

Aug. 21, 2006

06-064

Special Flu Bulletin - Texas

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This bulletin should be shared with all health care practitioners and managerial members of the physician/supplier staff. Bulletins are available at no cost from our Web site:

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INFLUENZA AND PNEUMOCOCCAL PNEUMONIA VACCINES

The influenza virus vaccine and the Pneumococcal Pneumonia Vaccine (PPV) are covered services in the Medicare program. Medicare also helps pay the charges for administering these vaccines. This informational bulletin will provide instructions for using Medicare's simplified billing process for submission of claims for the influenza virus vaccine and the PPVs. 

SUBMITTING MEDICARE CLAIMS FOR INFLUENZA VIRUS VACCINE AND ITS ADMINISTRATION

Medicare pays for influenza virus vaccines and their administration. Generally, only one influenza virus vaccination is medically necessary per year. Medicare beneficiaries may receive the vaccine once each flu season without a physician's order and without the supervision of a physician. The Medicare Part B deductible and coinsurance do not apply.

The Social Security Act requires providers bill Medicare for covered Part B services rendered to eligible beneficiaries. Public health clinics that have not provided Medicare-covered services to their clients in the past must now bill Medicare for the influenza virus vaccine and its administration when provided to Medicare beneficiaries.

To alleviate concerns expressed by some public health clinics that have never provided Medicare-covered services, the Centers for Medicare & Medicaid Services (CMS) initiated a simplified process for certain entities that administer the flu shot to file claims for multiple beneficiaries.

Continued on page 2

INFLUENZA VIRUS VACCINE

SUBMITTING MEDICARE CLAIMS FOR INFLUENZA VIRUS VACCINE AND ITS ADMINISTRATION (CONTINUED)

Generally, providers will qualify to use the simplified process if they:

- Bill Medicare for influenza virus vaccines for multiple beneficiaries.
- Agree to accept assignment for influenza vaccination claims.

However, the roster should not be used for single-patient bills and the dates of service for each vaccination administered must be entered.

Providers who **do not** qualify to use the simplified process must complete a standard CMS-1500 claim form or bill electronically for each Medicare beneficiary receiving the influenza vaccine. Medicare will issue a provider number for those providers who qualify for simplified billing procedures for influenza claims and who do not have a Medicare provider number. Call (866) 528-1602 to obtain a provider number for the Texas area. Physicians may use their current provider number for roster billing.

Health Maintenance Organizations (HMOs) that furnish influenza immunizations to non-member Medicare beneficiaries are treated as suppliers and should bill the carrier. HMOs must obtain a provider number for Part B billing purposes by calling Provider Services at (866) 528-1602 for the CMS-855 provider/supplier enrollment

application. The HMO may use simplified billing only if influenza immunizations are the only Medicare-covered services furnished by the HMO to non-member Medicare patients.

A sample preprinted CMS-1500 claim form, an influenza vaccine record form and an influenza vaccine roster form are included with this article. Providers who **do** qualify to use the simplified process can use the preprinted CMS-1500 claim form to bill Medicare for the influenza or PPV. Providers are only required to complete the shaded blocks on the CMS-1500 claim form. Use the influenza record form or the influenza vaccine roster form as a record of the beneficiary information for those receiving the influenza vaccine. Include the name and health insurance claim number for each beneficiary. Use these forms **only** to report the influenza vaccination.

Medicare is also available to help providers comply with this requirement by providing assistance in filing these claims electronically and with information concerning the provider's decision regarding acceptance of assignment of these claims. A free software package called Influenza/Pneumococcal Roster Billing (Pro32) is available to all providers who wish to file electronically. Please call the Technology Support Center at (866) 749-4302 or complete the enclosed request form for roster software. **(Please see the Pro32 sample form on page 22).** ☒

CLAIMS FILING REQUIREMENTS

Please send the paper simplified billing claims to the following special post office box:

**Medicare Part B
Influenza Special Claims
P.O. Box 660157
Dallas, TX 75266-0157**

Put **one** CMS-1500 claim form with each group of influenza vaccine record forms (up to 100) and group these together (e.g., rubber band, etc.). Put **one** CMS-1500 claim form with five influenza roster forms and group these together. A stamped "signature on file" is acceptable on a simplified claim to qualify as an actual signature if the provider has a signed authorization on file to bill Medicare for services rendered.

