June 26, 2015

«Contracted_Vendor_Name»
«Address»
«City», «State» «Zip»

Dear Healthcare Provider:

Effective August 1, 2015, the new CMS-1500 (02-12) claim form will be the required version for all Patient-Inmate claim submissions. If older versions of the CMS-1500 are submitted to our Third Party Administrator after August 1, 2015, they will be denied.

Enclosed is the new CMS-1500 Claim Form Reference Guide enclosed, which was tailored specifically to the newly updated *CMS-1500, version (02-12)*.

If there are any questions or concerns, please contact me by phone at (916) 691-5470, or by email at Jason.Jung@cdcr.ca.gov.

Sincerely,

Jason Jung
Staff Services Manager I
Provider Payment Support Team
Healthcare Invoicing Branch

Enclosure

Claim Form Reference Guide

Please fill out all required information on the proper claim form. Claims for Physician and Ambulance services should be submitted using form CMS-1500 (02-12). Please type all information, since the computer processing system cannot read handwritten claim forms. ***Incorrect or incomplete claim forms may cause processing delays or rejection of claims. Handwritten claims will be denied. Only the listed fields are required, all other fields are optional and can be left blank.***

Patient-Inmate Information	• Box 1a – Enter the Patient-Inmate or DJJ Youth ward's ID number
	  ○ CDCR numbers are six character alpha-numeric identification numbers beginning with either one or two letters followed by either four or five numbers. Anything other than the six character alpha-numeric CDCR number will result in a denial of the claim
	  ▪ **Adult Identifications can be obtained at: http://inmatelocator.cdcr.ca.gov**
	  ○ DJJ Youth numbers are five characters in length and can begin with either one or two letters followed by three or four numbers, Youth identification numbers can also be five numbers. Anything other than the five character DJJ Youth number will result in a denial of the claim
	  ▪ **If a DJJ Youth ID is needed, please contact the Help Desk at (916) 691-0699**
	• Box 2 – Enter the Patient-Inmate's name
	  ○ Names should be entered in Last Name, First Name format to avoid a claim denial
	• Box 3 – Enter the Patient-Inmate's correct Date of Birth and mark the appropriate gender
	• Box 6 – Mark as "Self"

Patient-Inmate Address	• Box 5 – Enter the Prison Facility's abbreviation/acronym followed by the City, State and Zip Code for where the Patient-Inmate is housed ○ A list of Prison Facility information is attached at the back of this guide

Claim Information	• Box 21 – List any needed diagnosis codes in fields A-L
	  ○ Ensure that the Diagnosis Pointer in box 24E is filled out
	• Box 24 – Fill out all fields listed
	  ○ A – List the beginning and ending Date of Service
	  • Note: If there are multiple Dates of Service that are not concurrent, please submit on a separate claim form to avoid denials in error
	  ○ B – Enter the appropriate Place of Service Code for where services were provided.
	  ▪ For services performed on-site at a prison, utilize place of service code **09**
	  ▪ Telemedicine services should use the appropriate POS code for the "distant site", meaning the site where the

	physician or practitioner providing the professional service is located at the time the service is provided via telecommunications • Service Facility Location Information (Box 32) must be consistent with box 24B o D – List the appropriate CPT/HCPCS Code(s) along with any required Modifier(s) o E – Ensure that the Diagnosis Pointer for each code is matched to the Diagnosis code related to the CPT/HCPCS o F – Enter the billed amount for the service provided o G – Enter the number of units being billed for the service o J – Enter the Provider's individual NPI Number • The individual NPI number in Box 24J must match the physician/provider listed in box 31 • Not required for Ambulance Transport Services • Box 25 – Enter the FEIN (Federal Employer Identification Number) or TIN (Tax Identification Number) o Please use the contracting entity's ID number. For example, if a physician provides medical services as part of a medical group that is contracted with CDCR, provide the medical group's FEIN/TIN, not the physician's FEIN/TIN • Box 26 – Enter the Claim/Invoice number assigned to the claim • Box 28 – Enter the Total Claim amount o If more than 6 CPT/HCPCS codes are being billed, please list the Total Billed charges as "Continued" and complete on a second CMS-1500 claim form, number the form at the bottom right (1/2 or 2/2) • Box 31 – Enter the Physician's Name, please ensure that the name listed is legible • Box 32 – Enter the Service Facility Location Information including the full physical address o A – List the NPI Number for the Service Facility Location o Ambulance Providers must list both pick-up and drop-off locations in this field along with the Zip codes • Box 33 – Enter the Billing Provider's Information including a phone number o A – Enter the Billing Provider's NPI Number
For Ambulance Providers Only	• Include the number of miles traveled in Box 19 of form CMS-1500 • List pick-up and drop-off addresses (including zip codes) in Box 32
For Anesthesia Providers Only	• Provide the number of anesthesia minutes, as well as start and stop times, in Box 19 of form CMS-1500.

