Long Term Support Services .......................................................................................................................... 1
LTSS Billing Grid – Adult Day Care ................................................................................................................ 5
LTSS Billing Grid – Adult Foster Care ............................................................................................................ 7
LTSS Billing Grid – Assisted Living (AL)/Residential Care (RC) ................................................................ 9
LTSS Billing Grid – Emergency Response Systems .................................................................................... 12
LTSS Billing Grid – Habilitation .................................................................................................................... 14
LTSS Billing Grid – Home Delivered Meals ................................................................................................. 17
LTSS Billing Grid – Minor Home Modifications .......................................................................................... 19
LTSS Billing Grid – Primary Home Care/PAS Services ............................................................................ 21
LTSS Billing Grid – Professional Services ................................................................................................. 24
LTSS Billing Grid – Respite Care .................................................................................................................. 28
LTSS Billing Grid – Supportive Employment/Employment Assistance ....................................................... 31
LTSS Billing Grid – Transition Assistance Services .................................................................................... 33
LONG TERM SUPPORT SERVICES

CMS-1500 claim form filing instructions

These claims filing instructions are for Long Term Services and Supports (LTSS) providers only. Acute care and other non-LTSS provider types should not rely solely on these instructions for filing claims to Cigna-HealthSpring STAR+PLUS or Cigna-HealthSpring CarePlan. Please Refer to Cigna-HealthSpring STAR+PLUS or Cigna-HealthSpring CarePlan Provider Manual for additional information.

The CMS-1500 form is the standard claim form used by non-institutional providers and suppliers. The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Cigna-HealthSpring scans ALL paper claims received using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. In order to take advantage of this technology we require ALL providers use only the red line CMS-1500 claim form. Claims submitted on copies will cause a delay in processing since these claims cannot be scanned and will require manual review.

CMS-1500 instruction table

These instructions describe what information must be entered in each of the field numbers on the CMS-1500 claim form.

<table>
<thead>
<tr>
<th>FIELD #</th>
<th>DESCRIPTION</th>
<th>GUIDELINES</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other</td>
<td>Indicate the type of health insurance coverage applicable to this claim by placing an X in the MEDICAID box. Only one box can be marked.</td>
<td>Y</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s ID No. (for program checked above, include all letters)</td>
<td>Enter the patient’s nine-digit Texas Medicaid Number. This information can be found on the Member’s Cigna-HealthSpring STAR+PLUS ID Card.</td>
<td>Y</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
<td>Enter the patient’s last name, first name, and middle initial as printed on the Medicaid identification form.</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s date of birth and sex</td>
<td>Enter numerically the month, day, and year (MM/DD/YYYY) the patient was born. Indicate the patient’s gender by checking the appropriate box. Only one box can be marked.</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s address</td>
<td>Enter the patient’s complete address as described (street, city, state, and ZIP code).</td>
<td>Y</td>
</tr>
</tbody>
</table>
| 9       | Other insured’s name | **Situational**: Required for special situations - use this space to provide additional information such as:  
- If the patient is deceased, enter “DOD” in field 9 and the time of death in 9a  
- If the services were rendered on the date of death, enter the date of death in Field 9b. |
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>DESCRIPTION</th>
<th>GUIDELINES</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>10a</td>
<td>Is patient’s condition related to:</td>
<td>Check the appropriate box. If other insurance is available, enter appropriate information in fields 11, 11a, and 11b.</td>
<td>Y</td>
</tr>
<tr>
<td>10b</td>
<td>a. Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10c</td>
<td>(current or previous)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10b</td>
<td>b. Auto accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10b</td>
<td>c. Other accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Other health insurance coverage</td>
<td><strong>Situational</strong>: Required if another insurance company has made payment or denied a claim; enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. <strong>Situational</strong>: Required if the patient is enrolled in Medicare. Please attach a copy of the Medicare Remittance Advice Notice to the claim form.</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance plan or program name</td>
<td><strong>Situational</strong>: Required if patient has other insurance. Please enter the plan name of the other coverage.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or authorized person’s signature</td>
<td>Enter “Signature on File,” “SOF”, or legal signature. When legal signature is entered, enter the date signed in eight-digit format (MM/DD/YYYY). Cigna-HealthSpring STAR+PLUS will process the claim without the signature of the patient.</td>
<td>Y</td>
</tr>
<tr>
<td>14</td>
<td>Date of current</td>
<td><strong>Situational</strong>: Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of referring physician or other source</td>
<td><strong>Situational</strong>: Enter the complete name (Field 17) and the NPI (Field 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider.</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or nature of illness or injury</td>
<td>Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient’s diagnosis and/or condition codes. List no more than four diagnosis codes to the highest level of specificity available. Please see authorization letter for approved ICD-9 code.</td>
<td>Y</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission and/or original reference number</td>
<td>When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7 - Replacement of prior claim. 8 - Void/cancel of prior claim. Then list the original reference number for resubmitted claims.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization #</td>
<td>Enter the Authorization number issued by Cigna-HealthSpring STAR+PLUS.</td>
<td></td>
</tr>
<tr>
<td>FIELD #</td>
<td>DESCRIPTION</td>
<td>GUIDELINES</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| 24      | (Various)   | General notes for Fields 24a through 24j:  
• Unless otherwise specified, all required information should be entered in the unshaded portion.  
• If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28 line items for the entire claim.  
• For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form. | Y |
| 24a     | Date(s) of service | Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given on a separate line. | Y |
| 24b     | Place of service | Enter the appropriate Place of Services (POS) code for each service. Please see authorization letter for approved POS code. | Y |
| 24d     | Procedures, services, or supplies | Enter the appropriate procedure codes and modifier for all services billed. Please see authorization letter for approved procedure codes and modifiers. | Y |
| 24e     | Diagnosis pointer | Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in Field 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service. | Y |
| 24f     | Charges | Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients. | Y |
| 24g     | Days or units | If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). | Y |
| 24j     | Rendering provider ID # (performing) | • Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual.  
• Enter the TPI in the shaded area of the field.  
• Entered the NPI or API in the unshaded area of the field. | Y |
<p>| 25      | Federal tax ID number | Enter either the TIN or SSI number along with the corresponding check box selected. | Y |
| 26      | Patient’s account number | Optional: Enter the patient identification number if it is different than the subscriber/insured’s identification number. Used by provider’s office to identify internal client account number. | |
| 27      | Accept assignment | All providers of the Texas Medicaid must accept assignment to receive payment by checking “Yes.” | Y |</p>
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>DESCRIPTION</th>
<th>GUIDELINES</th>
<th>REQUIRED</th>
</tr>
</thead>
</table>
| 28     | Total charge                       | • Enter the total charges.  
• For multi-page claims enter “continue” on initial and subsequent claim forms.  
• Indicate the total of all charges on the last claim.  
Note: Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form. | Y        |
| 29     | Amount paid                        | Optional: Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. If no payment was made enter “$0.00.”                                                          |          |
| 31     | Signature of physician or supplier | The physician, supplier or an authorized representative must sign and date the claim. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. | Y        |
| 32     | Service facility location information | If services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and ZIP code of the facility where the service was provided.                           | Y        |
| 33     | Billing provider info and phone number | Enter the billing provider’s name, street, city, state, ZIP+4 code, and telephone number.                                                                                                                | Y        |
| 33a    | NPI                                | Enter the NPI or API of the billing provider.                                                                                                                                                              | Y        |
| 33b    | Other ID #                         | Enter the TPI number of the billing provider.                                                                                                                                                              | Y        |
LTSS BILLING GRID – ADULT DAY CARE

