

NC Health Choice for Children
How to Complete a
HCFA 1500

Please Note:

- 1) Your claims will process quicker if you TYPE the claim form instead of hand printing it
- 2) Do not use any colons, semi-colons, commas, etc when entering info in 24D
- 3) If you are providing outpatient psychotherapy along with another "special service, please file a separate claim form.

Block	Block Name	Explanation
1	Type of Coverage	Place an (X) in the Group Health Plan block
1a.	Insured's ID Number	Enter the child's complete identification number including all alpha characters, nine digits, and the two digit suffix; <i>found on the Health Choice card</i> . Newer cards may also have a three alpha prefix, a "W", eight digits and the two digit suffix.
2	Patient's Name	Enter the child's full name (last name, first name, middle initial) exactly as it appears on the insurance card.
3	Patient's Birth Date	Enter the child's date of birth using six digits (e.g. July 19, 1990 would be entered as 07 19 90)
	Sex	Place an (X) in the appropriate block to indicated the child's sex (M=male F=female)
4	Insured's Name	Can be left blank
5	Patient's address	Enter the child's complete address where they live with their legal guardian (including city, state and zip code)
	Telephone	This is optional
6	Patient Relationship to insured	Enter an (X) in the Self block
7	Insured's Address	Can be left blank
8	Patient Status	Can be left blank

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9	Other Insured's Name	There should be none, please leave blank
10	Is Patient's Condition Related to:	Can be left blank
11	Insured's Policy Group or FECA Number	Can be left blank
12	Patient's or Authorized Person's Signature	"Signature on file" can be written here
13	Insured's or Authroized Person's Signature	"Signature on file" can be written here
14	Date of Current:	Can be left blank
15	If Patient Has Had Same or Similar Illness...	Can be left blank
16	Dates Patient Unable to Work.....	Can be left blank
17	Name of Referring Physician	Can be left blank
18	Hospitalization Dates Related to Current Illness	Can be left blank
19	Reserved for Local Use	Can be left blank
20	Outside Lab?	Can be left blank
21	Diagnosis or Nature of Illness or Injury	Must have an ICD-9 diagnosis code
22	Medicaid Resubmission Code	Can be left blank
23	Prior Authorization Number	Can be left blank
24a.	Date(s) of Service	For RESIDENTIAL SERVICES : Can be a continuous range of dates (07/01/06 - 07/12/06) as long as there was no therapeutic leave, elopement, etc. OR Individual dates if the child was gone from the facility for therapeutic leave or elopement, medical admission, etc.
		For all other services (Day Treatment; Intensive Case Management, etc): Individual dates of services MUST be listed

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24b.	Place of Service	12- patients home, 53-community mental health center, 55-residential substance abuse treatment facility, 56-psychiatric residential treatment center, 99-other unlisted facility
24c.	Type of Service	Can be left blank
24d.	Procedures, Services or Supplies	FOR RESIDENTIAL: this will be H0019
		For all other services (Day Treatment; Community Support, etc): It will be the specific code for the service rendered (it will appear on your authorization letter from VO)
		MODIFIER: this must be filled in when the treatment calls for it (H2012 HA; H0036HA, etc.) If needed, this too will be on the authorization letter
24e.	Diagnosis Code	Primary Diagnosis code goes here (DSM IV or ICD 10)
24f.	\$ Charges	If billing for a date span, the total amount billed should be placed in this block. OR If billing for individual days, the daily rate goes in this block
24g.	Days or Units **if billing services other than Residential, bill service dates separately	If billing for a date span**, the total number of days being billed goes in this block OR If billing for individual days then the number "1" goes in this block
24h.	EPSDT	Can leave this block blank
24i.	EMG	Can leave this block blank
24j.	COB	Can leave this block blank

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24k.	Reserved for Local Use	Can leave this block blank
25	Federal Tax ID Number	The EIN of the program or the SS# of home owner goes in this block. Be sure to check the appropriate block SSN or EIN
26	Patient's Account Number	Can leave this block blank
27	Accept Assignment?	Can leave this block blank
28	Total Charge	Enter the total amount charged (should equal what is being listed in column 24f)
29	Amount Paid	Can leave this block blank
30	Balance Due	Can leave this block blank
31	Signature of Physician or Supplier	The physician, supplier or an authorized representative must either 1. sign and dated all claims or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable) Printed initials and printed signatures are not acceptable and will result in a denied claim
32	Name and Address of Facility Where Services Were Rendered	Name and Address of the Group Home where the child is being treated goes here
33	Physician's, Supplier's Billing Name, Address, Zip Code & Phone	Name, Address, Zip Code & Phone where the checks are to be sent goes here PIN# and GRP# should remain blank

To check status of your claim, please call 800-422-4658 - ValueOptions does not have access to the claims processors system to see what has been received/paid, etc.

Remember, it takes approximately 30 - 45 days for a "clean" claim to process

Billing Address:

Claims Processing Contractor

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