HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	LML000A36NL2	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY 08 31 57 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Frasier, William, I.		Frasier, William, I.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
111 Hollywood Blvd	Self [ ] Spouse [X] Child [ ] Other [ ]	111 Hollywood Blvd
CITY: Los Angeles STATE: CA	8. RESERVED FOR NUCC USE	CITY: Los Angeles STATE: CA
ZIP CODE: 90027 TELEPHONE (Include Area Code): (213) 974-3211		ZIP CODE: 90027 TELEPHONE (Include Area Code): (213) 974-3211
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
Frasier, Robin, M.		776892N8B3
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY 08 31 57 SEX M [X] F [ ]
LML000A69NM1	YES [ ] NO [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES [ ] NO [X]	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES [ ] NO [X]	Anthem Blue Cross
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
Anthem Blue Cross		YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 11 15 16 QUAL.	15. OTHER DATE QUAL. MM DD YY 11 01 16	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 11 15 16 TO 12 22 16
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Mark Schlumberg	17a. 17b. NPI 8681342735	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 15 16 TO 12 22 16
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES 33 60
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE 2134 ORIGINAL REF. NO. 45990393
A. 389.01 B. L15 C. 689.22 D. 671.45 E. 341.22 F. 322.98 G. 300.11 H. L10 I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 459302111

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	11	15	16	11	20	16	25	Y	100124	31	389.01	132.00	6		NPI	1245994810
2	11	21	16	11	29	16	25		100458	27	L15	233.80	9		NPI	4532678934
3	11	30	16	12	1	16	25		27386	43	689.22	71.33	2		NPI	4532678934
4	12	2	16	12	17	16	71	Y	35768	33 41 78	341.22	856.79	16		NPI	6745838283
5	12	18	16	12	20	16	71		37521		300.11	156.00	2		NPI	6743219033
6	12	21	16	12	22	16	71		37789	12 11 10 37	322.98	129.68	2		NPI	6743218399

25. FEDERAL TAX I.D. NUMBER SSN EIN: 890411657 [X]	26. PATIENT'S ACCOUNT NO. 5238	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 1604.20
29. AMOUNT PAID $ 123.71	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.) Jonathan Hall SIGNED 12/23/16 DATE	32. SERVICE FACILITY LOCATION INFORMATION UCLA Medical Center 757 Westwood Plaza Los Angeles, CA 90095 a. 6743218399 b.		33. BILLING PROVIDER INFO & PH # (310) 825-9111 UCLA Medical Center 757 Westwood Plaza Los Angeles, CA 90095 a. 6743218399 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form

Tracking # 87487

Contract Compliance:

Contract Review and Certification

I attest that this CSF, Contract(s)/Amendment(s) have been reviewed in full and the information is accurate and complete.

CONTRACTOR/NETWORK MANAGEMENT CONSULTANT/REPRESENTATIVE

Signature: Date: 10.10.16

DIRECTOR

I attest that the contract has been reviewed, and the information is accurate and complete.

Signature: Date: 10/11/2016

LEGAL DEPARTMENT

I have reviewed and approved the non-standard language used in this contract.

Signature: Date:

HEALTHCARE ANALYTICS

I have received and approved the fee schedule/rates.

Signature: Date:

REGIONAL VICE PRESIDENT

Signature: Date:

MEDICAL DIRECTOR (as necessary)

Signature: Date:

PROVIDER OPERATIONS (PO)

Date Routed to PO: October 14, 2016 **Date Received:**

Signature: Date:

Retroactive Effective Date? Y/N Approved? M R RA

Effective Date: Date Returned to CC

PROVIDER REIMBURSEMENT (PR)

Date Routed to PR: **Date Received:**

Signature: Date:

Date Loaded: Date Routed to PDO

Date Returned to CC:

PROVIDER DATABASE OPERATIONS (PDO)

Date Routed to PDO: October 19, 2016 **Date Received:**

Signature: Date:

Date Loaded: Date Routed to PDO

CONTRACT COMPLIANCE (CC)

Date Routed to CC: **Date Received:**

Signature: Date:

Common Submission Form

New Contract Or Amendment

(•) N/A ( ) This Is A New Contract ( ) This Is An Amendment

Tracking # 87487

CSF Purpose: Termination

☐ Priority Handling Requested

Tax ID: 582145629

A) Business Intent:

Discuss Business Intent

Demographic Change Only? ( ) YES (•) NO

Please terminate provider from Medical contracts only at location, 182 Jefferson Pkwy, Ste A, Newnan, GA 30263. The other locations have been completed previously. He is remaining active at the locations as NON PAR (load as IDNP) on the Medical side. Correspondence attached

B) Retroactivity:

Will this CSF result in retroactivity? (REQUIRED) (•) YES ( ) NO

* If this CSF is a New Contract or an Amendment, is it the result of a: (•) Not Result of Contract or Amendment ( ) Negotiation ( ) Quality Issue

* Responsible Party / Market	Network Management	* Retroactivity Reason	NM-Retro Changes due to Network management Submission Error <1k claims
Responsible Party / PO		* Retroactivity Effective Date:	3/10/2016

☑ Retro Adjustments Requested?

Estimated Dollar Amount of Adjustment:

Retroactivity Comments: csi # 12606 Retro ID 16206

☐ Interest Owed?

Date Issue Identified:

Prompt Pay Interest Comments: N/A

Image Number 1912929878

C) PDO Updates:

Are PDO Updates Required? (•) YES ( ) NO

Number of Individual Providers = 1

Number of QCare Records To Be Updated = 1

D) Completed By Information:

Name: Sonia Ferris **Start Date:** 10/10/2016 **Actual Date Rec'd:** 2/26/2016 **Phone:** (404) 842-8703

E) Provider Information:

QCare ID: **State License #:** **NPI #:** 1912929878

First Name: Vincent **Middle Initial:** J **Last Name/ Facility/Ancillary:** Perciaccante

Suffix: **Title:** DDS **Contact Name:** **Contact #:** **Ext.**

Contact E-mail: **Gender:**

DEA Number: **DEA Expiration Date:** **Medicare Number:**

Tracking # 87487

F) Group Information:

Tracking # 87487

Attention: | Provider Group Name:

☐ Group Agreement Applies | PHO Designation:

Blanket Agreement | ☐ Requires New Pricing Grid

☐ Are the Mid-Level Providers Included in this Agreement | ☐ Not Eligible To Reapply

G) Tax Information:

Tax ID:	582145629	Tax Name:	South OMS	NPI #:	1720274798
2nd Tax ID:		2nd Tax Name:		2nd NPI #:	

H) ProviderType:

Specialist

Provider Type Comments:

I) Location Information:

Address Type:	Physical	Address1:	406 Stevens Entry	Address2:			
City	Peachtree City	State:	GA	Zip:	30269	Market:	County:
Phone:		Fax:		☐	Primary		

Address Type:	Physical	Address1:	600 West Lanier Avve	Address2:	Suite 201		
City	Fayetteville	State:	GA	Zip:	30214	Market:	County:
Phone:		Fax:		☐	Primary		

Address Type:	Physical	Address1:	288 Hwy 314	Address2:			
City	Fayetteville	State:	GA	Zip:	30214	Market:	County:
Phone:		Fax:		☐	Primary		

Address Type:	Physical	Address1:	182 Jefferson Pkwy	Address2:	Suite A		
City	Newnan	State:	GA	Zip:	30263	Market:	County:
Phone:		Fax:		☐	Primary		

J) Covering Physician:

K) Specialty:

Specialty:	ORAL SURGERY	Board Status:		Age - Low:		Age - High:	
		Panel Size		Accepting New Patients			

Waiver Indicator | Waiver Update: ○ YES ◉ NO

Tracking # 87487

L) Hospital Privilege:

M) Language:

Staff Language:

Practictioner Language:

N) Contract Status:

☐ Credentialed Application CAQH Current Panel Size:

Date Sent to Andover Date Returned from Andover Credentialing Date Approved

O) Member Move:

Indicate where to move members if it is required

P) Billing/Contract Information :

Billing Format: CMS1500 Existing Contract ID:

Contract Status:

☐ Affiliated With An Existing Contract?