CMS 1500 Claim Form Field Number

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5101</td>
<td>99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Day Activities and Health Services (DAHS) 3 to 6 hours</td>
<td>3 - 6 hours = 1 unit</td>
</tr>
<tr>
<td>S5101</td>
<td>99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DAHS over 6 hours</td>
<td>Over 6 hours = 2 units</td>
</tr>
</tbody>
</table>

Billing Tips

1. If you are eligible for Attendant Care Enhancement Payments, you must bill at least the amount you expect to be reimbursed.
2. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
3. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
4. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
5. Always check member eligibility prior to providing services.
6. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.
7. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.
8. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.
9. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.
10. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
# Claim Example - Adult Day Care

5 Days Per Week (Wed-Sun)

S5101 x 5 Units = $76.20 ($15.24 x 5 Units)

1 Day = 1 Unit

## Health Insurance Claim Form

**Approved by National Uniform Claim Committee (NUCC) 02/12**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Medicare</strong></td>
<td>□ Medicare</td>
</tr>
<tr>
<td><strong>2. Patient's Name</strong></td>
<td>Smith, Mary</td>
</tr>
<tr>
<td><strong>3. Patient's Birth Date</strong></td>
<td>02/01/1938</td>
</tr>
<tr>
<td><strong>4. Insured's Name</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>5. Insured's Address</strong></td>
<td>100 Main Street</td>
</tr>
<tr>
<td><strong>6. Insured's Relationship</strong></td>
<td>Spouse</td>
</tr>
<tr>
<td><strong>7. Insured's Signature</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>8. Insured's Policy Group or Program Number</strong></td>
<td>11111111</td>
</tr>
<tr>
<td><strong>9. Insured's Name</strong></td>
<td>Smith-01</td>
</tr>
<tr>
<td><strong>10. Date of Current Illness, Injury, or Pregnancy (LMP)</strong></td>
<td>02/01/1938</td>
</tr>
<tr>
<td><strong>11. Insured's Group of FECA Number</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>12. Insured's I.D. Number</strong></td>
<td>1234567890</td>
</tr>
<tr>
<td><strong>13. Insured's Date of Birth</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>14. Date of Current Illness, Injury, or Pregnancy (LMP)</strong></td>
<td>02/01/1938</td>
</tr>
<tr>
<td><strong>15. Other Date</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>16. Dates Patient Unable to Work in Current Occupation</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>17. Name of Referring Provider or Other Source</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>18. Hospitalization Dates Related to Current Services</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>19. Additional Claim Information</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>20. Outside Lab?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>21. Diagnosis or Nature or Illness or Injury</strong></td>
<td>S5101</td>
</tr>
<tr>
<td><strong>22. Resubmission Code</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>23. Prior Authorization Number</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>24. A. Dates of Service</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>25. Federal Tax I.D. Number</strong></td>
<td>23-3342322</td>
</tr>
<tr>
<td><strong>26. Patient's Account No.</strong></td>
<td>____________________________</td>
</tr>
<tr>
<td><strong>27. Accept Assignment?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>28. Total Charge</strong></td>
<td>76.20</td>
</tr>
<tr>
<td><strong>29. Amount Paid</strong></td>
<td>0.00</td>
</tr>
<tr>
<td><strong>30. Rsvd for NUCC Use</strong></td>
<td>____________________________</td>
</tr>
</tbody>
</table>

**Signature on File 05/01/2016**

**Payment or Medical Benefits to the undersigned physician or supplier for services described below.**

**Ready back of form before completing & signing this form.**

**Authorization of Release of Medical Information**

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 the party who accepts assignment below.

**Payment or Medical Benefits to the undersigned physician or supplier for services described below.**

**Signature on File 05/01/2016**

**Please Print or Type.**

**Approved OMB-0938-1197 Form 1500 (02-12)**

**NUCC Instruction Manual available at www.nucc.org**

---

**Adult Day Care**

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**See Back for NUCC Use.**

---

**Paid by National Uniform Claim Committee (NUCC) 02/12**

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**Paid by National Uniform Claim Committee (NUCC) 02/12**

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**Paid by National Uniform Claim Committee (NUCC) 02/12**

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**Paid by National Uniform Claim Committee (NUCC) 02/12**
LTSS BILLING GRID – ADULT FOSTER CARE

CMS 1500 Claim Form Field Number

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Place of Service</td>
<td>Modifier 1</td>
<td>Modifier 2</td>
<td>Modifier 3</td>
<td>Modifier 4</td>
<td>Description</td>
<td>Units</td>
</tr>
<tr>
<td>S5140</td>
<td>12</td>
<td>99</td>
<td>U3</td>
<td>AFC - Level 1 (one day)</td>
<td>1 Day = 1 Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5140</td>
<td>12</td>
<td>99</td>
<td>U4</td>
<td>AFC - Level 2 (one day)</td>
<td>1 Day = 1 Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5140</td>
<td>12</td>
<td>99</td>
<td>U5</td>
<td>AFC - Level 3 (one day)</td>
<td>1 Day = 1 Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5140</td>
<td>12</td>
<td>99</td>
<td>U6</td>
<td>Adult Foster Care Provider Agency Level 1 (one day)</td>
<td>1 Day = 1 Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5140</td>
<td>12</td>
<td>99</td>
<td>U7</td>
<td>Adult Foster Care Provider Agency Level 2 (one day)</td>
<td>1 Day = 1 Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5140</td>
<td>12</td>
<td>99</td>
<td>U8</td>
<td>Adult Foster Care Provider Agency Level 3 (one day)</td>
<td>1 Day = 1 Unit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Billing Tips

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDCARD TRICARE CHAMPVA GROUP FECA OTHER
   (Medicare #)(Medicaid #)(ID/DD)(Member #)(ID/DD)(ID)
   a. INSURED'S I.D. NUMBER (For Program in Item 1)
   111111111