When a provider accepts assignment, he may not collect any money from the beneficiary for the flu vaccination.

Note: Only the CMS-approved paper simplified forms as shown in this newsletter will be accepted for claims processing. All other forms will be returned. ☒

ELECTRONIC BILLING

For providers who qualify for roster billing, Medicare offers free software that will enable them to submit these claims electronically. The I/PRB software is easy to use and will allow providers to take advantage of the 14-day payment floor. Providers qualifying as roster billers can contact the Technology Support Center at (866) 749-4302 for information regarding the hardware and software requirements. ☒

REIMBURSEMENT INFORMATION

The description and allowable fees for the flu vaccines are:

Dates of Service Jan. 1, 2006 - March 31, 2006		
Procedure Code	Code Description	Allowed Amount \$
90655©	Flu vaccine no preserv 6-35m	14.68
90656©	Flu vaccine no preserv 3 & >	15.82
90657©	Flu vaccine, 6-35 mo, im	6.03
90658©	Flu vaccine, age 3 & over, im	12.06
90660©	Flu vaccine, nasal	0

Dates of Service April 1, 2006 - June 30, 2006		
Procedure Code	Code Description	Allowed Amount \$
90655©	Flu vaccine no preserv 6-35m	14.68
90656©	Flu vaccine no preserv 3 & >	15.82
90657©	Flu vaccine, 6-35 mo, im	6.03
90658©	Flu vaccine, age 3 & over, im	12.06
90660©	Flu vaccine, nasal	21.18

Dates of Service July 1, 2006 - Sept. 30, 2006		
Procedure Code	Code Description	Allowed Amount \$
90655©	Flu vaccine no preserv 6-35m	14.68
90656©	Flu vaccine no preserv 3 & >	15.82
90657©	Flu vaccine, 6-35 mo, im	6.03
90658©	Flu vaccine, age 3 & over, im	12.06
90660©	Flu vaccine, nasal	21.18

These are based on the Median Generic Price (MGP). As with all injectable drugs, the allowable is subject to change. See future newsletter articles for new allowables.

The allowable fee for the administration (G0008) is based on the locality of the provider. A list of fees by locality for the administration is included below:

2006 Allowables for Procedure Code G0008

Locality	County	Amount \$
09	Brazoria County	18.35
11	Dallas County	19.38
15	Galveston County	18.12
18	Harris County	18.95
20	Jefferson County	17.04
28	Tarrant County	18.46
31	Travis County	19.10
99	Rest of State	17.04

Note: If your county is not listed specifically, then you are in Locality 99-Rest of State. ☒

COMPLETION OF THE PREPRINTED CMS-1500 CLAIM FORM

INFLUENZA VIRUS VACCINE

Providers must submit an original CMS-1500 claim form. **Photocopies of the claim form are not acceptable.** Medicare provides free preprinted forms to mass immunizers. Call (866) 211-5708 for the forms and give the approximate number of injections anticipated. The following are the completion instructions for the preprinted CMS-1500 claim form for the influenza vaccine:

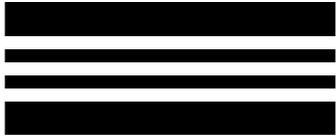
- Item 21* Enter the diagnosis code V0481 – Influenza virus vaccine.
Effective Oct. 1, 2006, providers should report diagnosis code V066 on claims for influenza virus and pneumococcal vaccines when the purpose of the visit is to receive both vaccines.
- Item 24d Enter the appropriate influenza immunization procedure code.
- Item 24f Enter the charge for the individual dose and the administration charge. **Do not** enter the total for all beneficiaries immunized.
- Item 25 Place the federal tax ID number in this block.
- Item 31 Enter the physician signature or that of an authorized person in this block. A signature stamp may be used.
- Item 32* Place the name and complete address including ZIP code of the facility where the services were furnished.
- Item 33 Place the provider's name, address, telephone number and provider number in this block.

