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**CERTIFICATE OF NECESSITY FOR
ABORTION (DMA-311)**

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse *only* for abortion which meet the criteria established in Part II, Chapter 900 of the *Policies and Procedures for Physician Services* manual.

**GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
CERTIFICATION OF NECESSITY FOR ABORTION**

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

MEMBER INFORMATION

NAME _____

MEDICAID # _____

ADDRESS _____

STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

- This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place this woman in danger of death unless an abortion is performed.
- The pregnancy is the result of rape.
- The pregnancy is the result of incest.

_____, M.D.
(Print Name)

_____, M.D.
(Signature of Physician)

Provider Administrative Review Request Form

- Georgia Families
- PeachCare for Kids

Request Date: _____

Has the service been provided yet? Yes No

Expedited Request? Yes No

(See reverse side for definition of Expedited Request)

Is this part of a bundled request? Yes No

(A bundled request refers to an issue related to multiple claims or member IDs.)

Provider/Appellant Information

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

Name: _____

ID Number: _____

Date of Birth: _____

Service Provided Information

Date(s) of Service: _____

Place of Service: _____

Reason Given for Denial (from EOP or denial letter)

Medical Necessity

Lack of Information

Not Prior Authorized

Benefits Exhausted

Out of Network

Not a Covered Benefit

Untimely Filing

Invalid Code

Inclusive

Exclusive

Incidental

Medicare Payment In Full

Claim Not Billed as Authorized

Exceeds Authorization

Other: _____

Reason for Request:

Unless your contract allows otherwise, WellCare will pay the Medicare or Medicaid allowable, depending on member's plan, for the service performed if we overturn our previous decision. By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays.

Signature: _____

Date: _____

This form is to be used when you want to appeal a claim or authorization denial. Fill out the form completely and keep a copy for your records. Send this form with all pertinent medical documentation to support the request to WellCare Health Plans, Inc., Attn: Appeals Department, P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request if fewer than 10 pages to (866) 201-0657. Your appeal will be processed once all necessary documentation is received and you will be notified of the outcome. See other side for additional information.

Filing on a Member's Behalf

Member appeals for medical necessity, out-of-network services benefit denials or services for which the member can be held financially liable must be accompanied by an Appointment of Representation form or other office documentation signed and dated by the member you are appealing on behalf of, unless you are an attorney, power of attorney, court appointed guardian or health care proxy agent with associated documentation.

Expedited Request

Applies when the standard 30-calendar-day time frame could jeopardize the life or health of the member or the member's ability to regain maximum function. A decision will be made within 72 hours of receipt.

Documentation needed: All Medical Information Needed to Determine Medical Necessity. Examples:

Inpatient or observation stays—doctor orders, progress notes, ER notes, medication record, lab reports, nurses notes, consultation reports, PT/OT/ST notes (if applicable)

Procedures—procedure report, supporting consultation reports, PCP progress notes, referring MD script

Consultations—consultation report, referring MD script

PT, OT, ST—progress notes, evaluations, summaries, Referring MD script

Radiology—reports, referring MD script

Timely filing—billing notes, fax confirmation, certified, signed mail card

Bundled Requests

In reviewing provider complaints or appeals related to denial of claims, providers may consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.



Non-Medicare Member Administrative Review Request Form

Please use this form to submit your administrative review in writing. You may attach additional sheets, if necessary. If you have filed a standard administrative review verbally, you must send this form back to the Plan prior to our completion timeframe of your verbal request. If the form or a written request is not received, no decision will be returned to you.

- Medicaid
 - PeachCare for Kids
- Request Date:** _____
Has the service been provided yet? __ Yes __ No
Expedited Request: __ Yes __ No * See Below

Requestor (Appellant) Information

Name: _____
 Address: _____
 City: _____
 Telephone: _____
 Contact Person: _____

Relationship to Member:

- Self
- Appointed Representative
- Power of Attorney
- Parent/Guardian
- Provider (must have written consent from member to file on member’s behalf)

Member Information

Name: _____
 Address: _____
 City: _____
 ID Number: _____
 Date of Birth: _____
 Telephone: _____

SERVICES PLANNED INFORMATION (Pre-service Request)

Who are you requesting to provide the service?

Name: _____
 Address: _____
 City: _____
 Telephone: _____
 Contact Person: _____

What date is the service planned to begin? _____



Why do you feel the planned service should be authorized?

If your denial received was for a request for an out-of-network provider, why do you feel we should authorize the request?

SERVICES PROVIDED INFORMATION (Retrospective request)

Who provided the service(s) or who are you being billed by?

Name: _____
Address: _____
City: _____
Telephone: _____
Contact Person: _____
Date(s) of Service: _____

Please state why the services were not authorized prior to services being rendered:

I hereby request an administrative review described in this document and understand that in order for the administrative review to be considered, WellCare of Georgia, Inc.(the Health Plan), may need medical records and other records or other information related to my appeal. I authorize persons or entities that have any medical or other records, or knowledge of me or my dependants, to release such information to WellCare of Georgia, Inc.(the Health Plan). Those persons or entities may include any: 1) licensed physician; 2) medical practitioner; 3) hospital, 4) clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7) other organization, institution, or person. I specifically authorize the release of the following records or information if needed for the review of my administrative review: any and all medical records and information about, associated with, or with reference to: 1) a positive test result for HIV infection; 2) ARC; 3) AIDS; 4) alcohol or drug dependency; and 5) mental and nervous disorders.

Member or Authorized Representative's Signature

Date



You may fax to (813) 262-2907 or mail to:

WellCare of Georgia, Inc.
Attn: Appeals & Grievance Coordinator
PO Box 31368
Tampa, Florida 33631-3368

If you have any further questions or concerns regarding this form, or about your administrative review and grievance rights, please contact Customer Service at 1-866-231-1821, or you may also access TYY/TDD (877) 247-6272, if hearing impaired. Our hours of operation are Monday - Friday 7:00 A.M. – 7:00 P.M. EST, except for holidays.

*** Expedited Administrative Review:**

An administrative review for a service that has not already been rendered and which taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

- **A request for expedited administrative review submitted by your treating physician or with support from your treating physician will automatically be processed as an expedited administrative review.**
- **If either of these are lacking, the Plan will review your request and determine if your request should be processed as expedited. If we do not agree with your request, we will notify you and provide you with grievance rights to grieve our decision not to expedite your grievance. Your request will then be transferred to the Standard Administrative Review process and a decision will be issued within 45-calendar days.**

Administrative Review Timeframes

Standard request: 30-calendar days from receipt

Expedited request: 72-hours from receipt

APPLICABLE CO- PAYMENTS

Children under the age of 21, pregnant women, nursing facility residents and hospice care members are exempt from co-payments. There are no co-payments for family planning or emergency services except as defined below. Services may not be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount
Ambulatory Surgical Centers		A \$3 co-payment to be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one \$3 amount will be deducted per date of service.
FQHC/RHCs		A \$2 co-payment on all FQHC and RHC.
Outpatient		A \$3 co-payment is required on all non-emergency outpatient hospital visits.
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility are exempted from the inpatient co-payment.	A co-payment of \$12.50 will be imposed on hospital inpatient services.
Emergency Department		A \$6 co-payment will be imposed if the condition is not an emergency medical condition.
Oral Maxiofacial Surgery		A \$2 co-payment will be imposed on all evaluation and management procedure codes (99201-99499) billed by oral surgeons.
Prescription Drugs		Drug Cost / Co-pay Amount Less than \$10.01 / \$.50 \$10.01 - \$25.00 / \$1.00 \$25.01 - \$50.00 / \$2.00 More than \$50.01 / \$3.00



Non-Medicare Member Appointment of Representative Statement

SECTION I APPOINTMENT OF REPRESENTATIVE

Member Name

Member ID Number

Name of Provider in Question

Dates of Service

\$ _____
Amount of Charges

Requested Service (Pre-Service)

I do hereby swear that I am the above-mentioned member or have the legal authority to appoint a representative for the above-mentioned member. I do hereby appoint the following individual _____ to act as my representative in requesting a reconsideration from the above- referenced health plan and for the services for which the above-referenced health plan has denied payment or authorization.

Member's Signature

Date

SECTION II ACCEPTANCE OF APPOINTMENT

I, _____ hereby accept the above appointment.
(Appointed Representative)

Signature of Appointed Representative

Date



Case Management Referral Form

Fax to: 1-866-287-3286

Please print or type requested information below.

Mail available medical records to:
Attn: Case and Disease Management
WellCare Health Plans, Inc.
P.O. Box 31401
Tampa, FL 33631-3401

Date:

Referral Date:

CHECK ONE OF THE FOLLOWING:

Case Management

Disease Management

PATIENT INFORMATION

Please verify with patients that all demographic information is correct for timely and effective processing.

County

Member Phone #:

Member Name (Last, First, MI):

Member DOB:

Member Address (Full Address):

Subscriber ID #:

PCP Name:

PCP Phone Number:

Hospital Name:

Hospital Phone Number:

REFERRAL INFORMATION

Name of Referring PCP or Specialist (Full Name):

Phone Number: (Include Area Code)

Fax Number: (Include Area Code)

REASON FOR REFERRAL: (Include CLINICAL INFORMATION below)

DIAGNOSIS: (Include CLINICAL INFORMATION below)

CASE MANAGEMENT USE ONLY

CM STATUS Accepted Rejected

CM Screening Date:

Screened by:

Assigned to CM:

Fill in if different from reviewer name

Reason for REJECTION:

CMS-1500 Submission Guidelines for Paper Claims

Following are instructions for completing the CMS-1500 form, version OMB-0938-0999(08/05). Refer to the Medicare Claims Processing Manual Chapter 26 for full details. If a claim is submitted with invalid or incomplete information, it will be returned to the submitter unprocessed. Fields specific to HIPAA NPI requirements are marked in red.

Field #	Designation	Data Required	Source of Data
1a	Insured's ID Number	Member's ID Number	Member's ID Card
2	Patient's Name	Last Name, First Name, Middle Initial of Patient	Member
3	Patient's Birth Date/Sex	MMDDYY - M or F	Member
4	Insured's Name	Member's Last Name, First Name, Middle Initial	Member
5	Patient's Address	Number and Street, City, State, Zip Code	Member
7	Insured's Address	Number and Street, City, State, Zip Code	Member
10a	Employment	Selection	Member
10b	Auto Accident	Selection	Member
10c	Other Accident	Selection	Member
11a	Insured's Date of Birth	MMDDYY - M or F	Member
11d	Is there another health benefit plan?	Selection	Member
17	Name of Referring Provider or Other Source	Name of Referring Physician, if any	Provider
17a	ID Number of Referring Physician	Not to be reported as of May 23, 2008.	n/a
17b	NPI Number	NPI Number of Referring Physician	Issued for CMS by the National Plan and Provider Enumeration System (NPPES)
21	Diagnosis or Nature of Illness or Injury	Diagnosis Codes	ICD-9-CM 2006
23	Prior Authorization Number	Authorization Number	Plan Issued Authorization Number
24a	Date(s) of Service	MMDDYY	Physician Service Dates
24b	Place of Service	2 digit numeric e.g. 11	CMS website link
24d	Procedures, Services, or Supplies	Valid Codes Referenced in Source	CPT4/HCPCS 2006
24e	Diagnosis Pointer	Diagnosis Pointers to Field 21 e.g. 1, 2, 3, 4, 5, 6	Field 21
24f	Charges	000000.00	Service Performed
24g	Days or Units	Number of Days or Units for Line Item	Service Performed
24i Lines 1-6	ID Qual	Not to be reported as of May 23, 2008.	n/a
24j Lines 1-6	Rendering Provider NPI	NPI only	Provider
25	Federal Tax ID	Must include 9-digit Federal TAX ID	State Issued
26	Patient's Account Number	Provider Issued	Provider
28	Total Charge	000000.00	Verify Total of Line Charges
31	Signature of Physician	TYPED Last Name, First Name, Middle Initial, Credentials	Provider
32	Service Facility Location Information	Where Services Were Performed	Provider
32a	NPI Number	NPI Number for Service Facility	Issued for CMS by the National Plan and Provider Enumeration System (NPPES)
32b	Service Facility Qual & ID	Not to be reported as of May 23, 2008.	n/a
33	Billing Provider Info & PH #	Vendor Information for Billing Purposes	Physician
33a	Billing Provider NPI	NPI Number of Billing Provider or Group	Issued for CMS by the National Plan and Provider Enumeration System (NPPES)
33b	Billing Provider Qual & ID	Not to be reported as of May 23, 2008.	n/a

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										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 <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
ZIP CODE					TELEPHONE (Include Area Code) ()					CITY					STATE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE										10d. RESERVED FOR LOCAL USE									
12. PATIENT'S SIGNATURE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21. DIAGNOSIS (Report to Item 24E by Line)										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 CPT/HCPCS) E. F. G. DAYS OR UNITS H. ICD-9-CM CODE I. ID. QUAL J. RENDERING PROVIDER ID. #									
1. NPI of Referring Provider Field 17b.										NPI of Rendering Provider Fields 24J. 1-6									
2. NPI of Referring Provider										NPI of Rendering Provider									
3. NPI of Referring Provider										NPI of Rendering Provider									
4. MUST include TAX ID Number (no qualifier needed in this field)										Billing Provider's Qualifier & ID Not to be reported effective 5/23/08.									
5. Facility Qualifier & ID Not to be reported effective 5/23/08.										NPI of Billing Provider or Group Field 33a.									
25. FEDERAL TAX ID. NUMBER SSN										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION									
NPI of Service Facility Field 32a.										33. BILLING PROVIDER INFO & PH # ()									
SIGNED a. NPI b.										SIGNED a. NPI b.									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Provider Complaint Form

- Georgia Families
- PeachCare for Kids

Request Date: _____

Provider Information

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

Name: _____

ID Number: _____

Date of Birth: _____

Multiple Members
 (List all issues on a single form with supplemental information attached)

Information on Service Provided

Date(s) of Service: _____

Place of Service: _____

√ Complaint Reason

- WellCare Administration
- Member Behavior
- Health Care Delivery
- Provider Reimbursement
- Contracting

Explanation of Issue(s)

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to WellCare of Georgia, Inc. Attn: **Grievance Department at P.O. Box 31384 Tampa, FL 33631-3384**. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

***Failure to submit supporting documentation may delay our response to your complaint.**

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Medicaid Program

RECEIPIENT INFORMATION

RECEIPIENT NAME: LAST FIRST INITIAL SUFFIX

RECEIPIENT MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section 1— Recipient's Statement

I have been told and I understand that this hysterectomy (operation to remove my womb uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Recipient Date

OR

Signature of Recipient Date

STATEMENT OF MEDICAL NECESSITY

Section II – Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable**. – (Recipient's signature not required if number 1 or 2 is applicable.)

1. Recipient was sterile prior to hysterectomy. The recipient was sterile because _____

2. Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

Physician's Name (Please print)

Physician's Signature Date



Hysterectomy Information

WellCare reimburses for those hysterectomy procedures outlined in the **Scope of Services** section of the Georgia Medicaid Hospital Services Handbook. .

A copy of the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA-276) is attached. This form must be signed either before or after the hysterectomy, as follows, and must be attached to the claim form submitted to WellCare for payment.

Claims submitted to WellCare for payment without the required documentation or with incomplete or inaccurate documentation will be denied. WellCare does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Reference the attachment:

- Section I - Member's Statement

The member or her representative must sign and date this form in the spaces provided unless the member was sterile prior to the hysterectomy or the hysterectomy was an emergency.

- Section II - Physician's Statement

The physician must sign and date this form on all hysterectomies performed. If the member was sterile prior to the hysterectomy, the physician must indicate this condition beside #1 and state the reason for prior sterility. If the hysterectomy was an emergency, the physician must indicate this condition beside #2 and attach the discharge summary and operative record.