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   a. OTHER INSURED'S POLICY OR GROUP NUMBER
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME
   e. IS THERE ANOTHER HEALTH BENEFIT PLAN/
   f. CLAIM CODES (Designated by NUCC)
   g. OTHER CLAIM INFORMATION (Designated by NUCC)
   h. INSURANCE PLAN NAME OR PROGRAM NAME
   i. OTHER INSURED'S POLICY OR GROUP NUMBER
   j. EMPLOYMENT? (Current or Previous)
   k. AUTO ACCIDENT?
   l. OTHER ACCIDENT?
   m. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
   n. OTHER INSURED'S POLICY OR GROUP NUMBER

3. PATIENT'S BIRTH DATE
   SEX
   a. INSURED'S DATE OF BIRTH
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME
   e. INSURED'S NAME (Last Name, First Name, Middle Initial)

4. PATIENT'S ADDRESS (No., Street)
   a. OTHER INSURED'S POLICY OR GROUP NUMBER
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME

5. PATIENT'S ADDRESS (No., Street)
   a. OTHER INSURED'S I.D. NUMBER
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME

6. PATIENT'S ADDRESS (No., Street)
   a. OTHER INSURED'S I.D. NUMBER
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME

7. PATIENT'S RELATIONSHIP TO INSURED
   a. SELF
   b. SPOUSE
   c. CHILD
   d. OTHER

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
   a. OTHER INSURED'S POLICY OR GROUP NUMBER
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME

10. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OF FECA NUMBER
    a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
    b. INSURED'S NAME (Last Name, First Name, Middle Initial)
    c. INSURED'S DATE OF BIRTH
    d. RESERVED FOR NUCC USE
    e. RESERVED FOR NUCC USE
    f. INSURANCE PLAN NAME OR PROGRAM NAME

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 the party who accepts assignment below.

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

14. INSURED'S ADDRESS (No., Street)
    a. OTHER INSURED'S I.D. NUMBER
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

15. OTHER DATE
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    From
    To
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
    b. INSURED'S NAME (Last Name, First Name, Middle Initial)
    c. INSURED'S DATE OF BIRTH
    d. RESERVED FOR NUCC USE
    e. RESERVED FOR NUCC USE
    f. INSURANCE PLAN NAME OR PROGRAM NAME

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
    From
    To
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

20. OUTSIDE LAB? $ CHARGES
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY
    a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
    b. INSURED'S NAME (Last Name, First Name, Middle Initial)
    c. INSURED'S DATE OF BIRTH
    d. RESERVED FOR NUCC USE
    e. RESERVED FOR NUCC USE
    f. INSURANCE PLAN NAME OR PROGRAM NAME

22. RESUBMISSION CODE
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

23. PRIOR AUTHORIZATION NUMBER
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

24. A. DATE(S) OF SERVICE
    PLACE OF SERVICE
    PROCEDURES, SERVICES, OR SUPPLIES
    D. MODIFIER
    E. modifier
    F. $ CHARGES
    G. DAYS OR UNITS
    H. EPSDT
    I. ID. QUAL.
    J. PROVIDER ID. #
    K. RENDERING PROVIDER ID. #
    L. NPI
    M. REND. PROVIDER ID. #
    N. NPI
    O. NPI
    P. NPI
    Q. NPI

25. FEDERAL TAX I.D. NUMBER
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

26. PATIENT'S ACCOUNT NO.
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

27. ACCEPT ASSIGNMENT?
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

28. TOTAL CHARGE
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    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

29. AMOUNT PAID
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    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

30. Rvrd for NUCC Use
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    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

32. SERVICE FACILITY LOCATION INFORMATION
    a. INSURED'S DATE OF BIRTH
    b. RESERVED FOR NUCC USE
    c. RESERVED FOR NUCC USE
    d. INSURANCE PLAN NAME OR PROGRAM NAME

SIGNED ON FILE 05/01/2016

SIGNATURE ON FILE 05/01/2016

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

PLEASE PRINT OR TYPE

A PROOF OF OMB-0938-1197 FORM 1500 (02-12)

NUCC Instruction Manual available at www.nucc.org
<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Description</th>
<th>Units</th>
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<td>U1</td>
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<td></td>
<td>13</td>
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<td>U7</td>
<td>U1</td>
<td>Level 5: PB1, CA1 and PB2</td>
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<td>T2031</td>
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<td>13</td>
<td>99</td>
<td>U6</td>
<td>U1</td>
<td>Level 4: SSA, PC2, BB2, IB2 and PD1</td>
<td>1 Per Day</td>
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<td>T2031</td>
<td></td>
<td>13</td>
<td>99</td>
<td>U5</td>
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<td>Level 3: CA2, PC1, BB1 and IB1</td>
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<td>T2031</td>
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<td>U4</td>
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<td>Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1 and SSB</td>
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<td></td>
<td>13</td>
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<td>U3</td>
<td>U1</td>
<td>Level 1: SSC, CC1, RAD, CC2, PE2, SE3 and SE1</td>
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<tr>
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<td>RC Apartment - Double Occupancy (one day)</td>
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<td>U7</td>
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<tr>
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<td>99</td>
<td>U6</td>
<td>U2</td>
<td>Level 4: SSA, PC2, BB2, IB2 and PD1</td>
<td>1 Per Day</td>
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<td>T2031</td>
<td></td>
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<td>99</td>
<td>U5</td>
<td>U2</td>
<td>Level 3: CA2, PC1, BB1 and IB1</td>
<td>1 Per Day</td>
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<tr>
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<td></td>
<td>13</td>
<td>99</td>
<td>U4</td>
<td>U2</td>
<td>Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1 and SSB</td>
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</tr>
<tr>
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<td>99</td>
<td>U3</td>
<td>U2</td>
<td>Level 1: SSC, CC1, RAD, CC2, PE2, SE3 and SE1</td>
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<td>RC - Non-Apartment (one day)</td>
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<td>U2</td>
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<tr>
<td>T2031</td>
<td></td>
<td>13</td>
<td>99</td>
<td>U7</td>
<td>U2</td>
<td>Level 5: PB1, CA1 and PB2</td>
<td>1 Per Day</td>
</tr>
<tr>
<td>T2031</td>
<td></td>
<td>13</td>
<td>99</td>
<td>U6</td>
<td>U2</td>
<td>Level 4: SSA, PC2, BB2, IB2 and PD1</td>
<td>1 Per Day</td>
</tr>
<tr>
<td>T2031</td>
<td></td>
<td>13</td>
<td>99</td>
<td>U5</td>
<td>U2</td>
<td>Level 3: CA2, PC1, BB1 and IB1</td>
<td>1 Per Day</td>
</tr>
<tr>
<td>T2031</td>
<td></td>
<td>13</td>
<td>99</td>
<td>U4</td>
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<td>Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1 and SSB</td>
<td>1 Per Day</td>
</tr>
<tr>
<td>T2031</td>
<td></td>
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<td>U2</td>
<td>Level 1: SSC, CC1, RAD, CC2, PE2, SE3 and SE1</td>
<td>1 Per Day</td>
</tr>
</tbody>
</table>
Billing Tips

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
CLAIM EXAMPLE - AL/RC SERVICES

PROVIDER LEVEL 23
 SINGLE APARTMENT - LEVEL 5
 T2031 x 30 UNITS = $1844.40 ($61.48 x 30 UNITS)
 30 DAY = 30 UNIT

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICARE  TRICARE  CHAMPVA
   GROUP FECA OTHER
   (Medicare #) (Medicaid #) (ID/DOD #) (Member ID #) (ID #)
   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 the party who accepts assignment below.

   2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
      SMITH, MARY

   3. PATIENT'S BIRTH DATE
      02 01 1938

   5. PATIENT'S ADDRESS (No., Street)
      100 MAIN STREET

   6. PATIENT RELATIONSHIP TO INSURED
      Self

   7. INSURED'S ADDRESS (No., Street)
      FORT WORTH, TX 76101

   8. RESERVED FOR NUCC USE

   9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
      SMITH, MARY

   10. OTHER INSURED'S ADDRESS (No., Street)
       100 MAIN STREET

   11. INSURED'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 the party who accepts assignment below.

   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, INJURY, or, PREGNANCY (LMP)
       05/01/2016

   15. OTHER DATE
       05/01/2016

   16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
       From
       To

   17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
       23-3342322

   18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
       From
       To

   19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

   20. OUTSIDE LAB?
       No

   21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY
       E11.52

   22. RESUBMISSION CODE
       ORIGINAL REF. NO.

   23. PRIOR AUTHORIZATION NUMBER

   24. DATES OF SERVICE
       MM
       DD
       YYYY
       MM
       DD
       YYYY
       10
       01
       16
       10
       31
       16
       13

   25. FEDERAL TAX I.D. NUMBER
       23-3342322

   26. PATIENT'S ACCOUNT NO.
       SMITH-01

   27. SIGNATURE OF PHYSICIAN OR SUPPLIER
       Assisted Living/Residential Care

   28. TOTAL CHARGE
       $1844.40

   29. AMOUNT PAID
       $0.00

   30. Rsvd for NUCC Use

   31. SIGNATURE ON FILE 05/01/2016

   32. SERVICE FACILITY LOCATION INFORMATION
       TEXAS AL/RC
       234 1ST AVE
       FORT WORTH, TX 76101

   33. BILLING PROVIDER INFO & PH #
       TEXAS AL/RC
       234 1ST AVE
       FORT WORTH, TX 76101

   34. ADDRESS
       100 MAIN STREET

   35. SIGNATURE ON FILE 05/01/2016
### LTSS BILLING GRID – EMERGENCY RESPONSE SYSTEMS

#### CMS 1500 Claim Form Field Number

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Description</th>
<th>Units</th>
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<tr>
<td>S5161</td>
<td>12</td>
<td>U3</td>
<td>U3</td>
<td></td>
<td></td>
<td>Emergency Response Systems</td>
<td>1 Per Month</td>
</tr>
<tr>
<td>S5161</td>
<td>12</td>
<td>U7</td>
<td>U7</td>
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<td>Emergency Response Services</td>
<td>1 Per Month</td>
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<td>S5161</td>
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<td>U3</td>
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<td>Emergency Response Services</td>
<td>1 Per Month</td>
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<td>S5161</td>
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<td>Emergency Response Services</td>
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<tr>
<td>S5160</td>
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<td></td>
<td></td>
<td></td>
<td>Emergency Response Systems (Installation and Testing)</td>
<td>1 Per Installation</td>
</tr>
</tbody>
</table>

### Billing Tips

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

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9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.  
   **Note:** Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
**CLAIM EXAMPLE - EMERGENCY RESPONSE SYSTEMS**

**INSTALL AND ONE MONTH FEE**

S5160 x 1 UNITS = $100.00 (NEGOTIATED RATE)

S5161 x UNIT = $29.76 (1 UNIT = 1 MONTH)

---

**HEALTH INSURANCE CLAIM FORM**

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

---

1. **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 or medical benefits to the undersigned physician or supplier for services described below.

2. **SIGNATURE ON FILE**
   DATE 05/01/2016

3. **DATE OF CURRENT ILLNESS, INJURY, or, PREGNANCY (LMP)**
   MM DD YY QUAL

4. **OTHER DATE**
   MM DD YY TO MM DD YY

5. **NAME OF REFERRING PROVIDER OR OTHER SOURCE**
   A. OTHER INSURED'S POLICY OR GROUP NUMBER
   B. RESERVED FOR NUCC USE
   C. OTHER ACCIDENT
   D. INSURANCE PLAN NAME OR PROGRAM NAME
   E. INSURANCE PLAN ID (Designated by NUCC)
   F. OTHER CLAIM ID (Designated by NUCC)

6. **READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

---

**BILLING PROVIDER INFO & PH #**

**SIGNED**

---

**RENDERING PROVIDER NPI**

---

**SIGNATURE ON FILE 05/01/2016**

---

**NUCC Instruction Manual available at www.nucc.org**
## LTSS BILLING GRID – HABILITATION
### CMS 1500 Claim Form Field Number

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<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Description</th>
<th>Units</th>
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<td>Habilitation Agency Model (Non-SPW) (CFC)</td>
<td>1 hour = 1 unit</td>
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<td>UC</td>
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<td>CFC PCS Only- Agency Model (members 20 and younger)</td>
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<td>CFC HAB- Agency Model (members 20 and younger)</td>
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<td></td>
<td></td>
<td>CFC HAB- Consumer Directed Services Model (members 20 and younger)</td>
<td>15 minutes = 1 unit</td>
</tr>
</tbody>
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HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE  
   - (Medicare #)  
   - Medicare #

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)  
   - SMITH, MARY

3. PATIENT’S ADDRESS (No., Street)  
   - 100 MAIN STREET

4. INSURED’S NAME (Last Name, First Name, Middle Initial)  
   - MEDICARE

5. PATIENT’S RELATIONSHIP TO INSURED  
   - Spouse

6. INSURED’S POLICY GROUP OF FECA NUMBER  
   - 32. SERVICE FACILITY LOCATION INFORMATION

7. PATIENT’S BIRTH DATE  
   - 02 01 1938

8. TOTAL CHARGE  
   - $75.72

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)  
   - 23. PRIOR AUTHORIZATION NUMBER

10. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
    - From 01 01 01 To 01 01 01

11. INSURED’S DATE OF BIRTH  
    - 01 01 72

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 the party who accepts assignment below.

13. INSURED’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 the party who accepts assignment below.

14. DATE OF CURRENT ILLNESS, INJURY, OR, PREGNANCY (LMP)  
    - From 01 01 16 To 01 01 16

15. OTHER DATE  
    - From 01 01 16 To 01 01 16

16. DATES PATIENTUnable to Work in Current Occupation  
    - From 01 01 16 To 01 01 16

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
    - SMITH-01

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
    - From 01 01 16 To 01 01 16

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  
    - 1. MEDICARE

20. OUTSIDE LAB?  
    - Yes

21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY  
    - A. OTHER INSURED’S POLICY OR GROUP NUMBER

22. RESUBMISSION CODE  
    - 23. PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER  
    - 24. A. DATES OF SERVICE

24. A. DATES OF SERVICE  
    - Form MM DD YY To MM DD YY

25. FEDERAL TAX I.D. NUMBER  
    - 26. SERVICE FACILITY LOCATION INFORMATION

26. SERVICE FACILITY LOCATION INFORMATION  
    - TEXAS HABILITATION

27. ACCEPT ASSIGNMENT?  
    - Yes

28. TOTAL CHARGE  
    - $75.72

29. AMOUNT PAID  
    - $00

30. OUTSIDE LAB?  
    - Yes

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  
    - TEXAS HABILITATION

33. SIGNATURE ON FILE  
    - 05/01/2016

34. 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.

35. SIGNATURE ON FILE  
    - 05/01/2016

36. SIGNATURE ON FILE  
    - SIGNATURE ON FILE 05/01/2016

37. 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.

38. SIGNATURE ON FILE  
    - SIGNATURE ON FILE 05/01/2016

39. 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.

40. SIGNATURE ON FILE  
    - SIGNATURE ON FILE 05/01/2016

41. 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.

42. SIGNATURE ON FILE  
    - SIGNATURE ON FILE 05/01/2016

43. 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.
LTSS BILLING GRID – HOME DELIVERED MEALS

CMS 1500 Claim Form Field Number

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<th>Modifier 3</th>
<th>Modifier 4</th>
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<th>Units</th>
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<td>S5170</td>
<td>12</td>
<td>U3</td>
<td></td>
<td></td>
<td></td>
<td>SPW Home Delivered Meals (HDM)</td>
<td>1 Per Meal</td>
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<tr>
<td>24G</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

Billing Tips

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
# Home Delivered Meals

## Claim Example - Home Delivered Meals

3 Meals per Day for 7 Days

S5171 X 21 Units = $128.52 ($6.12 Per Unit)

1 Meal = 1 Unit

## Health Insurance Claim Form

Approved by National Uniform Claim Committee (NUCC) 02/12

<table>
<thead>
<tr>
<th>Field</th>
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<td><strong>2. Patient's Name</strong></td>
<td>Smith, Mary</td>
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<td><strong>3. Patient's Birth Date</strong></td>
<td>02 01 1938</td>
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<td><strong>4. Insured's Name</strong></td>
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<td><strong>5. Insured's Address</strong></td>
<td></td>
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<td><strong>6. Insured's Policy Group of FECA Number</strong></td>
<td></td>
</tr>
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<td><strong>7. Insured's Address</strong></td>
<td></td>
</tr>
<tr>
<td><strong>8. Insured's Policy Group of FECA Number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>9. Insured's Signature</strong></td>
<td>I authorize the release of any medical or other information necessary to apply to this bill and are made a part thereof.</td>
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<tr>
<td><strong>10. Insured's I.D. Number</strong></td>
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<tr>
<td><strong>11. Insured's Date of Birth</strong></td>
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<tr>
<td><strong>12. Medicare #</strong></td>
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<td><strong>13. Insured's Policy or Group Number</strong></td>
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<td><strong>14. Date of Current Illness, Injury, or Pregnancy (LMP)</strong></td>
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<td><strong>15. Other Date</strong></td>
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<td><strong>16. Dates Patient Unable to Work in Current Occupation</strong></td>
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<td><strong>17. Name of Referring Provider or Other Source</strong></td>
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<td><strong>18. Hospitalization Dates Related to Current Services</strong></td>
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<td><strong>19. Additional Claim Information (Designated by NUCC)</strong></td>
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<td><strong>20. Outside Lab?</strong></td>
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<td><strong>21. Diagnosis or Nature of Illness or Injury</strong></td>
<td>E11.52</td>
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<td><strong>22. Resubmission Code</strong></td>
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<td><strong>23. Prior Authorization Number</strong></td>
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<td><strong>24. A. Dates of Service</strong></td>
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<td><strong>25. Federal Tax I.D. Number</strong></td>
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<td><strong>26. Patient's Account No.</strong></td>
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<td><strong>27. Accept Assignment?</strong></td>
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<td><strong>28. Total Charge</strong></td>
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<tr>
<td><strong>29. Amount Paid</strong></td>
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<tr>
<td><strong>30. Reserved for NUCC Use</strong></td>
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## Claim Example - Home Delivered Meals

S5171 X 21 Units = $128.52 ($6.12 Per Unit)

1 Meal = 1 Unit

---

Home Delivered Meals

18
LTSS BILLING GRID – MINOR HOME MODIFICATIONS

CMS 1500 Claim Form Field Number

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<td>Modifier 2</td>
<td>Modifier 3</td>
<td>Modifier 4</td>
<td>Description</td>
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<td>S5165</td>
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<td></td>
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<td></td>
<td></td>
<td>All Minor Home Modifications</td>
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Billing Tips

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SIGNATURE ON FILE DATE 05/01/2016

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, MARY
5. PATIENT'S ADDRESS (No., Street) 100 MAIN STREET

3. PATIENT'S BIRTH DATE 02 01 1938

4. INSURED'S NAME (Last Name, First Name, Middle Initial) SMITH, MARY

11. INSURED'S POLICY GROUP OF FECA NUMBER ____________________________________________

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 the party who accepts assignment below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE

DATE 05/01/2016

Claim Example - Minor Home Modifications
Install ramp to front door
Negotiated rate = $2350.00
S5165 x 1 units = $2350.00

NNUC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

A PROVED OMB-0938-1197 FORM 1500 (02-12)
## LTSS BILLING GRID – PRIMARY HOME CARE/PAS SERVICES

### CMS 1500 Claim Form Field Number

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<td>Agency Model (Non-SPW)</td>
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<td>Consumer Directed Option for Personal Attendant Services (SPW)</td>
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<td>U7</td>
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<td>Consumer Directed Option for Personal Attendant Services (Non-SPW) (CFC)</td>
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<td>S5125</td>
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<td>Consumer Directed Option for Personal Attendant Services (SPW) (CFC)</td>
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<td>S5125</td>
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<td>Protective Supervision Agency Model (SPW)</td>
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<td>Protective Supervision (CDS) (SPW)</td>
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<td>Administration Fee for Consumer Directed Option (SPW)</td>
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<td>Administration Fee for Consumer Directed Option (Non-SPW)</td>
<td>$1.00 = 1 unit</td>
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</table>

### Billing Tips

1. If you are eligible for Attendant Care Enhancement Payments, you must bill at least the amount you expect to be reimbursed.

2. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
3. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

4. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

5. Always check member eligibility prior to providing services.

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8. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

9. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

10. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
PAS Services

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

1. MEDICARE □ MEDICAID □ TRICARE □ CHAMPVA □ GROUP HEALTH PLAN □ BLK LUNG □ FECA □ OTHER □

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
SMITH, MARY

5. PATIENT'S ADDRESS (No., Street)
100 MAIN STREET

8. MEDICARE #

11. INSURED'S I.D. NUMBER (For Program in Item 1)
11111111

13. INSURED'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 the party who accepts assignment below.

signed

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)

15. OTHER DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Explain unusual circumstance)

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

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.)

signed

NUPP Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)
## LTSS BILLING GRID – PROFESSIONAL SERVICES

### CMS 1500 Claim Form Field Number

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<td>1 hour = 1 unit</td>
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<td>Place of Service</td>
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<td>Cognitive Rehabilitation Therapy (CDS) (SPW)</td>
<td></td>
</tr>
<tr>
<td>97537</td>
<td>12</td>
<td>U3</td>
<td>U3</td>
<td></td>
<td></td>
<td>Community/Work Reintegration-CRT (SPW)</td>
<td></td>
</tr>
<tr>
<td>97537</td>
<td>12</td>
<td>U3</td>
<td>99</td>
<td>99</td>
<td>UC</td>
<td>Community/Work Reintegration-CRT (CDS)(SPW)</td>
<td></td>
</tr>
</tbody>
</table>

*Code changes are effective November 1, 2017

**Billing Tips**

1. If you are eligible for Attendant Care Enhancement Payments, you must bill at least the amount you expect to be reimbursed.

2. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

3. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

4. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

5. Always check member eligibility prior to providing services.
6. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

7. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

8. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

9. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

10. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

Note: Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPAV GROUP HEALTH PLAN FECA BLK LUNG OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   SMITH, MARY

3. PATIENT'S BIRTH DATE
   02 01 1938 M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
   100 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED
   Self

7. INSURED'S ADDRESS (No., Street)
   SMITH-01

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
       NO
    b. OTHER INSURED? (Designated by NUCC)
       NO
    c. OTHER ACCIDENT?
       NO

11. INSURED'S POLICY GROUP OF FECA NUMBER

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 the party who accepts assignment below.

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

14. DATE OF CURRENT ILLNESS, INJURY, or, PREGNANCY (LMP)
   05/01/2016

15. OTHER DATE
    a. INSURED'S DATE OF BIRTH
       01 01 1938 M F
    b. OTHER INSURED'S POLICY OR GROUP NUMBER
       01111111

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    From 05/01/2016 To

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
    From MM DD YY To MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?
    Yes No

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    Relate ALL to service line below (24 E)
    A E11.52
    B F
    C G
    D H
    E I
    F J
    G K

22. RESUBMISSION CODE
    ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE
    MM DD YY MM DD YY
    05 05 16 05 16

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.
    SMITH-01

27. ACCEPT ASSIGNMENT
    Yes No

28. TOTAL CHARGE
    $ 216.95

29. AMOUNT PAID
    $ 0.00

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
    TEXAS PROFESSIONAL SERVICES
    234 1ST AVE
    FORT WORTH, TX 76101

33. BILLING PROVIDER INFO & PH #
    TEXAS PROFESSIONAL SERVICES
    234 1ST AVE
    FORT WORTH, TX 76101
    555 ) 555-5555

SIGNATURE ON FILE 05/01/2016

RETAIL 그럼 업로드 로고

SIGNATURE: SMITH

TELEPHONE (Include Area Code)
555-5555

DATE 05/01/2016

SIGNED

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
# LTSS BILLING GRID – RESPITE CARE

**CMS 1500 Claim Form Field Number**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
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<td>Code</td>
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<td>Modifier 1</td>
<td>Modifier 2</td>
<td>Modifier 3</td>
<td>Description</td>
<td>Units</td>
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</table>

### Respite Care - Assisted Living Apartment (Single Occupancy)

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Description</th>
<th>Units</th>
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<tbody>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U8</td>
<td>U1</td>
<td>Level 6: PA1, BA1, PA2, BA2, IA1 and IA2</td>
<td>1 day = 1 unit</td>
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<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U7</td>
<td>U1</td>
<td>Level 5: PB1, CA1 and PB2</td>
<td>1 day = 1 unit</td>
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<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U6</td>
<td>U1</td>
<td>Level 4: SSA, PC2, BB2, IB2 and PD1</td>
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<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U5</td>
<td>U1</td>
<td>Level 3: CA2, PC1, BB1 and IB1</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U4</td>
<td>U1</td>
<td>Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1 and SSB</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U3</td>
<td>U1</td>
<td>Level 1: SSC, CC1, RAD, CC2, PE2, SE3 and SE1</td>
<td>1 day = 1 unit</td>
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</table>

### Respite Care - Residential Care Apartment (Double Occupancy)

<table>
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<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Description</th>
<th>Units</th>
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<tr>
<td>S5151</td>
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<td>1 day = 1 unit</td>
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<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U7</td>
<td>U2</td>
<td>Level 5: PB1, CA1 and PB2</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U6</td>
<td>U2</td>
<td>Level 4: SSA, PC2, BB2, IB2 and PD1</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U5</td>
<td>U2</td>
<td>Level 3: CA2, PC1, BB1 and IB1</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
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<td>99</td>
<td>U4</td>
<td>U2</td>
<td>Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1 and SSB</td>
<td>1 day = 1 unit</td>
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<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U3</td>
<td>U2</td>
<td>Level 1: SSC, CC1, RAD, CC2, PE2, SE3 and SE1</td>
<td>1 day = 1 unit</td>
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</table>

### Respite Care - Residential Care (Non-Apartment)

<table>
<thead>
<tr>
<th>Code</th>
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<th>Modifier 1</th>
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</thead>
<tbody>
<tr>
<td>S5151</td>
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<td>99</td>
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<td>U2</td>
<td>Level 6: PA1, BA1, PA2, BA2, IA1 and IA2</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U7</td>
<td>U2</td>
<td>Level 5: PB1, CA1 and PB2</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U6</td>
<td>U2</td>
<td>Level 4: SSA, PC2, BB2, IB2, &amp; PD1</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U5</td>
<td>U2</td>
<td>Level 3: CA2, PC1, BB1, &amp; IB1</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U4</td>
<td>U2</td>
<td>Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1 and SSB</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>S5151</td>
<td>13</td>
<td>99</td>
<td>U3</td>
<td>U2</td>
<td>Level 1: SSC, CC1, RAD, CC2, PE2, SE3 and SE1</td>
<td>1 day = 1 unit</td>
</tr>
<tr>
<td>Code</td>
<td>Place of Service</td>
<td>Modifier 1</td>
<td>Modifier 2</td>
<td>Modifier 3</td>
<td>Modifier 4</td>
<td>Description</td>
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<tr>
<td>--------</td>
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<td>------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
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<td>U3</td>
<td>U3</td>
<td>UC</td>
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<td>Respite Care - In-Home</td>
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<td>U3</td>
<td>99</td>
<td>99</td>
<td>UC</td>
<td>Respite Care - Consumer Directed Services (CDS) (SPW)</td>
</tr>
</tbody>
</table>
| S5151  | 12               | 99         | U3         |            |            | Respite Care - Adult Foster Care (Level 1)                                    | 1 day = 1 unit 

**Billing Tips**

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

**Note:** Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
CLAIM EXAMPLE - AFC RESPITE CARE- LEVEL III
5 DAYS PER WEEK FOR 2 WEEKS (MON-FRI)
S5 151 X 10 UNITS = $813.00 ($81.30 x 10 UNITS)
1 DAY = 1 UNIT

Respite Care

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

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ]
   (Medicare #) [Medicaid #] [ID/DD/ID] (Member ID #) [ID/DD/ID]
   HEALTH PLAN [ ] FEE [ ] BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
   1111111

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   SMITH, MARY

5. PATIENT'S ADDRESS (No., Street)
   100 MAIN STREET

8. RESERVED FOR NUCC USE
   CITY
   TARRANT
   STATE
   TX
   ZIP CODE
   7501
   TELEPHONE (Include Area Code)
   655-5555

10. IS PATIENT'S CONDITION RELATED TO:
   a. OTHER INSURED'S POLICY OR GROUP NUMBER
   b. RESERVED FOR NUCC USE
   c. RESERVED FOR NUCC USE
   d. INSURANCE PLAN NAME OR PROGRAM NAME
   e. INSURANCE PLAN NAME OR PROGRAM NUMBER
   f. CLAIM CODES (Designated by NUCC)

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   a. HOSPITALIZATIONS FOR CURRENT DATES
   b. HOSPITALIZATIONS FOR PREVIOUS DATES
   c. HOSPITALIZATIONS FOR FUTURE DATES

22. RESUBMISSION CODE
   ORIGINAL REF. NO.
   0000

23. PRIOR AUTHORIZATION NUMBER
   N/A
   NPI
   1234567890

30. BILLING PROVIDER INFO & PH.
    PROVIDER ID. #
    1234567890
    NPI
    1234567890

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.)

SIGNED
SIGNATURE ON FILE
05/01/2016

SIGNED
DATE
05/01/2016

PICA

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

RESpite Care
**LTSS BILLING GRID –**
**SUPPORTIVE EMPLOYMENT / EMPLOYMENT ASSISTANCE**

**CMS 1500 Claim Form Field Number**

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Description</th>
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<tbody>
<tr>
<td>H2023</td>
<td>12</td>
<td>U3</td>
<td>U3</td>
<td>NOT</td>
<td>NOT</td>
<td>Supportive Employment (SPW)</td>
<td>1 Hour = 1 Unit</td>
</tr>
<tr>
<td>H2023</td>
<td>12</td>
<td>U3</td>
<td>99</td>
<td>99</td>
<td>UC</td>
<td>Supportive Employment (CDS)(SPW)</td>
<td>1 Hour = 1 Unit</td>
</tr>
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<td>H2025</td>
<td>12</td>
<td>U3</td>
<td>U3</td>
<td>NOT</td>
<td>NOT</td>
<td>Employment Assistance (SPW)</td>
<td>1 Hour = 1 Unit</td>
</tr>
<tr>
<td>H2025</td>
<td>12</td>
<td>U3</td>
<td>99</td>
<td>99</td>
<td>UC</td>
<td>Employment Assistance (CDS) (SPW)</td>
<td>1 Hour = 1 Unit</td>
</tr>
</tbody>
</table>

*Code changes are effective November 1, 2017*

**Billing Tips**

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

**Note:** Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
### Supportive Employment / Employment Assistance

**CLAIM EXAMPLE - SUPPORTIVE EMPLOYMENT / EMPLOYMENT ASSISTANCE**

3 HOURS PER DAY FOR 2 DAYS = 6 HOURS

**HEALTH INSURANCE CLAIM FORM**

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

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Medicare #)&lt;br&gt;(ID#)&lt;br&gt;(Member ID #)</td>
<td>SMITH, MARY&lt;br&gt;(100 MAIN STREET&lt;br&gt;CITY&lt;br&gt;TARRANT, TEXAS&lt;br&gt;ZIP CODE&lt;br&gt;76101)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. PATIENT'S BIRTH DATE</th>
<th>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 01 1938</td>
<td>SMITH, MARY&lt;br&gt;(100 MAIN STREET&lt;br&gt;CITY&lt;br&gt;TARRANT, TEXAS&lt;br&gt;ZIP CODE&lt;br&gt;76101)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. PATIENT'S ADDRESS (No., Street)</th>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
</tr>
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<tbody>
<tr>
<td>100 MAIN STREET&lt;br&gt;CITY&lt;br&gt;TARRANT, TEXAS&lt;br&gt;ZIP CODE&lt;br&gt;76101</td>
<td>Self&lt;br&gt;Spouse&lt;br&gt;Child&lt;br&gt;Other</td>
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<thead>
<tr>
<th>7. INSURED'S ADDRESS (No., Street)</th>
<th>8. RESERVED FOR NUCC USE</th>
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<td>66 111 MAIN STREET&lt;br&gt;CITY&lt;br&gt;TARRANT, TEXAS&lt;br&gt;ZIP CODE&lt;br&gt;76101</td>
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<th>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
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<tr>
<td>76101</td>
<td>Self&lt;br&gt;Spouse&lt;br&gt;Child&lt;br&gt;Other</td>
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</table>

<table>
<thead>
<tr>
<th>11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</th>
<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
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<tbody>
<tr>
<td>I authorize the release of any medical or other information necessary to</td>
<td>I authorize the release of any medical or other information necessary to</td>
</tr>
<tr>
<td>process this claim. I also request payment of government benefits either to</td>
<td>process this claim. I also request payment of government benefits either to</td>
</tr>
<tr>
<td>myself or the party who accepts assignment below.</td>
<td>myself or the party who accepts assignment below.</td>
</tr>
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<table>
<thead>
<tr>
<th>13. EMPLOYMENT? (Current or Previous)</th>
<th>14. DATE(S) OF SERVICE</th>
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<tr>
<th>15. OTHER DATE</th>
<th>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</th>
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<tr>
<td>MM DD YY&lt;br&gt;QUAL</td>
<td>MM DD YY&lt;br&gt;From&lt;br&gt;To</td>
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<table>
<thead>
<tr>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
<th>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</th>
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<tbody>
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<td>MM DD YY&lt;br&gt;From&lt;br&gt;To</td>
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<table>
<thead>
<tr>
<th>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</th>
<th>20. OUTSIDE LAB?</th>
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<tbody>
<tr>
<td></td>
<td>Yes&lt;br&gt;No</td>
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<th>21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY</th>
<th>22. RESUBMISSION CODE</th>
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<td>MM DD YY&lt;br&gt;QUAL</td>
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<th>24. FEDERAL TAX I.D. NUMBER</th>
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</thead>
<tbody>
<tr>
<td>#</td>
<td>SSN&lt;br&gt;EN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25. MEDICARE</th>
<th>26. PATIENT'S ACCOUNT NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Medicare #)&lt;br&gt;(ID#)&lt;br&gt;(Member ID #)</td>
<td>SMITH-01&lt;br&gt;(23-3342322&lt;br&gt;24-3342322)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>27. ACCEPT ASSIGNMENT?</th>
<th>28. TOTAL CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes&lt;br&gt;No&lt;br&gt;For govt. claims, see back</td>
<td>MM DD YY&lt;br&gt;$ 156 42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>29. AMOUNT PAID</th>
<th>30. Rsvd for NUCC Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY&lt;br&gt;$</td>
<td>555 555-5555&lt;br&gt;555 555-5555</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</th>
<th>32. SIGNATURE ON FILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I certify that the statements on the reverse apply to this bill and</td>
<td>SIGNATURE ON FILE 05/01/2016&lt;br&gt;SIGNED&lt;br&gt;SIGNATURE ON FILE 05/01/2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</th>
<th>34. SIGNATURE ON FILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes&lt;br&gt;No&lt;br&gt;For govt. claims, see back</td>
<td>SIGNATURE ON FILE 05/01/2016&lt;br&gt;SIGNED&lt;br&gt;SIGNATURE ON FILE 05/01/2016</td>
</tr>
</tbody>
</table>

**NNUC Instruction Manual available at www.nucc.org**

**PLEASE PRINT OR TYPE A PROOVED OMB-0838-1197 FORM 1500 (02-12)**
**LTSS BILLING GRID – TRANSITION ASSISTANCE SERVICES**

CMS 1500 Claim Form Field Number

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2038</td>
<td>12</td>
<td></td>
<td></td>
<td>NOT APPLICABLE</td>
<td></td>
<td>Transition Assistance Services (TAS)</td>
<td>1</td>
</tr>
</tbody>
</table>

**Billing Tips**

1. Always use the service codes and modifiers located on the Authorization Form received from Cigna-HealthSpring Services Utilization Management. Failure to use these codes may result in denial or delay in payment.

2. If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.

3. If services are not rendered on consecutive days, a separate line item must be billed for each date of service.

4. Always check member eligibility prior to providing services.

5. If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span.

6. STAR+PLUS claims appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

7. MMP claims appeals must be filed within sixty days (60) from the date of the Explanation of Payment.

8. Refer to the HHSC website, SPH, Appendix XVI, Long Term Services and Supports Codes and Modifiers for the most up to date information.

9. Refer to the HHSC website, Long-term Care Bill Code Crosswalk for the most up to date information.

**Note:** Cigna-HealthSpring makes no recommendations to Providers on the amount to bill per service code.
**CLAIM EXAMPLE - TRANSITION ASSISTANCE SERVICES**

T2038 X 1 UNIT = 375.00 SET-UP OF UTILITIES (NEGOTIATED RATE)
(+ ONE TIME AGENCY FEE OF $158.28) = $533.28

**HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>2. PATIENT'S NAME</td>
<td>SMITH, MARY</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>02-01-1938</td>
</tr>
<tr>
<td>4. MEDICAL NATURE OF ILLNESS OR INJURY</td>
<td>Relate A - L to service line below (24 E)</td>
</tr>
<tr>
<td>5. PATIENT RELATIONSHIP TO INSURED</td>
<td>Self</td>
</tr>
<tr>
<td>6. INSURED'S ADDRESS</td>
<td>100 MAIN STREET</td>
</tr>
<tr>
<td>7. INSURED'S SIGNATURE ON FILE</td>
<td>SIGNATURE ON FILE 05/01/2016</td>
</tr>
<tr>
<td>8. OTHER INSURED'S NAME</td>
<td>ME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>9. OTHER INSURED'S ADDRESS</td>
<td>100 MAIN STREET</td>
</tr>
<tr>
<td>10. INSURED'S SIGNATURE</td>
<td>SIGNATURE ON FILE 05/01/2016</td>
</tr>
<tr>
<td>11. INSURED'S GROUP OF FECA NUMBER</td>
<td></td>
</tr>
<tr>
<td>12. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td></td>
</tr>
<tr>
<td>13. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
</tr>
<tr>
<td>15. CLAIM CODES</td>
<td></td>
</tr>
<tr>
<td>16. CLAIM CODES</td>
<td></td>
</tr>
<tr>
<td>17. ADDITIONAL CLAIM INFORMATION</td>
<td></td>
</tr>
<tr>
<td>18. TOTAL CHARGE</td>
<td>533.28</td>
</tr>
<tr>
<td>19. OUTSIDE LAB?</td>
<td>No</td>
</tr>
<tr>
<td>20. PATIENT'S ACCOUNT NO.</td>
<td>1234567890</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY</td>
<td></td>
</tr>
<tr>
<td>22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td></td>
</tr>
<tr>
<td>24. PLACE OF SERVICE</td>
<td></td>
</tr>
<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td></td>
</tr>
<tr>
<td>26. PATIENT'S ACCOUNT NO.</td>
<td></td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT</td>
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<td>28. TOTAL CHARGE</td>
<td>533.28</td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td></td>
</tr>
<tr>
<td>30. ROD FOR NUCC USE</td>
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2208 Highway 121, Ste. 210
Bedford, TX 76021

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