***Note:** This information must be entered on the claim for processing. ☒



SAMPLE PREPRINTED CLAIM FORM

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

INFLUENZA VIRUS VACCINATION ONLY HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
2. PATIENT S NAME (Last Name, First Name, Middle Initial) SEE ATTACHED FORMS				3. PATIENT S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT S ADDRESS (No., Street) CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) _____ ()				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED S ADDRESS (No., Street) CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (INCLUDE AREA CODE) _____ ()					
9. OTHER INSURED S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED S POLICY GROUP OR FECA NUMBER NONE a. 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. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.					
12. PATIENT S OR AUTHORIZED PERSON S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED S OR AUTHORIZED PERSON S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V0481 2. _____ 3. _____ 4. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER				
24. A DATE(S) OF SERVICE From To MM DD YY MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1		60	60	G0008								
2												
3												
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ 0 00	30. BALANCE DUE \$ _____			
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 _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN S, SUPPLIER S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

The provider must enter the appropriate influenza procedure code here.

COMPLETION OF THE INFLUENZA VACCINE RECORD FORM

The Texas Department of Health Form C-93 (CDC revision date 4/14/00) may be substituted for the influenza vaccine record form. Complete each box as indicated. Mass immunizers may attach up to 100 influenza vaccine record forms to one CMS-1500 claim form.

Provider Identification Number	Enter the provider number issued by Provider Enrollment, or for physicians, enter your current Medicare provider number.
Patient's Medicare Health Insurance Claim Number	This is the beneficiary's HIC number found on the beneficiary's Medicare card.
Patient's Name	Enter the last name, first name and middle initial (if known).
Patient's Birth Date	Enter the beneficiary's birth date if known. This will help identify the beneficiary if the HIC number is not correct.
Patient's Sex	Enter "F" for female or "M" for male.
Patient's Address	Enter the beneficiary's address.
Date Vaccine Administered	Enter the actual date the vaccine is administered.
Signature	Have the beneficiary sign the form or a relative if the beneficiary is unable to sign. A stamped "signature on file" is acceptable if the provider has a signed authorization on file to bill Medicare for services rendered.



INFLUENZA VACCINE RECORD

Provider Identification Number

Medicare Health Insurance Claim Form

Name

LAST

FIRST

M.I.

Birthdate

Sex

Address

STREET

CITY

COUNTY

STATE

ZIP

Date Vaccine Administered

I have read or have had explained to me the information in this pamphlet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Statement: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Signature

Date

Continued on page 8

For Clinic/Office Use

(Do not send to Medicare)

Clinic/Office Address _____

Date Vaccine Administered _____

Vaccine Manufacturer _____

Vaccine Lot Number _____

Site of Injection _____

Signature of Vaccine Administrator _____

Title of Vaccine Administrator _____

COMPLETION OF THE INFLUENZA VACCINE ROSTER FORM FOR MASS IMMUNIZERS

The roster form is for 20 beneficiaries. Providers may bill for up to 100 beneficiaries by attaching five roster forms to one CMS-1500 claim form. Complete the form as follows:

	<i>(Do not write in the shaded areas.)</i>
Provider Identification Number	Enter the provider number issued by Provider Enrollment, or for physicians, enter your current Medicare provider number.
Patient's Medicare Health Insurance Claim Number	Enter the patient's HIC number exactly as it appears on the patient's Medicare card.
Patient's Sex	Enter "M" for male or "F" for female.
Patient's Date of Birth	Enter the birth date of the patient if known.
Patient's Name	Enter the patient's complete name, first, middle initial and last.
Patient's Address	Enter the patient's address.
Patient's Signature	Have the patient sign the roster form or a relative or agent if the patient is unable to sign. A stamped "signature on file" is acceptable if the provider has a signed authorization on file to bill Medicare for services rendered.
Date Vaccine Administered	Enter the actual date the vaccine is administered.
	<i>Continue to complete the list for each patient.</i>

Note: Roster forms may be reproduced from this newsletter. 



INFLUENZA VACCINE ROSTER FOR MASS IMMUNIZERS

Provider Identification Number _____

For Internal Medicare Use Only. Do not write in the shaded areas—



PLEASE TYPE OR PRINT CLEARLY

1. ----- -----	Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name			Patient's Address			Patient's Signature and Date Vaccine Administered	
				First	MI	Last	Street	City	St/ZIP		
2. ----- -----											
3. ----- -----											
4. ----- -----											
5. ----- -----											
6. ----- -----											
7. ----- -----											
8. ----- -----											
9. ----- -----											
10. ----- -----											

For Internal Medicare Use Only. Do not write in the shaded areas—

PLEASE TYPE OR PRINT CLEARLY

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City St/ZIP	Patient's Signature and Date Vaccine Administered
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					
6. _____					
7. _____					
8. _____					
9. _____					
10. _____					

SUBMITTING MEDICARE CLAIMS FOR PNEUMOCOCCAL PNEUMONIA VACCINE (PPV)

Medicare pays for PPVs and their administration. Typically, these vaccines are administered once in a lifetime except for people at highest risk.

Medicare does not require the PPV to be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

An initial vaccine may be administered only to people at high risk of pneumococcal disease. Those considered at high risk are people age 65 or older and immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness.

If at least five years have passed since receipt of a previous dose of PPV, revaccination may be administered only to people at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels. This group includes people with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the PPV nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about his vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he was vaccinated in the last five years, the vaccine should not be given. If the patient is certain the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

The Social Security Act requires providers bill Medicare for covered Part B services rendered to eligible beneficiaries. Public health clinics that have not provided Medicare-covered services in the past must now bill Medicare for the PPV and its administration when provided to Medicare beneficiaries.

To alleviate concerns expressed by some public health clinics that have never provided Medicare-covered services, CMS initiated a simplified process for certain entities that administer the PPV to file claims for multiple beneficiaries. Providers who bill carriers and intermediaries, with the exception of independent rural health clinics and freestanding federally qualified health centers, may use the simplified form to bill PPV.

To qualify for simplified billing, providers may use the simplified process if they:

- Bill Medicare for PPVs for multiple beneficiaries.
- Agree to accept assignment for PPV claims.

However, the roster should not be used for single-patient bills, and the dates of service for each vaccination administered must be entered.

Providers who **do not** qualify to use the simplified process must complete a standard CMS-1500 claim form or bill electronically for each Medicare beneficiary receiving the pneumonia vaccine.

Medicare will issue a provider billing number for those providers who qualify for simplified billing procedures for PPV claims. Providers should call (866) 528-1602 to obtain a provider number.

Health Maintenance Organizations (HMOs) that furnish PPVs to non-member Medicare beneficiaries are treated as suppliers and should bill the carrier. HMOs must obtain a provider number for Part B billing purposes by contacting Provider Enrollment at (866) 528-1602 for the CMS-855, the provider/supplier enrollment application. The HMO may use simplified billing only if PPVs are the only Medicare-covered services furnished by the HMO to non-member Medicare patients.

Included with this article are a sample preprinted CMS-1500 claim form, a PPV record form and a sample roster for mass immunizations form. Providers who **do** qualify to use the simplified process can use the preprinted CMS-1500 claim form to bill Medicare for the PPV. Providers are only required to complete the blocks that are shaded on the CMS-1500 claim form. Use the PPV record form or the PPV roster as a record of the beneficiary information for those receiving the PPV. Include the name and health insurance claim number for each beneficiary. Use these forms only to report the PPV. Providers may make copies of the forms to submit to Medicare. 📎

CLAIMS FILING REQUIREMENTS

Please send the paper simplified billing claims to:

**Medicare Part B
Pneumococcal Special Claims
P.O. Box 660157
Dallas, TX 75266-0157**

Put **one** CMS-1500 claim form with each group of PPV record forms (up to 100) and group these together (e.g., rubber band, etc.). Put **one** CMS-1500 claim form with each five pneumococcal roster forms and group these together. A stamped “signature on file” is acceptable on a simplified claim to qualify as an actual signature if the provider has a signed authorization on file to bill Medicare for services rendered.

Note: When a provider accepts assignment, he may not collect any money from the beneficiary for the PPV. ❏

REIMBURSEMENT INFORMATION

The allowable for the pneumococcal (90732) vaccine is:

Procedure Code	Code Description	Dates of Service	Allowed Amount \$
90732©	Pneumococcal vaccine	Jan. 1, 2006 - March 31, 2006	24.57
		April 1, 2006 - June 30, 2006	27.03
		July 1, 2006 - Sept. 30, 2006	27.03

This is based on the Median Generic Price (MGP). As with all injectable drugs, the allowable is subject to change. See future newsletter article for updates.

The allowable fee for the administration (G0009) is based on the locality of the provider. A list of fees by locality for the administration is included below:

2006 Allowables for Procedure Code G0009

Locality	County	Amount \$
09	Brazoria County	18.35
11	Dallas County	19.38
15	Galveston County	18.12
18	Harris County	18.95
20	Jefferson County	17.04
28	Tarrant County	18.46
31	Travis County	19.10
99	Rest of State	17.04

Note: If your county is not listed specifically, then you are in Locality 99-Rest of State. ❏

COMPLETION OF THE PREPRINTED CMS-1500 CLAIM FORM FOR THE PPV

Providers must submit an original CMS-1500 claim form. Photocopies of the claim form are not acceptable. Medicare provides free preprinted forms to mass immunizers. Contact (866) 211-5708 for the forms and give the approximate number of injections anticipated. These forms will be mailed free of charge. The following are the completion instructions for the preprinted CMS-1500 claim form for the PPV:

- Item 21* Enter the diagnosis code V0382 for pneumococcal immunization.
Effective Oct. 1, 2006, providers should report diagnosis code V066 on claims for influenza virus and pneumococcal vaccines when the purpose of the visit is to receive both vaccines.
- Item 24d Enter the appropriate pneumococcal immunization procedure code.
- Item 24f Enter the charge for the individual dose and the individual administration charge. **Do not** enter the total for each patient.
- Item 25 Place the federal tax ID number in this block.
- Item 31 Enter the physician signature or that of an authorized person in this block. A signature stamp may be used.
- Item 32* Place the name and complete address including ZIP code of the facility where the services were furnished.
- Item 33 Place provider's name, address, telephone number and provider number in this block.

***Note:** This information must be entered on the claim for processing.

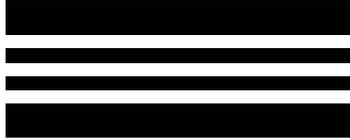
Warning:

- Ask beneficiaries if they have been vaccinated with PPV.
- Rely on the patient's memory to determine prior vaccination status.
- If the patient is uncertain whether he has been vaccinated within the past five years, administer the vaccine.
- If the patient is certain he has been vaccinated within the past five years, do not revaccinate.
- If the patient is certain he has been vaccinated and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk. ❏



SAMPLE PREPRINTED CLAIM FORM

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PICA **PNEUMOCOCCAL PNEUMONIA VACCINATION ONLY HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SEE ATTACHED FORMS		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ()	
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"/> 10d. RESERVED FOR LOCAL USE	
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 PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V03.82 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER			

PHYSICIAN OR SUPPLIER INFORMATION

24. A	DATE(S) OF SERVICE		B	C	D	E	F	G	H	I	J	K
	From	To										
1			60		G0009	1						
2			60		90732	1						
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____ \$ _____		29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ _____	
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 _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____			

COMPLETION OF THE PPV RECORD FORM

Complete each box as indicated.

Provider Identification Number	Enter the provider number issued by Provider Enrollment, or for physicians, enter your current Medicare provider number.
Patient's Medicare Health Insurance Claim Number	Enter the patient's HIC number exactly as it appears on the patient's Medicare card.
Patient's Name	Enter the last name, first name and middle initial (if known).
Patient's Date of Birth	Enter the birth date of the patient (if known).
Patient's Sex	Enter "M" for male or "F" for female.
Patient's Address	Enter the patient's address.
Patient's Signature	Have the patient sign the roster form or a relative or agent if the patient is unable to sign. A stamped "signature on file" is acceptable if the provider has a signed authorization on file to bill Medicare for services rendered.
Date Vaccine Administered	Enter the actual date the vaccine is administered.
	<i>Continue to complete the list for each patient.</i>
	Notice the warning on the form: Ask patients if they have been vaccinated with PPV.

Note: Mass immunizers may attach up to 100 PPV record forms to one CMS-1500 claim form. 



PNEUMOCOCCAL PNEUMONIA VACCINE RECORD

Warning: Ask patients if they have been vaccinated with PPV.

Provider Identification Number

Medicare Health Insurance Claim Form

Name

LAST

FIRST

M.I.

Birthdate

Sex

Address

STREET

CITY

COUNTY

STATE

ZIP

Date Vaccine Administered

I have read or have had explained to me the information in this pamphlet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Statement: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Signature

Date

For Clinic/Office Use

(Do not send to Medicare)

Clinic/Office Address _____

Date Vaccine Administered _____

Vaccine Manufacturer _____

Vaccine Lot Number _____

Site of Injection _____

Signature of Vaccine Administrator _____

Title of Vaccine Administrator _____

COMPLETION OF THE PPV ROSTER FORM FOR MASS IMMUNIZERS

The roster form is for 20 beneficiaries. Providers may bill for up to 100 beneficiaries by attaching five roster forms to one CMS-1500 claim form. Complete the form as follows:

Provider Identification Number	Enter the provider number issued by Provider Enrollment, or for physicians, enter your current Medicare provider number.
Patient's Medicare Health Insurance Claim Number	Enter the patient's HIC number exactly as it appears on the patient's Medicare card.
Patient's Sex	Enter "M" for male or "F" for female.
Patient's Date of Birth	Enter the birth date of the patient if known.
Patient's Name	Enter the patient's complete name, first, middle initial and last.
Patient's Address	Enter the patient's address.
Patient's Signature	Have the patient sign the roster form or a relative or agent if the patient is unable to sign. A stamped "signature on file" is acceptable if the provider has a signed authorization on file to bill Medicare for services rendered.
Date Vaccine Administered	Enter the actual date the vaccine is administered.
	<i>Continue to complete the list for each patient.</i>
	Notice the warning on the form: Ask patients if they have been vaccinated with PPV.

Note: Roster forms may be reproduced from this newsletter. 

PNEUMOCOCCAL PNEUMONIA VACCINE ROSTER FOR MASS IMMUNIZERS

Provider Identification Number _____

For Internal Medicare Use Only. Do not write in the shaded areas—

PLEASE TYPE OR PRINT CLEARLY **WARNING: ASK PATIENT IF THEY HAVE BEEN VACCINATED WITH PPV.**

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City St/ZIP	Patient's Signature and Date Vaccine Administered
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					
6. _____					
7. _____					
8. _____					
9. _____					
10. _____					

For Internal Medicare Use Only. Do not write in the shaded areas—

PLEASE TYPE OR PRINT CLEARLY

Patient's Medicare Health Insurance Claim Number (as shown on Medicare card)	Patient's Sex M or F	Patient's Date of Birth	Patient's Name First MI Last	Patient's Address Street City St/ZIP	Patient's Signature and Date Vaccine Administered
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					
6. _____					
7. _____					
8. _____					
9. _____					
10. _____					

Pro32 Claim Submission Software Request Form

I have read and understand the system requirements for the free Pro32 software, and have verified that my system meets the minimum equipment requirements to submit my claims electronically using the Pro32 software.

Medicare #(s): _____

Provider/Group Name: _____

Submitter Name (if not provider's office): _____

Address: _____

City: _____ State: _____ ZIP: _____

Office Phone: _____ Fax: _____

Contact Person: _____

Computer Type (brand): _____

Processor (check one): Pentium I Pentium II Pentium Pro Pentium III

Processor Speed (check one): 133 200 233 266 Other _____

Available Conventional Memory: _____

Available Extended Memory (XMS): _____

Available Disk Space: _____

Modem Type (Brand): _____ Baud Rate: _____

Communication Software: _____

On a Network (check one): Yes No

Pro32 Software is available on CD-ROM

Signature: _____ Date: _____



This bulletin must be shared with all health care practitioners and managerial members of the provider/supplier staff. Visit us on the Web at:

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Dallas, TX 75266-0156

The selection form is available online at the TrailBlazer Web site or by calling the Provider Feedback line at (866) 237-4482 for Texas providers or (866) 828-6264 for Mid-Atlantic providers.

Be sure to include your PIN, a return name and mailing address.



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