CorrectCare's Address	• Claims for Physician, Ambulance and Anesthesia services must be sent to CorrectCare Integrated Health for processing at the following address: **CorrectCare Integrated Health** **P.O. Box 349026** **Sacramento, CA 95834-9026**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M F					4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other					7. INSURED'S ADDRESS (No., Street)
CITY	STATE	8. RESERVED FOR NUCC USE					CITY STATE
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO					c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. _____ B. _____ C. _____ D. _____

E. _____ F. _____ G. _____ H. _____

I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

California Department of Corrections and Rehabilitation

List of Institution abbreviations, Cities, State, and Zip Codes

Prison Name	*Abbreviation*	*City*	*State*	*Zip*
Avenal State Prison	ASP	Avenal	CA	93204
California City Correctional Center	CAC	California City	CA	93505
California State Prison, Calipatria	CAL	Calipatria	CA	92233
California Correctional Center	CCC	Susanville	CA	96130
California Correctional Institution	CCI	Tehachapi	CA	93561
Centinela State Prison	CEN	Imperial	CA	92251
Central California Women's Facility	CCWF	Chowchilla	CA	93610
California Health Care Facility	CHCF	Stockton	CA	95215
California Institution for Men	CIM	Chino	CA	91710
California Institution for Women	CIW	Corona	CA	92878
California Men's Colony	CMC	San Luis Obispo	CA	93409
California Medical Facility	CMF	Vacaville	CA	95696
California State Prison, Corcoran	COR	Corcoran	CA	93212
California Rehabilitation Center	CRC	Norco	CA	92860
Correctional Training Facility	CTF	Soledad	CA	93960
Chuckawalla Valley State Prison	CVSP	Blythe	CA	92225
Deuel Vocational Institute	DVI	Tracy	CA	95376
Folsom State Prison	FSP	Represa	CA	95671
High Desert State Prison	HDSP	Susanville	CA	96127
Ironwood State Prison	ISP	Blythe	CA	92225
Kern Valley State Prison	KVSP	Delano	CA	93216
California State Prison, Lancaster	LAC	Lancaster	CA	93536
Mule Creek State Prison	MCSP	Ione	CA	95640
North Kern State Prison	NKSP	Delano	CA	93215
Pelican Bay State Prison	PBSP	Crescent City	CA	95531
Pleasant Valley State Prison	PVSP	Coalinga	CA	93210
RJ Donovan Correctional Facility	RJD	San Diego	CA	92179
California State Prison, Sacramento	SAC	Represa	CA	95671
Substance Abuse Treatment Facility	SATF	Corcoran	CA	93212
Sierra Conservation Center	SCC	Jamestown	CA	95327
California State Prison, Solano	SOL	Vacaville	CA	95696
San Quentin	SQ	San Quentin	CA	94964
Salinas Valley State Prison	SVSP	Soledad	CA	93960
Valley State Prison	VSP	Chowchilla	CA	93610
Wasco State Prison	WSP	Wasco	CA	93280
N.A. Chaderjian Youth Corr. Facility	NAC	Stockton	CA	95215
O.H. Close Youth Corr. Facility	OHC	Stockton	CA	95213
Pine Grove Youth Conservation Camp	PINE	Pine Grove	CA	95665
Ventura Youth Correctional Facility	VYCF	Camarillo	CA	93010

Updated 12/17/2013