Q) Contract Type: (Professional/Facility/Ancillary)

Type	Network	ID Type	ID
Professional	PPO	SPEC	2842

Contract Dates

Effective	Termination	Expire
3/10/2016		

☐ Use Current Date -->>

☐ Is Contract Evergreen

☐ Regardless Of Billed
☐ Lesser Of Charges
☐ Site Of Service
☐ Drugs Reimbursed at Corporate Methodology
☐ If Capitated, Over & Above

Blanket Agreement

Effective Date	Termination Date

☐ Medicare Based Fee Year ☐ RBRVS

☐ Update With Medicare A1 % A2 %

Timeliness Of Filing 180 Days

Termination Reason:

Type	Network	ID Type	ID
Professional	Traditional (PAR)	SPEC	3400

Contract Dates

Effective	Termination	Expire
3/10/2016		

☐ Use Current Date -->>

☐ Is Contract Evergreen

☐ Regardless Of Billed
☐ Lesser Of Charges
☐ Site Of Service
☐ Drugs Reimbursed at Corporate Methodology
☐ If Capitated, Over & Above

Blanket Agreement

Effective Date	Termination Date

☐ Medicare Based Fee Year ☐ RBRVS

☐ Update With Medicare A1 % A2 %

Timeliness Of Filing 365 Days

Termination Reason:

Tracking # 87487

Contract Other Comments

	IRF	NST / GNT	Pricing Code
Medicare Advantage-HMO-Facility			
Medicare Advantage-HMO-Professional			
Medicare Advantage-PPO-Facility			
Medicare Advantage-PPO-Professional			
Medicare Advantage-HMO-Facility-2			
Medicare Advantage-HMO-Professional-2			
Medicare Advantage-PPO-Facility-2			
Medicare Advantage-PPO-Professional-2			

R) Contract Language:

Contract Language: Standard

☐ Red Line Attached

Contract Language Comments

Specify contract intent if Non-Standard:

S) Contract Reimbursement:

Date Fee Schedule Requested From HCA

Discuss intent of reimbursement structure if Non-Standard:

Chargemaster Adjustment Comments

- ☐ Do reimbursement terms change mid-contract
- ☐ Automatic Rate Increase
- ☐ Index Adjustment
- ☐ Chargemaster Adjustment
- ☐ Change in Capitation Reporting Requirements
- ☐ Includes withhold on risk pool
- ☐ Does this contract qualify as an INC under the terms of the Managed Care Settlement
- ☐ Custom Reimbursement (higher than region standard)
- ☐ Termination Not For Cause (Other than 120 days)
- ☐ Fee Schedule can be reduced more than once per year
- ☐ Non-Standard reimbursement for Vaccines/Injectibles

Default Pricing

PA Exceptions

Add Provider

Add Tax ID

Tax Effective Date

Reason for Additional Tax ID

Change Tax ID

Reason for Tax ID change

Should the CURRENT Tax Affiliation be terminated? (Applies only if the Tax info is changing)

Add Other

Change Other

T) Special Instructions:

Comments

Tracking # 87487

☑ Submitted Date Submitted: 10/10/2016 3:14:31 PM

Ferris, Sonia

From: Lawrence, Deborah
Sent: Friday, October 14, 2016 2:27 PM
To: Sood, Pawan; Ferris, Sonia
Subject: Retro 16206 Approvals Complete

Retro 16206 approvals are complete.

Provider: Vincent Perciaccante, Vincent Perciaccante
Anthem Id(s): NA
Contract Manager: Ferris, Sonia
Provider Type: Professional
Market: Georgia
Business Unit:
Impact (Estimated claims): 100
Name of Requestor: Ferris, Sonia

Type: Request
Reason: PS-Retro Changes due to Network Management Submission Error =<1K Claims

View Retro Details

Xerox WC 7545 **Microsoft Outlook - Memo Style** Fri Oct 14 15:22:57 2016 **Media Type:** Default **Color:** