------------------

I agree to notify the Division of Medical Assistance immediately of any change
in referral arrangements and/or the provision of services at the center location.

Signed _____
Facility Administrator

MAP-346
(8/82)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the following named licensed medical professionals is currently entered into financial arrangements with _____
(Facility Name)
_____, for the purpose of rendering his/her special
(City) (State) services to patients of this facility, and that currently on file in this care center is a Statement of Authorization executed by each of these individuals which authorizes payment by the KMAP to the _____ for
(Facility Name) services rendered eligible Program beneficiaries.

<u>NAME</u>	<u>LICENSE</u> <u>NUMBER</u>	<u>POSITION</u> <u>(Physician, Psychiatrist, etc.)</u>	<u>DATE OF CENTER</u> <u>EMPLOYMENT</u>
-------------	---------------------------------	---	--

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION

I hereby declare that I, _____,
(Licensed Professional)

a duly-licensed _____, have entered into a
contractual agreement with _____
(Clinic/Corporation or Facility Name)

(City, State, & Zip Code)

to provide professional services. I authorize payment to

(Clinic/Corporation or Facility Name)

from the Kentucky Medical Assistance Program for covered services provided by me
and specified by the criteria of our contract. I understand that I, personally,
cannot bill the Kentucky Medical Assistance Program for any service that is
reimbursed to _____

(Clinic/Corporation or Facility Name)

as part of our contractual agreement, and that I am solely and completely responsible
for all Kentucky Medical Assistance Program documents submitted by this employer
in my name for services I provided.

Signature of Professional

Date Signed

License and/or Certification Number

Specialty

Social Security Number

Federal Employer Identification Number

KMAP Provider Number of
Clinic/Corporation or Facility

EDS
P.O. Box 2064
Frankfort, KY 40602

**COMMONWEALTH OF KENTUCKY
MEDICAL ASSISTANCE STATEMENT
PRIMARY CARE/RURAL HEALTH**

Do not write in this area

1. RECIPIENT LAST NAME	2. FIRST NAME	3. M.I.	4. MEDICAL ASSISTANCE I.D. NUMBER
5. <input type="checkbox"/> IF EMERGENCY CHECK BOX	6. If Claim Required A Prior Authorization, Enter The Prior Authorization Number Here	7. If Services Were Provided As A Result of A Screening Exam Referral, Check Box <input type="checkbox"/>	8. If Patient Was Referred To You, Enter The Name of The Referring Practitioner.

9. IF PATIENT HAS HEALTH INSURANCE, ENTER THE NAME AND ADDRESS OF COMPANY AND POLICY NUMBER. LEAVE BLANK

10. (1) FIRST DIAGNOSIS:

(2) SECOND DIAGNOSIS:

11. INDICATE SERVICE BY ENTERING APPROPRIATE CODE (SEE MANUAL) <input type="checkbox"/> General Health Assessment and Patient History <input type="checkbox"/> Development Assessment <input type="checkbox"/> Visual Screening <input type="checkbox"/> Audiometric Screening <input type="checkbox"/> Dental Screening <input type="checkbox"/> Urinalysis	12. INDICATE SPECIAL TESTS BY ENTERING APPROPRIATE CODE (SEE MANUAL) <input type="checkbox"/> Tuberculosis Test <input type="checkbox"/> Hematocrit or Hemoglobin <input type="checkbox"/> Lead Poisoning <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Assessment and Administration of Vaccines and Immunizations <input type="checkbox"/> Blood Pressure <input type="checkbox"/> V.D.R.L. <input type="checkbox"/> Sickle Cell Test <input type="checkbox"/> Bacteriuria Screening <input type="checkbox"/> Other (Specify)	13. INDICATE CATEGORY OF SERVICE Primary <input type="checkbox"/> Care Center Other <input type="checkbox"/> (Enter Code)
--	---	---

14. REFERRED TO: 01 PHYSICIAN 02 DENTIST OTHER (SPECIFY) _____

15. DISPOSITION OF CASE: A NORMAL VISIT SCHEDULED B REFERRED FOR TREATMENT

16. Line No.	17. Provider Number	18. Place of Service Note (1)	19. Procedure/Supply Description PRESCRIPTION NUMBER	20. Drug Number	21. Units of Service	22. Procedure Supply Code	23. Tooth ID	24. See Note (2)	25. Procedure Charge	26. LEAVE BLANK
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										

30. PROVIDER NAME AND ADDRESS	31. Provider Number	TOTAL CLAIM CHARGE	27.	39. LEAVE BLANK
		AMOUNT FROM HEALTH INSURANCE	28.	
		AMOUNT FROM MEDICARE	29.	

32. Authorized Certification and Signature

This is to certify that the foregoing information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the Kentucky Medical Assistance Program. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

33. COUNTY	34. AREA	35. INVOICE DATE Mo. Day Yr.
------------	----------	---------------------------------

36. Date of Service Mo. Day Yr.	NOTE (1) PLACE OF SERVICE CODES 1. Doctor's Office 2. Patient's Home 3. Outpatient Dept. Hospital 4. Inpatient Hospital 5. Skilled Nursing Home 6. Primary Care Center 7. Intermediate Care Facility 8. Independent Laboratory 9. Rural Health Clinics/HMO	NOTE (2) Enter Diagnosis Treated from Block 10 "1" First "2" Second	37. CHARGE DISPOSITION <input type="checkbox"/> Pay <input type="checkbox"/> Charge Accumulate
------------------------------------	---	---	---

AS OF 01/06/87

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
0231048	DONALDSON R	4834042135	9883324-552-580	111786	60.00	0.00	40.00	000
01 POS 6	PROCEDURE	09000			40.00		40.00	952
02 RX NO.	086510	DRUG CODE 0000300682			10.00		0.00	300
03 POS 6	PROCEDURE	08002			10.00		0.00	951

CLAIMS PAID IN THIS CATEGORY: 1

TOTAL BILLED: 60.00

TOTAL PAID: 40.00

TRANSMITTAL #17

AS OF 01/06/87

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

Page 2

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4834042135	9883324-552-010	111786	30.00	262
01 POS 6	PROCEDURE	11122			30.00	262

CLAIMS DENIED IN THIS CATEGORY: 1

TOTAL BILLED: 30.00

APPENDIX IX-B

AS OF 01/06/87

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION-NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	8032450731	9883324-552-060	110286	32.00	260
574632	MITCHELL J	4324180114	9883324-552-020	110186	24.00	260

CLAIMS PENDING IN THIS CATEGORY: 2

TOTAL BILLED: 56.00

AS OF 01/06/87

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	EOB
324789		4838021143	9883324-552-060	110486	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	40.00	0.00	40.00	0.00	40.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

AS OF 01/06/87

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

262 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260 ELIGIBILITY DETERMINATION IS BEING MADE
300 SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS
951 THIS SERVICE IS NOT COVERED BY MEDICAID
952 REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT
999 REQUIRED INFORMATION NOT PRESENT

PROVIDER INQUIRY FORM

EDS

P.O. Box 2009
Frankfort, Ky. 40602

Please remit **both**
copies of the Inquiry
Form to EDS.

1. Provider Number		3. Recipient Name (first, last)	
2. Provider Name and Address		4. Medical Assistance Number	
		5. Billed Amount	6. Claim Service Date
		7. RA Date	8. Internal Control Number
9. Provider's Message			

10. _____
Signature Date

Dear Provider:

- This claim has been resubmitted for possible payment.
- EDS can find no record of receipt of this claim. Please resubmit.
- This claim paid on _____ in the amount of _____.
- We do not understand the nature of your inquiry. Please clarify.
- EDS can find no record of receipt of this claim in the last 12 months.
- This claim was paid according to Medicaid guidelines.
- This claim was denied on _____ for EOB code _____

Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other: _____

EDS Date

MAIL TO: EDS FEDERAL CORPORATION
 P.O. BOX 2009
 FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)		EDS FEDERAL USE ONLY		
2. Recipient Name		3. Recipient Medicaid Number		
4. Provider Name/Number/Address		5. From Date Service		6. To Date Service
		7. Billed Amt.	8. Paid Amt.	9. R.A. Date
10. Please specify WHAT is to be adjusted on the claim.				

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature

13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:

PROVIDER NAME: _____ PROVIDER #: _____

RECIPIENT NAME: _____ MAID: _____

BIRTHDATE: _____ ADDRESS: _____

DATE OF SERVICE: _____ TO _____ DATE OF ADMISSION: _____

DATE OF DISCHARGE: _____ NAME OF INS. CO.: _____

POLICY #: _____ CLAIM NO.: _____

AMOUNT OF EXPECTED BENEFITS: _____

MAIL TO: EDS
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O. Box 2009
Frankfort, KY 40602

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ When I first asked for _____

(doctor or clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____

Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____

(doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature _____ Date: _____

Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- American Indian or Alaska Native
Black (not of Hispanic origin)
Hispanic
Asian or Pacific Islander
White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter _____ Date _____

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the _____

name of individual

consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent _____ Date _____

Facility _____

Address _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____

Name of individual to be sterilized _____ Date of sterilization _____

operation _____, I explained to him/her the nature of the sterilization operation _____, the fact that _____

specify type of operation

it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery:
Emergency abdominal surgery:

(describe circumstances): _____

Physician _____ Date _____

3. State Agency, Program or Project

Press firmly to assure legible copies

Completion of "Consent Form," MAP-250

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual being sterilized to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-250, "Consent Form" or another form approved by the Secretary of Health and Human Services, provides that documentation and must be signed by the recipient, the person obtaining the consent, and the physician according to Program policy. Refer to Section IV for Program policies pertaining to sterilizations.

2. General Instructions

The "Consent Form" (MAP-250) is a 5-part self-carbonized form.

All blanks must be completed.

The following individuals or offices should receive a copy of the completed MAP-250 form:

- the surgeon, to attach to the primary care center's claim form;
- the assistant surgeon, to attach to the assistant surgeon's claim form;
- the anesthesiologist, to attach to the anesthesiologist's claim form;
- the hospital, to attach to the hospital claim form; and
- the patient.

Additional copies of the completed MAP-250 form may be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-250 behind the corresponding claim form and submit for processing.

Order MAP-250 forms from:

Department for Medicaid Services
CHR Building, 3rd Floor East
275 East Main Street
Frankfort, KY 40621

Attention: Jim Garrison

3. Detailed Instructions for Completion of Form

a. Consent to Sterilization

This section must be completed at least 30 days prior to the sterilization procedure, except in cases of premature delivery and emergency abdominal surgery, in which cases a 72-hour waiting period is required. No more than 180 days may elapse between the date the form is signed and the date the procedure is performed.

Enter the name of the physician, center or the name of the physician and the phrase "and/or his/her associates" who expects to perform the procedure.

Enter the name of the procedure to be performed.

Enter the birthdate of the patient.

Enter the name of the patient.

Enter the name of the physician expected to perform the procedure.

Enter the method of sterilization.

The patient signs the form.

Enter the date the patient signs the form.

Race and ethnicity information may be designated by checking the appropriate block.

b. Interpreter's Statement

If appropriate, complete this section at the same time the above section is completed.

Enter the language used to read and explain the form.

The interpreter signs and dates the form.

c. Statement of Person Obtaining Consent

This section is completed at the same time or after the above two sections are completed.

Enter the patient's name.

Enter the procedure name.

The person obtaining the consent reads, signs, and dates the form. This date must be on or after the date the patient signed.

Enter the name and address of the primary care center employing the person obtaining consent.

d. Physician Statement

This section is completed at the same time or after the procedure is performed.

Enter the name of the patient and the date of the sterilization.

Enter the procedure performed.

Follow instructions on the form. Cross out the paragraph not used.

If the sterilization was performed less than 30 days but more than 72 hours after date of the individual's signature on the Consent Form, check the applicable block and provide the information requested.

In the case of premature delivery, enter the expected date of delivery. The expected date of delivery must be at least 30 days after the individual's signature date.

If the procedure was performed as a result of emergency abdominal surgery, enter a brief description in the designated area of the Consent Form, or attach an operative report to describe the circumstances as required.

The physician who performed the procedure signs the form. The actual signature of the physician is required.

Enter the date the physician signs the form. This date must be on or after the date of the surgery.

MAP-251
(1-79)COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE

HYSTERECTOMY CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO HAVE A HYSTERECTOMY WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I, _____, have requested and received information about
(print or type)

hysterectomies (abdominal and/or vaginal) from _____ .
(name of attending physician)

I was informed that a hysterectomy is the surgical removal of the uterus/womb and of the two (2) methods of performing the procedure (abdominal hysterectomy and vaginal hysterectomy).

I have been advised of the type of hysterectomy procedure (abdominal and/ or vaginal) that will be performed on me. I am aware of the complications that may result from the performance of this surgical procedure.

I was informed that a hysterectomy is intended to be a permanent/final and irreversible procedure. I understand that I will be unable to become pregnant or bear children.

I certify that I fully understand the above and voluntarily consent to the surgical procedure.

Signature of Patient/
Representative _____

Signature of Person
Obtaining Consent _____

Date _____

Completion of "Hysterectomy Consent Form," MAP-251

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual receiving a hysterectomy to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-251 or another form approved by the Secretary of Health and Human Services, provides that documentation and must be signed by the individual receiving the hysterectomy or her representative, except in circumstances described in Section IV of this manual.

2. General Instructions

The "Hysterectomy Consent Form" (MAP-251) is a 5-part self-carbonized form.

All blanks must be completed.

The following individuals or offices should receive a copy of the completed MAP-251 form:

- the surgeon, to attach to the primary care center's claim form;
- the assistant surgeon, to attach to the assistant surgeon's claim form;
- the anesthesiologist, to attach to the anesthesiologist's claim form;
- the hospital, to attach to the hospital claim form; and
- the patient or her representative, for her records.

Additional copies of the completed MAP-251 form may be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-251 behind the corresponding claim form and submit for processing. When a hysterectomy is performed on an individual who is already sterile, or who required a hysterectomy because of a life-threatening emergency, attach the physician's written certification behind the claim form and submit for processing.

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE

EDS Federal
P.O. Box 2036
Frankfort, KY 40602

MEDICAL ASSISTANCE STATEMENT
PRIOR AUTHORIZATION FOR VISION CARE
(Please press hard; you are making 3 copies)

1 RECIPIENT LAST NAME	2 FIRST NAME	3 M.I.	4 MEDICAL ASSISTANCE I.D. NO.	5 BIRTH DATE (MO.YR.)
-----------------------	--------------	--------	-------------------------------	-----------------------

6 SERVICE REQUESTED A <input type="checkbox"/> REPLACEMENT OF GLASSES B <input type="checkbox"/> REPLACEMENT OF LENS C <input type="checkbox"/> REPLACEMENT OF FRONT OR FRAMES D <input type="checkbox"/> TEMPLE REPLACEMENT OR HINGE REPAIR E <input type="checkbox"/> INITIAL	7 INDICATE REASON FOR REPLACEMENT											
	<table border="0"> <tr> <td>A <input type="checkbox"/> DIAGNOSTIC CORRECTION</td> <td>F <input type="checkbox"/> (1) LENS BROKEN</td> </tr> <tr> <td>B <input type="checkbox"/> FRAME BROKEN</td> <td>G <input type="checkbox"/> (2) LENS BROKEN</td> </tr> <tr> <td>C <input type="checkbox"/> FRONT BROKEN</td> <td>H <input type="checkbox"/> (1) LENS SCRATCHED</td> </tr> <tr> <td>D <input type="checkbox"/> (1) TEMPLE BROKEN</td> <td>I <input type="checkbox"/> (2) LENS SCRATCHED</td> </tr> <tr> <td>E <input type="checkbox"/> (2) TEMPLES BROKEN</td> <td>J <input type="checkbox"/> LOST GLASSES</td> </tr> <tr> <td></td> <td>K <input type="checkbox"/> OTHER _____</td> </tr> </table>	A <input type="checkbox"/> DIAGNOSTIC CORRECTION	F <input type="checkbox"/> (1) LENS BROKEN	B <input type="checkbox"/> FRAME BROKEN	G <input type="checkbox"/> (2) LENS BROKEN	C <input type="checkbox"/> FRONT BROKEN	H <input type="checkbox"/> (1) LENS SCRATCHED	D <input type="checkbox"/> (1) TEMPLE BROKEN	I <input type="checkbox"/> (2) LENS SCRATCHED	E <input type="checkbox"/> (2) TEMPLES BROKEN	J <input type="checkbox"/> LOST GLASSES	
A <input type="checkbox"/> DIAGNOSTIC CORRECTION	F <input type="checkbox"/> (1) LENS BROKEN											
B <input type="checkbox"/> FRAME BROKEN	G <input type="checkbox"/> (2) LENS BROKEN											
C <input type="checkbox"/> FRONT BROKEN	H <input type="checkbox"/> (1) LENS SCRATCHED											
D <input type="checkbox"/> (1) TEMPLE BROKEN	I <input type="checkbox"/> (2) LENS SCRATCHED											
E <input type="checkbox"/> (2) TEMPLES BROKEN	J <input type="checkbox"/> LOST GLASSES											
	K <input type="checkbox"/> OTHER _____											

8 IF PRESCRIPTION LENSES ARE REQUIRED, COMPLETE THE FOLLOWING

OLD RX	SPHERE	CYLINDER	AXIS	PRISM	BASE

OD	SPHERE	CYLINDER	AXIS	PRISM	BASE
OS					

9 DESCRIPTION OF SERVICES REQUIRING APPROVAL	10 LINE NO.	11 PROCEDURE NO. TO BE BILLED
	1	
	2	
	3	
	4	
	5	
	6	

SIGNATURE OF OPHTHALMOLOGIST/OPTOMETRIST/OPHTHALMIC DISPENSER	DATE OF SERVICE
---	-----------------

12 NAME AND ADDRESS OF OPHTHALMOLOGIST/OPTOMETRIST/OPHTHALMIC DISPENSER	13 PROVIDER NUMBER
---	--------------------

CAUTION: IN ORDER FOR YOU TO RECEIVE PAYMENT, RECIPIENT MUST BE ELIGIBLE ON DATE OF SERVICE. TO VERIFY, CHECK MEDICAID CARD.

DO NOT WRITE BELOW THIS LINE

14 ACTION TAKEN ON THIS REQUEST	15 PRIOR AUTHORIZATION TO BE USED ON CLAIM FORM
<input type="checkbox"/> APPROVED DATE APPROVED MO. DAY YR. <input type="checkbox"/> DENIED REASON FOR DENIAL: _____	_____

TRANSMITTAL #17

AUTHORIZED SIGNATURE _____

A. Prior Authorization

1. All services, other than examinations and diagnostic procedures, require prior authorization.
2. The limitation of two (2) complete pairs of eyeglasses per recipient per 12 months, requires prior authorization. This informs the provider what services will be payable by the KMAP. The approval of a Prior Authorization request has NO bearing on recipient Medicaid eligibility. The following guidelines should be adhered to by the provider when requesting authorization:
 - a. Check the Medical Assistance card to determine if the recipient is eligible on the date seen by the provider. If so, determination of what the patient requires is made. This includes the examination and selection of frame, lenses, or any materials.
 - b. The completed Prior Authorization Form, MAP-8, follows the instructions in this section. All parts of this form must be mailed to the following address for processing:

EDS
P.O. Box 2036
Frankfort, KY 40602

Please type or print in ink in order that entries are clearly marked on all required copies.

EDS staff will determine if, and what, services are approvable. This will be indicated on the MAP-8 form, and a prior authorization number will be entered for any services granted approval. The yellow copy of the form will be returned to the provider.

- c. Upon receipt of the yellow copy the provider can order the materials for those services that were granted approval.

IMPORTANT: Although the services were approved, reimbursement for materials will be made only if the recipient is eligible on the date the materials were ordered. It is the responsibility of the provider to verify the patient's eligibility. (Eligibility includes recipient name, MAID #, birthdate, and eligibility period.) Any materials ordered prior to the granting of approval by EDS are done so at the risk of the provider, as the services may be denied.

3. Completion of Prior Authorization

An example of a "Prior Authorization for Vision Care" form (MAP-8) is shown on Appendix XV-A. Instructions for the proper completion of this form are outlined below.

BLOCK NUMBER

1. RECIPIENT LAST NAME:

Enter the last name of the patient EXACTLY as it appears on his current Medical Assistance Identification (MAID) card.

2. FIRST NAME:

Enter the first name of the patient EXACTLY as it appears on his current MAID card.

3. M.I.:

Enter the middle initial of the patient.

4. Medical Assistance I.D. Number

Enter the patient's identification number exactly as it appears on his current MAID card. The number consists of 10 digits and all of them must be entered.

5. Birth Date

Enter the month and year of the patient's birthdate.

6. Service Requested

Check appropriate box to indicate service(s) being requested. Note: If it has been over 12 months since last initial pair, and only the lenses are being requested, this is considered to be a request for a replacement of lenses, not an initial. The date of the last initial pair is to be entered as the reason for replacement. The dispensing service requested (initial/replacement) must match the dispensing procedure code indicated. Each recipient can have only one initial pair per 12 months.

7. Indicate Reason for Replacement

Check the appropriate box(es) to indicate the reason(s) for the replacement. Each part being replaced must have a reason checked.

8. If Prescription Lenses are Required, Complete the Following

If lenses are required, enter the prescription in the box "New Rx." When new lenses are requested within 12 months due to diagnostic correction, both the old and new prescriptions must be entered. If new lenses are requested due to breakage or loss, and an examination was performed, enter the prescription in the box "New Rx." If no examination was performed to determine a new prescription enter the lens prescription in the box "Old Rx."

If the patient is photophobic and requires tint, this diagnosis must be entered.

9. Description of Services Requiring Approval

Enter a brief description of the service to be rendered and the supply item to be furnished to the patient.

When the patient is providing his/her own frames, for the initial pair of eyeglasses, indicate so in this area.

Signature of Ophthalmologist/Optomtrist/Ophthalmic Dispenser

The actual signature of the provider (not a facsimile) is required, or a billing authority, i.e. billing clerk, may enter the provider name with their own initials entered on the same line. Stamped signatures are not acceptable.

Date of Service

Enter the actual date of service, not the date the form is completed and signed by the provider.

10. Line No.

No Entry Required.

11. PROCEDURE NO. TO BE BILLED

Enter the procedure code which identifies the service or supply item to be furnished.

If procedure codes are incorrect or missing, the form will be returned to the provider.

12. NAME AND ADDRESS OF OPTOMETRIST/OPHTHALMIC DISPENSER

Enter the complete name and address of the provider performing the services being requested on this form. Use of a rubber stamp is permissible.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

PRIMARY CARE SERVICES MANUAL

13. PROVIDER NUMBER

Enter the 8-digit Medicaid provider number assigned to the provider indicated in block 12.

14. ACTION TAKEN ON THIS REQUEST

Leave blank. Program staff will complete this by indicating whether services were approved or denied, entering the date and signing the request form.

15. PRIOR AUTHORIZATION NO. TO BE USED ON CLAIM FORM

Leave blank. If approval is granted by EDS, the staff will enter the pre-authorization number assigned for this service.

16. Leave blank.

17. Leave blank.

18. No entry required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

DEFINITIONS OF DENTAL PROCEDURES

1. ORTHODONTIC SERVICES

(Procedures D1510, D1515, D1520, D1525, D8110, D8120) refers to an appliance necessary for the minor tooth movement or guidance of one or a few teeth. Payment applies to the appliance only. Diagnostic records and adjustment visits are presently outside the scope of covered benefits. Definitions of these procedures are as follows:

Fixed Space Maintainer

Definition: An appliance requiring cemented orthodontic bands with varying attachments such that patient removal or adjustment is difficult.

D1510 Fixed, Unilateral Type

- Examples: a. Band and Loop
b. Cantilever type

D1515 Fixed, Bilateral Type

- Examples: a. Soldered or adjustable lingual arch
b. Soldered or adjustable transpalatal arch
c. Cantilever type

Removable Space Maintainer

Definition: A space maintenance appliance which is readily removed by the dentist or the patient. The appliance may or may not have bands or stainless steel crowns.

Example: acrylic base appliance with or without clasps and/or teeth

D1520 Removable, Unilateral type

D1525 Removable, Bilateral type

NOTE: D1510, D1515, D1520 and D1525 are used for the maintenance of existing intertooth space.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

DEFINITIONS OF DENTAL PROCEDURES

D8110 Removable Appliance for Minor Tooth Guidance

Definition: An appliance, used for the positioning of one or a few teeth, that is readily removed by the dentist or patient.

- Examples:
- a. Hawley type with a variety of activating attachments
 - b. lip bumper with a variety of activating attachments
 - c. headgear with two molar bands and a facebow

D8120 Fixed or Cemented Appliance for Minor Tooth Guidance

Definition: An appliance requiring cemented orthodontic bands, with varying attachments for the positioning of one or a few teeth, such that patient removal or adjustment is difficult.

- Examples:
- a. diastema closing spring
 - b. adjustable lingual arch
 - c. adjustable transpalatal arch
 - d. crossbite correction (two bands and crossbite elastic)
 - e. segmented arch appliance (usually used for molar rotation and limited to one quadrant)
 - f. 2 X 4 or 2 X 6 appliance (involves two molars and four or six anteriors to correct anterior tooth rotation - limited to one arch)

TRANSITIONAL APPLIANCE

An acrylic or plastic appliance, so named because of its application during the period of transition from the primary to the permanent dentition; space maintenance or space management, and interceptive or preventive orthodontics.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

DEFINITIONS OF DENTAL PROCEDURES

2. EXTRACTIONS

(Procedure D7110 and D7120) - apply to simple, uncomplicated extractions. Surgical extractions are outside the scope of covered benefits. Procedure D7110 is to be used to bill the first tooth extracted on a given day; all additional teeth extracted on the same day must be billed as procedure D7120.

CERTIFICATION FORM FOR INDUCED ABORTION
OR INDUCED MISCARRIAGE

I, _____, certify that on the basis of
(Physician's Name)

my professional judgement, the life of _____
(Patient's Name)

_____ of _____
(MAID #) (Patient's Address)

would be endangered if the fetus were carried to term. I further certify that the following procedure(s)
was medically necessary to induce the abortion or miscarriage.

(Please indicate date and the procedure that was performed.) _____

Physician's Signature

Name of Physician

License Number

Date

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

I, _____, certify that on the basis of

 (*Physician's Name*)

my professional judgement, it was necessary to perform the following procedure on _____

 (*Date*)

to induce premature birth intended to produce a live viable child. _____

 (*Procedure*)

This procedure was necessary for the health of _____

 (*Name of Mother*)

_____ of _____

 (*MAID #*) (*Address*)

and/or her unborn child.

Physician's Signature

Name of Physician

License Number

Date

KENTUCKY MEDICAL ASSISTANCE PROGRAM
DRUG PRE-AUTHORIZATION POLICIES AND PROCEDURES

INTRODUCTION

The purpose of the Drug Pre-Authorization Procedure is to provide Kentucky Medical Assistance Program (KMAP) recipients with access to certain legend drugs not normally covered on the KMAP Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. Such requests are referred to the Program by physicians, pharmacists, and social workers. Determinations are made based on the merits of the individual request and information received.

To assist with determining the kinds of requests which can be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.

I. DRUG PRE-AUTHORIZATION CRITERIA

A. Request Criteria

1. The requested drug is to be used in lieu of hospitalization to maintain the patient on an outpatient basis and/or prevent a higher level of care.
2. The requested drug must be a legend drug. The only exception will be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition is maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.
3. The requested drug is to be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).
4. The requested drug will not be considered for pre-authorization if it is currently classified by FDA as "less than effective" or "possibly effective."
5. Drugs on the formulary must have been tried, when appropriate, with documentation of ineffectiveness.

6. The Program will not pre-authorize the trial usage of a maintenance drug except when the drug has been tried for at least two weeks with successful results prior to the request. In such cases, when all criteria are met, retroactive pre-authorization for two weeks will be considered in addition to the usual pre-authorization period.

B. Pre-Authorization of Therapeutic Categories

Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines must be met.

C. Guidelines For Specific Drug Categories

1. Analgesics

Requests for analgesics will be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six months.

2. Antibiotics

Requests for antibiotics will be considered ONLY if culture and sensitivity tests have identified specific sensitivity and/or ONLY if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration will be given to the request.

3. Anti-Inflammatory Drugs (NSAID's)

Requests for anti-inflammatory drugs will not be pre-authorized unless drugs on the Drug List have been tried unsuccessfully.

4. Antitussives, "Cough Mixtures," Expectorants, Antihistamines

Requests for "cough mixture" preparations such as expectorants and antitussives will not be pre-authorized. Only specified antihistamines may be pre-authorized if all other criteria have been met.

5. Chemotherapeutic Agents

Requests for anti-neoplastic agents will be considered for approved FDA indications.

6. Hypnotics and Sedatives

Requests for sedatives and hypnotics will be considered only after covered antidepressant and/or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also such requests must be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives will not be approved for more than two weeks, unless there is a diagnosis of terminal cancer.

7. Maintenance-Type Drugs

Requests for maintenance-type drugs will be considered only if such drugs have been tried for at least two weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.

8. Non-Legend Drugs

Non-legend (over-the-counter) drugs will be excluded from coverage under drug pre-authorization.

The only exception will be non-legend nutritional supplements as noted in I. A. 2. above and nicotinic acid.

9. Ophthalmics and Topical Preparations

Requests for ophthalmics or topical preparations will not be pre-authorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.

10. Tranquilizers, Minor

Requests for minor tranquilizers will be considered only for acute anxiety, alcohol or drug withdrawal (with a one-month limitation), cancer, seizure disorders, and quadraplegia/paraplegia.

11. Ulcer Treatment Drugs, Legend

On the basis of ulcer symptoms, legend ulcer treatment drugs may be pre-authorized if other applicable pre-authorization criteria are met.

12. Total Parenteral Nutrition

May be pre-authorized if the need exists. Medicare maximum amounts allowed/month and maximum fees/month are applicable. The maximum amounts/fees allowed/month are subject to post payment review.

13. Transdermal Antihypertensive Medication

Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.

D. Pharmacy Lock-In

The pharmacy originally selected by the recipient must remain the provider during the period of the pre-authorization unless a valid reason for change exists.

E. Pre-Authorization Period

The maximum period for which any drug may be pre-authorized will be six months. A request for renewal may be considered if the need for the drug continues to exist. Extensions may be backdated if the dates do not interfere with already existing segments on the drug file.

F. Minimum Cost Requirement

Only those requests for oral, non-liquid drugs which cost \$5.00 or more to the pharmacy for a month's supply or a course of treatment will be considered for pre-authorization.

G. Routine Immunizations

Immunizations requested for routine health care will not be approved. An underlying medical condition which would make the patient more susceptible to the disease must be present.

H. Exceptions to Existing Policy

The Commissioner for the Department for Medicaid Services, or his designate, may grant an exception to existing policy when sufficient documentation exists to override this policy. The request should be written, or followed up in writing, if necessary.

II. THE REQUEST PROCEDURE

A. Initiating a Request

1. Requests for pre-authorization may be initiated by the prescribing physician or office personnel under his direct supervision. Requests from pharmacists and social workers who are working directly with the recipient's physician are also accepted.
2. The primary concern is that the caller have available the information necessary for staff to make an accurate determination.

B. Transmittal Methods

1. Written Requests

The drug pre-authorization request may be made IN WRITING to:
EDS, P.O. Box 2036, Frankfort, Kentucky 40602.

2. Telephone Requests

Or by PLACING A TELEPHONE CALL to the following toll-free number between 8:00 a.m. and 4:30 p.m. EST/EDST, on Monday through Friday (except during holidays):

Telephone Number: 1-800-372-2944
Out of State: (502) 227-9073.

III. INFORMATION REQUIRED FOR A DETERMINATION

Persons requesting a pre-authorization of medications should provide information, line for line from the Pre-Authorization Request Form. Special attention should be given to giving a specific statement, indicating the need for the requested drug as well as previous medications tried unsuccessfully. Primary Care Centers requesting a drug pre-authorization number should always give the provider number of the center as the provider and not the prescribing physician.

IV. DISPOSITION OF REQUEST

- A. Nurses will review each request and make determinations on the basis of established Program criteria. Extenuating circumstances should be directed to the medical consultant.
- B. If the appropriate information is received and the medication meets the Program criteria, an approval is made. However, if the request does not meet the basic criteria or if insufficient or contradictory information is provided, the request will be disapproved. Drug Pre-Authorization staff will NOT assume responsibility for calling physicians for more information.
- C. Unusual or unique situations are reviewed by consultant pharmacists, physicians, and recognized University staff.
- D. When the medication is not on the KMAP Drug List and is disapproved for pre-authorization, the recipient must assume responsibility for the cost or obtain an alternative source of payment.
- E. Determinations will be made daily Monday through Friday, except on holidays.

V. NOTIFICATION OF DISPOSITION

- A. Notification regarding the disposition (approval or disapproval) of each pre-authorization request will be made as follows:
 - 1. DISAPPROVALS: When disapproved, the prescribing physician will be notified by mail. The request and reason for disapproval will be provided.
 - 2. APPROVALS: When approved, notification will be made by phone to the selected pharmacy. The pharmacist will provide the pre-authorization staff with the NDC number and provider number.

NOTE: Pre-authorization is not guaranteed for any request until reviewed and approved by pre-authorization staff members. If any change should occur, i.e. NDC #, MAID #, quantity, etc., please notify pre-authorization staff immediately to assure Program payment.

B. Period of Coverage

The effective date for Program coverage of pre-authorized drugs will begin on the date the request is postmarked or date received by phone. Upon request, it is possible to allow up to a 10-day grace period on the beginning date. The pre-authorization will remain in effect for the specified time on the "Authorization to Bill" or until the recipient becomes ineligible, whichever comes first.

CAUTION: Pre-authorization does not guarantee payment.
Recipient must be eligible on date of service.
Verify by checking the recipient's Medicaid card.

VI. REIMBURSEMENT INFORMATION

- A. Pre-authorized drugs will be reimbursed in the same manner as any other prescription drug entered on the MAP-7 claim form. The only addition to the claim form is the assigned pre-authorization number which is to be entered in Block #6 of the MAP-7 claim form. List the number as shown 0 0 0 0.
- B. Private insurance companies, if applicable, must be billed prior to submitting claims for payment.

VII. ADDITIONAL INFORMATION

Any questions regarding the Drug Pre-Authorization Procedure should be directed to:

EDS
P.O. Box 2036
Frankfort, KY 40602

Telephone Number: 1-800-372-2944

Medicare Maximum Allowables
for Enteral/Parenteral Home Hyperalimentation

Description	Amount Allowed	
Compleat-B (liquid), 8 oz., per 24	\$ 50.60	8 per month
Magnacal (liquid), 8 oz., per 24	50.60	8 per month
Vitaneed (liquid), 355 ml., per 24	50.60	8 per month
Criticare HN (liquid), 8 oz., per 24	81.35	10 per month
Compleat Modified (liquid), 8 oz., per 24	81.35	10 per month
Isocal HCN (liquid), 8 oz., per 12	26.20	8 per month
Meritene (liquid), 8 oz., per 24	26.20	8 per month
Sustacal (liquid), 8 oz., per 24	21.44	10 per month
Ensure (liquid), 8 oz., per 24	21.44	10 per month
Ensure Plus (liquid), 14 oz., per 6	21.44	10 per month
Osmolite (liquid), 8 oz., per 24	21.44	10 per month
Renu (liquid), 250 ml., per 24	21.44	10 per month
Isocal (liquid), 8 oz., per 24	21.44	10 per month
Travasorb whole protein, any flavor (liquid), 8 oz., per 24	21.44	10 per month
Vivonex HN (powder), 80 mg., per 10	45.68	31 per month
Precision HN (powder), 87.9 mg., per 10	45.68	31 per month
Travasorb Renal (powder), 112 gm., per 5	45.68	31 per month
Sustagen (powder), 5 lb., each	34.88	7 per month
Meritene (powder), 4.5 lb., each	34.88	7 per month
Precision isotonic (powder), 61.8 gm., per	17.28	31 per month
Travasorb STD, any flavor (powder), 83.3 mg., per 6	17.28	31 per month
Travasorb MCT (powder), 89 mg., per 5	17.28	31 per month
Flexical (powder), 60 mg., per 8	14.90	31 per month
Vivonex STD (powder), 80 mg., per 6	14.90	31 per month
Precision LR (powder), 90 mg., per 6	14.90	31 per month
Intralipids (500 ml.)	36.40	31 per month
Heparin (2 cc)	30.60	Monthly Maximum
Nutrient expander (saline, 500 ml.)	5.00	31 per month
Parenteral nutrients, 1 liter/day	79.31	31 per month
Parenteral nutrients, 2 liters/day	132.00	31 per month
Sustagen (powder), 1 lb, each	10.05	31 per month
Portagen (powder), 1 lb, each	10.05	31 per month
Meritene (powder), 1 lb, each	9.58	16 per month
Sustacal (powder), 54.5 gm., per 24	9.58	16 per month
Vital HN (powder), 78 gm., per 24	76.60	7 per month
Travasorb HN (powder), 83.3 gm., per 6	32.47	31 per month

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL SERVICES

CONFIDENTIAL
SUSPECTED ABUSE/NEGLECT, DEPENDENCY OR EXPLOITATION REPORTING FORM

TYPE REPORT: Child Adult Spouse County of Report _____

Time Report Received _____

Report Date _____

Incident Date(s) _____

1. Name(s)	Age	Sex	Nature of Report			
a. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C
H
I
L
D

A
D
U
L
T

- | |
|----------------------|
| 1. Physical Injury |
| 2. Sexual Abuse |
| 3. Mental Injury |
| 4. Neglect |
| 5. Dependency |
| 6. Adult Abuse |
| 7. Spouse Abuse |
| 8. Self-Neglect |
| 9. Caretaker Neglect |
| 10. Exploitation |

2. Current Address _____
Street/Rural Route City/Zip County Telephone #

3. Directions _____

4. Parent(s)/Guardian/Caretaker _____ Relationship _____

5. Other Known Household Members _____

6. Describe nature/extent/causes of abuse/neglect/dependency, or exploitation. List witnesses and/or collateral contacts, previous incidents or reports. Describe behavior of adult victim and of alleged perpetrator (dangerous?)

7. Alleged Perpetrator, if different from 4 above

Name _____ Relationship _____

Address _____
Street/Rural Route City/Zip County Telephone #

8. Person Taking Report _____ Title _____

9. Worker Assigned to Investigate _____ County _____ Telephone # _____

by: Family Services Office Supervisor _____

10. ATTENTION: LAW ENFORCEMENT Certification of Receipt of Report on Form JC-3 or by Other Law Enforcement Means.

Kentucky Revised Statutes, Chapter 620.030 and/or 209.030(2), dealing with suspected child physical or sexual abuse and suspected adult abuse, neglect, exploitation, or spouse abuse requires the Department for Social Services to notify the appropriate law enforcement agency.

INTERVENTION REQUESTED At your discretion

Sent to: _____, County Attorney

11. Person Making Report _____ Title/Relationship _____

Address _____
Street/Rural Route City/Zip County Telephone #

TABLE OF CONTENTS

	PAGE NO.
I. INTRODUCTION	
A. Introduction	1.1-1.2
B. Fiscal Agent	1.1
II. KENTUCKY MEDICAID [MEDICAL ASSISTANCE] PROGRAM [KMAP]	2.1-2.8
A. General Information	2.1
B. Administrative Structure	2.2
C. Advisory Council	2.2-2.3
D. Policy	2.3-2.5
E. Public Law 92-603	2.5-2.8
F. Timely Submission of Claims	2.8
III. CONDITIONS OF PARTICIPATION	3.1-3.7
A. Definition and Intent	3.1
B. Participation Requirements	3.2-3.5
C. Termination of Participation	3.5-3.7
IV. SERVICES COVERED	4.1-4.101
A. Basic Services	4.1-4.2
B. Supplemental Services	4.2
C. Non-Covered Services	4.3
D. Medical	4.3-4.25
E. Laboratory	4.26
F. Dental	4.27-4.42
G. Family Planning	4.43-4.52
H. Pharmacy	4.53-4.61
I. Clinical Pharmacist	4.61
J. Audiology	4.62-4.71
K. Vision	4.72-

TABLE OF CONTENTS

	PAGE NO.
V. REIMBURSEMENT	5.1-5.5
A. Method of Reimbursement	5.1
B. Medicare, Title XVIII Coverage	5.2
C. Reimbursement in Relation to Other Third-Party Coverage	5.2-5.5
D. Duplicate or Inappropriate Payments	5.5
VI. COMPLETION OF INVOICE FORM	6.1-6.5[7]
VII. REMITTANCE STATEMENT	7.1-7.5
A. General Information	7.1
B. Section I -- Claims Paid	7.2-7.3
C. Section II -- Denied Claims	7.3
D. Section III -- Claims in Process	7.4
E. Section IV -- Returned Claims	7.4
F. Section V -- Claims Payment Summary	7.4-7.5
G. Section VI -- Description of Explanation Codes	7.5
VIII. GENERAL INFORMATION -EDS	8.1-8.7
A. Correspondence Forms Instructions	8.1
B. Telephone Inquiry Information	8.2
C. Filing Limitation	8.3
D. Provider Inquiry Form	8.4-8.5
E. Adjustment Request Form	8.6-8.7

TABLE OF CONTENTS

PRIMARY CARE SERVICES APPENDIX

Appendix I	-Medicaid [KMAP] Services
Appendix II	-Eligibility Information
Appendix II-A	-KMAP MAID Card
Appendix II-B	-KMAP Lock-In Card
Appendix III	-KMAP Provider Agreement (MAP-343)
Appendix IV	-Provider Information Sheet (MAP-344)
Appendix V	-Statement of On-Site Services and Referral Arrangements (MAP-231)
Appendix VI	-Certification of Conditions Met (MAP-346)
Appendix VII	-Statement of Authorization (MAP-347)
Appendix VIII	-Health Insurance Claim Form (HCFA-1500) (12/90) [Primary Care Billing Form (MAP-7)]
Appendix IX-A	-Paid Claims Remittance Advice
Appendix IX-B	-Denied Claims Remittance Advice
Appendix IX-C	-Claims in Process Remittance Advice
Appendix IX-D	-Returned Claims Remittance Advice
Appendix IX-E	-Description of Explanation Codes
Appendix X	-Provider Inquiry Form (EDS)
Appendix XI	-Adjustment Request Form (EDS)
Appendix XII	-Third Party Liability Lead Form
Appendix XIII-A	-Sterilization Consent Form (MAP-250)
Appendix XIII-B	-Instructions for Use of MAP-250
Appendix XIV-A	-Hysterectomy Consent Form (MAP-251)
Appendix XIV-B	-Instructions for Use of MAP-251
Appendix XV-A	-Prior Authorization for Vision Care (MAP-8)
Appendix XV-B	-Instructions for Use of MAP-8 Form
Appendix XVI	-Definitions of Dental Procedures
Appendix XVII-A	-Certification Form for Induced Abortion or Induced Miscarriage
Appendix XVII-B	-Certification Form for Induced Premature Birth
Appendix XVIII	-Drug Pre-Authorization Policies and Procedures
Appendix XIX	-Report of Suspected Child Abuse/Neglect (DSS-115)

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General

The Health Insurance Claim Form (HCFA-1500) (12/90) [~~Primary Care Invoice (MAP-7)~~] shall ~~must~~ be used to bill for all primary care services rendered eligible Kentucky Medicaid [~~Medical Assistance~~] Program recipients. A ~~an~~ claim or invoice is to be completed to reflect all services rendered a recipient on a given date, even when the services do not constitute a "billable service." A definition of billable service may be found in Section V - Reimbursement, and in the Reimbursement Manual, PART I, Section 103, page 3.01.

The original of the two part invoice set shall ~~should~~ be submitted to EDS as soon as possible after the service is provided. The carbon copy of the invoice shall ~~should~~ be retained by the provider as a record of claim submitted.

Invoices shall ~~should~~ be mailed to:

EDS
P.O. Box 2018 ~~64~~
Frankfort, Kentucky 40602

B. Completion of the Health Insurance Claim Form, HCFA-1500 (12/90) [~~Primary Care Invoice~~]

An example of a Health Insurance Claim Form, HCFA-1500 (12/90) [~~Primary Care Invoice~~] is shown in the appendix. Instructions for the proper completion of this form are presented below.

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card shall ~~should~~ be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. There can be no Medicaid [~~KMAP~~] payment for services rendered to an ineligible person.

The age of the patient will also be reflected on the Identification Card. This shall ~~should~~ be noted, specifically in cases where the patient requires services that are limited to recipients UNDER the age of 21.

SECTION VI - COMPLETION OF INVOICE FORM

HCFA-1500 (12/90) forms may be obtained from:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

Telephone: 1-800-621-8335

<u>BLOCK NO.</u>	<u>ITEM NAME AND DESCRIPTION</u>
<u>2</u>	<u>PATIENT'S NAME</u> <u>Enter the recipient's last name, first name, middle initial exactly as it appears on the current Medical Assistance Identification (MAID) card.</u>
<u>9A</u>	<u>OTHER INSURED'S POLICY OR GROUP NUMBER:</u> <u>Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.</u>
<u>10B,C</u>	<u>ACCIDENT:</u> <u>Check the appropriate block if treatment rendered was necessitated by some form of accident.</u>
<u>11</u>	<u>INSURED'S POLICY GROUP OR FECA NUMBER</u> <u>Complete if the recipient has any kind of private health insurance that has made a payment, other than Medicare.</u>
<u>11C</u>	<u>INSURANCE PLAN NAME OR PROGRAM NAME</u> <u>Enter the name of the insurer and the policy number.</u>
<u>19</u>	<u>INSURED'S GROUP NUMBER</u> <u>Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.</u>

CONTINUATION PAGE 6.2

[BLOCK

~~NO. ITEM NAME AND DESCRIPTION~~

~~1 RECIPIENT LAST NAME:~~

~~Enter the last name of the recipient EXACTLY as it appears on his/her current Medical Assistance Identification (MAID) card.~~

~~2 FIRST NAME:~~

~~Enter the first name of the recipient EXACTLY as it appears on his/her current MAID card.~~

~~3 M. I.:~~

~~Enter the middle initial of the recipient.~~

~~4 MEDICAL ASSISTANCE I.D. NUMBER:~~

~~Enter the recipient's identification number EXACTLY as it appears on his/her current MAID card. The number consists of 10 digits and all of them must be entered.~~

~~5 EMERGENCY:~~

~~Check box provided if the treatment rendered recipient was necessitated by some form of emergency.~~

~~6 PRIOR AUTHORIZATION:~~

~~If the service rendered required prior authorization by the Cabinet, enter the authorization number assigned by EDS.~~

~~7 SCREENING RELATED SERVICES:~~

~~Check box provided if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment examination.]~~

SECTION VI - COMPLETION OF INVOICE FORM

21 DIAGNOSIS CODE

Enter the appropriate ICD-9-CM diagnosis codes. Does not apply to pharmacy and non-emergency dental services.

23 PRIOR AUTHORIZATION NUMBER

If the service provided requires prior authorization, enter the prior authorization number assigned by EDS.

24A DATE OF SERVICE

Enter the date on which each service was rendered in month, day, year sequence, and numeric format. For example, April 16, 1992 would be entered as 04-16-92.

24B PLACE OF SERVICE

Enter the appropriate place of service code from the list on the back of the claim form identifying where the service was provided.

24D PROCEDURE CODE

Enter the procedure code which identifies the service or supply rendered to the recipient. For pharmacy claims, enter the twelve (12) digit NDC number.

24E DIAGNOSIS CODE INDICATOR

Transfer "1", "2" or "3" from the field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.

CONTINUATION PAGE 6.3

~~8 REFERRING PRACTITIONER: Required for all referrals~~

~~For KenPAC and Lock-In recipients who are referred to the center, enter the 8-digit KMAP number of the referring KenPAC or Lock-In provider. All other referrals enter either the name or KMAP provider number of the referring physician.~~

~~9 HEALTH INSURANCE:~~

~~If the recipient has any kind of health insurance, other than Medicare, enter the name and address of the insurer and the policy number.~~

~~10 ICD 9 CM DIAGNOSIS CODE: Required (except for the drug and non-emergency dental services)~~

~~(1) First Diagnosis - enter the ICD-9-CM code on the right side of the MAP-7 in the Leave Blank area.~~

~~(2) Second Diagnosis - enter the ICD-9-CM code on the right side of the MAP-7 in the Leave Blank area.~~

~~11 INDICATE SERVICES FOR EPSDT (SCREENING) REQUIREMENTS:~~

~~Enter code as appropriate in each box for service rendered. Codes for Blocks #11 and #12 are as follows:~~

- ~~A Normal~~
- ~~B Abnormal, referred~~
- ~~C Abnormal, under treatment~~

~~Leave Blank if service was not indicated for child's age and health history.]~~

SECTION VI - COMPLETION OF INVOICE FORM

24F PROCEDURE CHARGE

Enter your usual and customary charge for the service rendered.

24G DAYS OR UNITS

Enter the number of times this procedure was provided for the recipient on this date of service. For pharmacy services, enter the drug quantity of each prescription billed.

24H EPSDT Family Plan

Enter a "Y" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment Examination.

24K RESERVED FOR LOCAL USE

When billing pharmacy services, enter the prescription number. When billing dental services, enter the tooth number(s). Enter the vaccine dose for vaccinations. Enter the EPSDT referral codes, if applicable, for EPSDT.

26 PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key the first seven or fewer digits. This number will appear on the Remittance Statement as the invoice number.

28 TOTAL CHARGE

Enter the total of the individual procedure charges listed in column 24F.

CONTINUATION PAGE 6.4

~~[12] INDICATE SPECIAL TESTS FOR EPSDT (SCREENING REQUIREMENTS):~~

~~Enter code as appropriate in each box for Special test rendered. Codes for Blocks #11 and #12 are as follows:~~

- ~~A = Normal~~
- ~~B = Abnormal, referred~~
- ~~C = Abnormal, under treatment~~

~~Leave Blank if service was not indicated for child's age and health history.~~

~~13] INDICATE CATEGORY OF SERVICE:~~

~~Place a check in the appropriate box to identify the type of provider submitting this claim. If "other" is checked, the two digit code found in the appropriate provider manual should also be entered in the space provided.~~

~~14] REFERRED TO (For EPSDT services only):~~

~~If the recipient was referred for further treatment, place a check in the appropriate box. If the referral was to someone other than a physician or dentist, identify the type of provider in the space provided (e.g., optometrist, audiologist) and code appropriately using the following codes:~~

41 Audiologist	56 Orthopedics	12 Mental Disorders
54 Ophthalmologist	55 Neurology	90 All Other Referrals
51 Optometrist	72 Speech	(Please identify type of provider)

~~15] DISPOSITION OF CASE (For EPSDT services only):~~

~~Check the appropriate box to indicate the disposition of the case.~~

~~16] No entry required.~~

~~17] PROVIDER NUMBER:~~

~~Enter the eight digit assigned provider number of professional rendering the service.]~~

SECTION VI - COMPLETION OF INVOICE FORM

29 AMOUNT PAID

Enter the amount received by any other private insurance, DO NOT INCLUDE Medicare. If no health insurance payment amount, leave blank.

30 BALANCE DUE

Enter the amount received from Medicare.

31 SIGNATURE/INVOICE DATE

The actual signature of the provider (not a fascimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.

33 PROVIDER NUMBER

Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit individual Medicaid provider number.

CONTINUATION PAGE 6.5

~~[18] PLACE OF SERVICE:~~

~~Enter the place of service code from note 1 of the claim form to indicate the site at which the services were provided.~~

~~19] PROCEDURE/SUPPLY DESCRIPTION, PRESCRIPTION:~~

~~Enter description of service, supply item furnished, or prescription number for service rendered this patient.~~

~~20] DRUG NUMBER:~~

~~Enter the 10 digit NDC drug number from the Outpatient Drug List. The first 5 digits are the manufacturers number, the last five digits are the product number.~~

~~21] UNITS OF SERVICE (Required):~~

~~Enter the number of times this procedure was performed on the recipient on this date. For dental services enter the number of times this procedure was performed on this date. For pharmacy services, enter the drug quantity of each prescription billed.~~

~~22] PROCEDURE/SUPPLY CODE (Required):~~

~~Enter the five-digit code identifying the service of supply furnished to this recipient.~~

~~23] TOOTH ID:~~

~~Enter up to 3 tooth identification codes (from Universal Tooth Identification Chart) per line for teeth treated by service billed. If more than 3 teeth were treated complete next line.~~

~~24] DIAGNOSIS TREATED:~~

~~Enter the applicable number from note 2 (diagnosis treated). Required for all medical services (excludes only dental and drug services).~~

~~25] PROCEDURE CHARGES:~~

~~Enter the usual and customary charge for the service rendered.]~~

~~[26] No entry required.~~

~~27 TOTAL CLAIM CHARGE:~~

~~Enter the total of lines 1-10.~~

~~28 HEALTH INSURANCE AMOUNT:~~

~~Enter the total amount (if any) received from the patient's health insurance for services billed.~~

~~29 AMOUNT FROM MEDICARE:~~

~~Enter the total amount received from Medicare for services billed. Attach a copy of the Medicare Explanation of Benefits to claim.~~

~~30 PROVIDER NAME:~~

~~Enter the name and address of the Primary Care Center performing the services being billed.~~

~~31 PROVIDER NUMBER:~~

~~Enter the eight digit Medicaid provider number assigned to the provider listed in block 30.~~

~~32 AUTHORIZED SIGNATURE:~~

~~The actual signature of the provider or authorized representative is entered here.~~

~~33 COUNTY:~~

~~No entry required.~~

~~[34 AREA:~~

~~No entry required.~~

~~35 INVOICE DATE:~~

~~Enter the month, day, and year that the invoice was signed and submitted to Medical Assistance (i.e. November 15, 1988 would be entered 11 15 88).~~

~~36 DATE OF SERVICE:~~

~~Enter the month, day and year (numeric equivalent as block 35) the services were provided. One date of service per claim.~~

~~37 CHARGE DISPOSITION:~~

~~No entry required.~~

~~38 INVOICE NUMBER:~~

~~No entry required.~~

~~39 No entry required.]~~

* * * * *
Claims for covered services must be received by EDS within twelve
*(12) months from the date of service. Claims with service dates *
more than twelve (12) months old can be considered for processing
*only with appropriate documentation such as one or more of the *
*following: Remittance Statements no more than 12 months of age *
which verify timely filing, backdated MAID cards, Social Security
*documents, correspondence describing extenuating circumstances, *
*Action Sheets, Return to Provider Letters, Medicare Explanation *
*of Medicare Benefits, etc. *
* * * * *

EDS
P.O. Box 2064
Frankfort, KY 40602

COMMONWEALTH OF KENTUCKY
MEDICAL ASSISTANCE STATEMENT
PRIMARY CARE/RURAL HEALTH

Do not write in this area

1. RECIPIENT LAST NAME	2. FIRST NAME	3. M.I.	4. MEDICAL ASSISTANCE I.D. NUMBER
------------------------	---------------	---------	-----------------------------------

5. IF EMERGENCY CHECK BOX <input type="checkbox"/>	6. If Claim Required A Prior Authorization, Enter The Prior Authorization Number Here	7. If Services Were Provided As A Result of A Screening Exam Referral, Check Box <input type="checkbox"/>	8. If Patient Was Referred To You, Enter The Name of The Referring Practitioner
--	---	---	---

9. IF PATIENT HAS HEALTH INSURANCE, ENTER THE NAME AND ADDRESS OF COMPANY AND POLICY NUMBER LEAVE BLANK

10. (1) FIRST DIAGNOSIS:

(2) SECOND DIAGNOSIS:

11. INDICATE SERVICE BY ENTERING APPROPRIATE CODE (SEE MANUAL)	12. INDICATE SPECIAL TESTS BY ENTERING APPROPRIATE CODE (SEE MANUAL)	13. INDICATE CATEGORY OF SERVICE
<input type="checkbox"/> General Health Assessment and Patient History <input type="checkbox"/> Development Assessment <input type="checkbox"/> Visual Screening <input type="checkbox"/> Audiometric Screening <input type="checkbox"/> Dental Screening <input type="checkbox"/> Urinalysis	<input type="checkbox"/> Tuberculosis Test <input type="checkbox"/> Hematocrit or Hemoglobin <input type="checkbox"/> Lead Poisoning <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Assessment and Administration of Vaccines and Immunizations <input type="checkbox"/> Blood Pressure <input type="checkbox"/> V.D.R.L. <input type="checkbox"/> Sickle Cell Test <input type="checkbox"/> Bacteriuria Screening <input type="checkbox"/> Other (Specify)
		Primary 41 <input type="checkbox"/> Care Center Other <input type="checkbox"/> (Enter Code)

14. REFERRED TO: 01 PHYSICIAN 02 DENTIST OTHER (SPECIFY)

15. DISPOSITION OF CASE: A NORMAL VISIT SCHEDULED B REFERRED FOR TREATMENT

16. Line No.	17. Provider Number	18. Place of Service Note (1)	19. Procedure/Supply Description PRESCRIPTION NUMBER	20. Drug Number	21. Units of Service	22. Procedure Supply Code	23. Tooth ID	24. See Note (2)	25. Procedure Charge	26. LEAVE BLANK
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										

30. PROVIDER NAME AND ADDRESS	31. Provider Number	TOTAL CLAIM CHARGE	27.	39. LEAVE BLANK
		AMOUNT FROM HEALTH INSURANCE	28.	
		AMOUNT FROM MEDICARE	29.	

32. Authorized Certification and Signature

This is to certify that the foregoing information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the Kentucky Medical Assistance Program. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

33. COUNTY 34. AREA 35. INVOICE DATE

Mo. Day Yr.

38. INVOICE NO.

36. Date of Service	NOTE (1) PLACE OF SERVICE CODES	NOTE (2)	37. CHARGE DISPOSITION
Mo. Day Yr.	1. Doctor's Office 2. Patient's Home 3. Outpatient Dept. Hospital 4. Inpatient Hospital 5. Skilled Nursing Home	Enter Diagnosis Treated from Block 10 "1" First "2" Second	<input type="checkbox"/> Pay <input type="checkbox"/> Charge <input type="checkbox"/> Accumulate

0543752

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:427
Incorporation By Reference Of
Primary Care Services Manual

Summary of Incorporated By Reference Material
April 1992

1. The Primary Care Services Manual is used by agency staff and participating providers of the Kentucky Medicaid Program. The manual is being amended to reflect any policy changes which have been promulgated and approved in the appropriate administrative regulation and to show any clarifications of policy or procedure which have been made.
2. Nine (9) pages are being amended by this proposed regulation. The changes are listed below.
3. The Table of Contents is being amended to add, delete and change headings to reflect the correct sections and page contents. These changes have no major impact on policy.
4. Pages 6.1 through 6.5 are being amended to show the new instructions for completing the HCFA 1500 (12/90) billing form. This is a policy change.
5. Appendix VIII is being amended to show the revised HCFA 1500 (12/90) billing form.