

Instructions for ITP Providers Submitting CMS-1500 Claims to POMCS

Listed below are some important things for providers to know before sending in CMS-1500 claims to POMCS for payment. This information will help to ensure that claims are processed by POMCS without delay.

- Once POMCS authorizes the service, the provider will receive a *Reply to Authorization Request* form letter listing the child's case number as well as the authorization number for their requested service. Both the case number and authorization number must be listed on the CMS-1500 form in Block 23.
- ITP Providers must write "ITP" at the very top of each claim so that POMCS will know it is an ITP claim.
- All claims must contain the following information as well as any other relevant information needed for processing claims. The Block Numbers are from the CMS-1500 form.

Patient's full name (Block 2)

Patient's date of birth (Block 3)

Patient's full address (Section 5)

Other insurance, if allowed (Section 9)

Diagnosis: ICD-9 code (Block 21)

Case number and approved Authorization Number (Block 23)

Dates of service (Block 24 A)

Place of service code (Block 24 B)

CPT or HCPCS code and Modifier, if required (Block 24 D)

* For CC&E, write CCE in Block 24 D

Charges for service (Block 24 F)

Number of units (24 G)

Federal Tax ID Number (Block 25)

Total charges for claim (Block 28)

Insurance payment, if applicable (Block 29)

* Submit Insurance EOBs with the claim*

Signature of physician [or provider], supplier, or designee (Block 31)

Name and address of facility (Block 32)

Physicians or provider's billing name, address, and zip code (this is the address where the payment will be sent). Also provide the phone number. (Block 33)

NPI number (Block 33A)

Medicaid Provider number (Block 33B). This needs to be the Medicaid provider number you want the check written to. If the ITP Provider does not have a Medicaid provider number, a POMCS provider number will be assigned. The POMCS provider number will be on the first Remittance Advice form.

Providers must then put this number on all subsequent claims in Block 33 B until the Medicaid Provider number is received.

- All claims that are billable to private insurance must have an EOB attached to the claim. If there has been a previous EOB or letter from the insurance company stating that the particular service that was billed is not covered, attach a copy of the denial to the current claim form as well as all subsequent claim forms submitted for that authorization period. The denial must be in the current authorization period.

Exceptions:

1. Filing with private insurance for Special Instruction/CBRS service is not required since this service is not covered by private insurance in North Carolina. CBRS is covered by NC HealthChoice.
 2. The family will not allow their insurance to be billed.
 3. CC&E claims.
- Providers should always enter the amount paid by insurance companies on the CMS-1500 claim form and attach insurance EOB's with **each** claim as appropriate. Providers should never enter the amount of fees collected from parents when writing in payments received on the CMS-1500 form because the CMS-1500 form does not have a separate place for entering insurance payment and parent fees. POMCS will only need the insurance payment information entered in Block 29—POMCS will calculate the parent fees that apply, if any, based on the Sliding Fee Scale percentage and the ITP Family Payment Schedule.
 - Do not staple multiple claims together. An EOB must be attached to each claim form submitted.
 - Claims that are not completed properly will be returned to the ITP Provider.
 - All claims for CC&E and services for children who are not eligible for Medicaid should be sent to:

Purchase of Medical Care Services (POMCS)
Claims Processing Unit
1904 Mail Service Center
Raleigh NC 27699-1904