Incident Report

C O N F I D E N T I A L



WellCare Health Plans, Inc.
The WellCare Group of Companies

INSTRUCTIONS: This Incident Report Form is used to report adverse incidents or injuries that occur to members, visitors, or associates. Complete this report in full and submit the original to HR immediately after the incident. Do NOT make copies of this report. Fax the completed report to **800-873-5292**.

PERSON INJURED	Last Name, First Middle Initial		Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
	<input type="checkbox"/> Associate		<input type="checkbox"/> Visitor		<input type="checkbox"/> Member			
	Street Address				Member ID #			
	City, State, Zip Code				Contact Number			
DETAILS OF INCIDENT	Date of Incident:			Time of Incident:				
	Location (Be specific and include facility name, street address, building number, floor, direction such as NE corner, etc.)							
	Diagnosis and diagnosis codes			Is additional information attached?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Clear and concise description of incident.							
WITNESS(ES)	Last Name, First Middle Initial		Street Address		City, State, Zip			
	Last Name, First Middle Initial		Street Address		City, State, Zip			
PHYSICIAN INFORMATION	Physician notified?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hospitalized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, complete the following:	Name of Physician or Facility						
		Street Address						
		City, State, Zip						
		Summary of physician's recommendation, if applicable.						
PERSON COMPLETING REPORT	Last Name, First Middle Initial			Department		Telephone Number		
	Signature			Date		Time		
DO NOT WRITE BELOW THIS LINE								
HUMAN RESOURCES	Summary and Disposition:							
	Last Name, First Middle Initial			Title		Date:		
RISK MANAGER	Last Name, First Middle Initial			Title		Date:		

INFORMED CONSENT FOR VOLUNTARY STERILIZATION

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

1. I have asked for and received information about sterilization from _____
Physician or Clinic
2. I have asked for the sterilization, 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 and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not 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.

3. 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 children in the future. I have rejected these alternatives and chosen to be sterilized.
4. I understand that I will be sterilized by an operation known as a _____
Sterilization Procedure. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
5. I understand that the operation will not be done until at least thirty (30) 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.
6. I am at least 21 years of age and was born on _____
Month Day Year
7. I _____
Print name of Member hereby consent of my own free will to be sterilized by _____
Print name of Physician by a method called _____
Sterilization Procedure. My consent expires 180 days from the date of my signature below.
8. 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 funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature of Medicaid Recipient Date Signed: _____
Month / Day / Year

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)
Black (not Hispanic descent) _____
Hispanic _____
Asian or Pacific Islander _____
American Indian or Alaskan Native _____
White (not of Hispanic origin) _____

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to _____
Name of Member in _____
Language language and explained its contents to him/her.

To the best of my knowledge and belief he/she understood this situation.

Signature of Interpreter Date _____
Month Day Year

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed this 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.

Name Of Member
Sterilization Procedure

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 consequences of the procedure.

Signature Of Person Obtaining Consent

Date

Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____, 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.

Name of Member
Date Of Operation
Sterilization Procedure

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 consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

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.

- (1) At least 30 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 date of expected delivery _____

Emergency abdominal surgery (describe circumstances): _____

Physician's Signature _____ Date _____



REQUEST FOR REFERRAL/CERTIFICATION

Fax to: _____ (based on the member's county of residence – see attached)

MEMBER INFORMATION, DIAGNOSIS (ICD-9 CODE) & TREATMENT (HCPCS/CPT CODE)

* Request Type: Routine _____ Stat _____ Expedited _____
Request Date: _____ Request for Hospital Admission or Observation? Yes _____ No _____
Member Name: _____ Member Date of Birth: _____
Member ID #: _____ Member Telephone #: _____
Diagnosis: _____ ICD-9 Code: _____
Requested days/visits: _____ Expiration Date: _____
Start/Service Date: _____ HCPCS/CPT Code: _____
Service Requested: _____

REQUESTED BY

Physician: _____ Address: _____
WellCare Provider #: _____ City: _____ State: _____ Zip: _____
TIN# _____ Telephone #: _____ Fax #: _____

REFERRED TO

Physician/Provider: _____ Address: _____
WellCare Provider #: _____ City: _____ State: _____ Zip: _____
Facility Name: _____ Telephone #: _____ Fax #: _____
Facility Address: _____
City: _____ State: _____ Zip: _____

RESPIRATORY EQUIPMENT

Oxygen: _____ Concentrator: _____ Liter Flow: _____ (Requires O2 Sat% +/-Date)
C Pap/B Pap: _____ Settings: _____ (Studies req.) Nebulizer: _____ Masks/Kits: _____
Trach Supplies (specify) _____

DME

Member Weight: _____ Height: _____ (Required to ensure appropriate size) W/C: _____
Hospital Bed: _____ Walker: _____ Quad Cane: _____ BSC: _____ Special equipment needs: _____

Clinical Information: _____

Delivery Address: _____ City: _____ State: _____ Zip: _____
Phone # 1: _____ Phone # 2: _____

* See Provider Manual for definition of routine, stat and expedited.

Authorizations are not a guarantee of payment. Payment of claims is subject to a member's eligibility, covered benefits, limitations and exclusions on the date of service and to any other contractual provision of the plan.

Physician's Signature _____

Health Insurance UB-04 Claim Form Instructions



Following are instructions for completing the UB-04 form. Refer to the Medicare Claims Processing Manual Chapter 25 for full details. If a claim is submitted with invalid or incomplete information, it will be returned to the submitter unprocessed. Fields specific to HIPAA NPI requirements are marked in red.

CMS MANDATE					
Field #	Designation	Data Required	Source of Data	Other Information (Global)	State Specific Information
1	Provider Name and Address	Vendor information for billing purposes	Must match exactly vendor information submitted on contract	Last Name, First Name ### Street Name St. City, State #####	
2	Pay to: Name and Address	Pay to: name and address if different from field: 1	WellCare Explanation of Payment (EOP)	Last Name, First Name ### Street Name City, State #####	
3a	Patient Control Number	Provider issued	Provider		
3b	Patient Medical Record #	Situational: provide if one is assigned	Institution		
4	Type of Bill	Bill Type Code	CMS/Medicare Manual	Expanded from 3 to 4 digits	ILLINOIS only bill frequency 1 through 4 accepted
5	Federal Tax ID Number	9-digit Tax ID (24-xxxxxxx)	State issued	Mandate	
6	Statement Covers Period: From - Through	Beginning and ending DOS From: MMDDYY Through: MMDDYY	Institution		
7	Save for Future Use	Save for Future Use	Save for Future Use	This field holds 8 characters	
8a	Patient Name - ID	WellCare Member ID	ID Card		ILLINOIS submit either the WC ID or Medicaid ID
8b	Patient Name	Last Name, First Name and Middle Initial	ID card or member	Use comma to separate last and first names. Record hyphen on hyphenated names.	
9	Patient Address	Number and Street, City, State, Zip Code	Member	### Street Name St. City, State #####	
10	Member's Birth Date	MMDDYYYY	Member		
11	Sex	M or F	Member		
12	Admission Date	MMDDYY	Institution		
13	HR	HOUR (time of admission)	Provider	Military Time (hour only): HH	
14	Type	Required only on Inpatient Claims	CMS/Medicare Manual	CMS Code Structures: '1' - '9'. Note, codes '6' - '8' not yet in effect. Code '9' information not available.	ILLINOIS '9' is not an allowed code
15	SRC	Source of Referral for Admission or visit	CMS/Medicare Manual	CMS Code Structures: '1' - '9', and 'A' - 'Z'	
16	D HR	Discharge Hour		Military Time (hour only): HH	
17	Stat	Patient Discharge Status (2 digit code)	Hospital	There are many codes, refer to UB-04 manual	ILLINOIS Required for inpatient only
18-28	Condition Codes	2 digit code	CMS/Medicare Manual	There are many codes, refer to UB-04 manual. Note, if all condition codes are filled, use field 81 with the appropriate qualifier (A1) to indicate condition codes	

Health Insurance UB-04 Claim Form Instructions



Field #	Designation	Data Required	Source of Data	Other Information (Global)	State Specific Information
29	ACDT State	Not Required: two letter state in which an automobile accident occurred			
30	Save for Future Use	Save for Future Use	Save for Future Use	This field holds 13 characters	
31-34	Occurrence Code, Date	2-digit code followed by MMDDYY	CMS/Medicare Manual	There are many codes, refer to UB-04 manual	
35-36	Occurrence Span Code, From - Through	Required when matching condition code exists 2 characters followed by "from date" (MMDDYY) and "through date" (MMDDYY)	CMS/Medicare Manual	There are many codes, refer to UB-04 manual. Note, if all occurrence codes are filled, use field 81 with the appropriate qualifier (A2) to indicate occurrence codes.	
37	Save for Future Use	Save for Future Use	Save for Future Use	Holds 8 characters	
38	Responsible Party's name and address	Health Plan Name (i.e., WellCare Health Plans) #### Street Name St. City, State #####-####	Must match name and address of health plan responsible for the bill	Note, used to print the responsible party's name and address if a window envelope is used.	
39-41	Value Codes, Code, Amount	Alpha Numeric: Value Code: Alpha Numeric (2) Amount: Numeric (9)	Provider	The codes and amounts communicate specific information that will affect the claims processing. There are many codes, refer to UB-04 manual. Note, if all value codes are filled, use field 81 with the appropriate qualifier (A4) to indicate value codes.	
42	Rev. CD	Revenue Codes	CMS/Medicare Manual	22 available lines	
43	Description	Revenue Code Description	CMS/Medicare Manual		
44	HCPCS / Rates	Valid HCPCS Code or Revenue Code Rates	CPT4/HCPCS 2007	Also NDC codes (11 digits) for specific drugs; See Federal register.	ILLINOIS HCPCS code required for all outpatient 837I claims. 'Rate' required for all accommodation revenue codes.
45	Serv. Date	Date Service Was Performed (MMDDYY)	Provider		
46	Serv. Units	Service Units	Provider	Up to six digits	
47	Total Charges	Line Item Charge	Services Performed		
48	Non-Covered Charges				
49	Save for Future Use	Save for Future Use	Save for Future Use	Holds 2 characters	
50a	Payer Name - Primary	Health plan name (i.e., WellCare Health Plans)	Billing Entity		
50b	Payer Name - Secondary	Secondary payer if applicable			ILLINOIS Required if patient has other insurance.
50c	Payer Name - Tertiary	Tertiary payer if applicable			
51	Health Plan ID No.	n/a	Provider	Provider Medicaid or Medicare ID, or other Legacy ID not to be reported beginning 5/23/08.	ILLINOIS continue to send the proprietary 3-digit TPL codes & 2-digit status codes to Illinois in its prescribed format.

Health Insurance UB-04 Claim Form Instructions



Field #	Designation	Data Required	Source of Data	Other Information (Global)	State Specific Information
52	Rel Info	Release of Information (primary, secondary, tertiary)	Alpha Numeric: 1 per line; 3 lines		
53	ASG BEN.	Assignment of Benefits (primary, secondary, tertiary)	Alpha Numeric: 1 per line; 3 lines		
54	Prior Payments		Estimated patient prior payments		
55	Est. Amount Due		Estimated amount due		
56	NPI Number	Provider's NPI number	Issued for CMS by the National Plan and Provider Enumeration System (NPPES).	As of May 23rd mandated by CMS	
57a	Not Labeled	Provider's NPI Taxonomy	Refer to: http://www.wpc-edi.com/taxonomy/more_information	Taxonomy Code (15)	
57b	Not Labeled			Provider Medicaid or Medicare ID, or other Legacy ID not to be reported beginning 5/23/08.	
57c	Not Labeled			Provider Medicaid or Medicare ID, or other Legacy ID not to be reported beginning 5/23/08.	
58	Insured's Name	Member's Last Name, First Name, Middle Initial	Member's ID Card	Must be exactly what is on the member's ID card; In some states Medicaid uses the mother's ID for infants	
59	P. Rel	Patient's relationship to member		There are many codes, refer to UB-04 manual	
60a	Insured's Unique ID - primary	Member's ID Number	Member's ID Card	WellCare subscriber ID - primary	
60b	Insured's Unique ID - secondary	Member's ID Number	Member's ID Card	WellCare subscriber ID - secondary for dual eligible members	
60c	Insured's Unique ID - tertiary	Member's ID Number	Member's ID Card	Member Care/Caid ID	
61	Group Name	Insurance Group Name		If applicable (note, currently not used by WellCare Health Plans)	
62	Insurance Group No.	Insurance Group Number		If applicable (note, currently not used by WellCare Health Plans)	
63	Treatment Authorization Codes	Authorization Number	Plan Issued Authorization Number		
64	Document Control Number	N/A			ILLINOIS this field will be required when the State starts accepting bill frequency '7' & '8'.
65	Employer Name	N/A			
66	DX	Diagnosis Version Qualifier	ICD-9-CM 2007	ICD-10 in Oct 2008	
67	Prin. Diag. CD	Principal Diagnosis Code	ICD-9-CM 2007	ICD-10 in Oct 2008	
67A-Q	Other Diag. Codes	Other Diagnosis Code	ICD-9-CM 2007	ICD-10 in Oct 2008	

Health Insurance UB-04 Claim Form Instructions



Field #	Designation	Data Required	Source of Data	Other Information (Global)	State Specific Information
68	Save for Future Use	Save for Future Use	Save for Future Use	Top is 8 characters and bottom is 9 characters	
69	Adm.Diag. CD.	Admitting Diagnosis Code	ICD-9-CM 2007	ICD-10 in Oct 2008	ILLINOIS required for inpatient only.
70	Patient Reason DX	Patient's Reason for Visit Code(s)	Alpha Numeric: 7. Up to three lines	ICD-10 in Oct 2008	
71	PPS Code	Prospective Payment System DRG Code		Use for DRG Code	
72	ECI	External cause of injury code	ICD-9-CM 2007	ICD-10 in Oct 2008	
73	Save for Future Use	Save for Future Use	Save for Future Use	9 characters	
74	Principal Procedure Code, Date	Procedure Code/Date	ICD-9-CM 2007	ICD-10 in Oct 2008	
74a-e	Other Procedure Code, Date	Procedure Code/Date	ICD-9-CM 2007	ICD-10 in Oct 2008	
75	Save for Future Use	Save for Future Use	Save for Future Use	Room for 4 rows with 3, 4, 4, and 4 alpha-numeric characters, respectively.	
76	Attending Physician ID	NPI Number	Provider or Institution	The NPI goes in 1st box; A Qualifier ID goes in the next box (2 characters max) Common Qualifiers 24 Tax ID ZZ Taxonomy	
77	Operating Physician ID	NPI Number, Last Name, First Name, Qualifier ID	Provider or Institution		
78-79	Other Physician ID	NPI Number, Last Name, First Name, Qualifier ID	Provider or Institution	Same as above (field 76 and field 77), but designated space after "Other" to be used to indicate Other Type. Common other types include: DN = Referring Provider ZZ = Other Operating Physician 82 = Rendering Provider Note, consult the UB-04 Manual for more information.	
80	Remarks	The provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. ie. Renal Dialysis, DME specific.	Provider or Institution	The top line holds 21 characters, and each of the following three hold 26.	Illinois: this field is required to be blank to be used for the Document Control Number (DCN)
81	CC	Codes Codes: To report additional codes related to a form locator or to report external code list approved by the NUBC for inclusion to the institutional data set. A 2 character designator is used to signify the information that follows	Provider or Institution	For each line, the character limits are 2/10/12 Note, WellCare recommends using this field to contain the Taxonomy Codes corresponding to fields 76-79. The qualifier for taxonomy is ZZ.	

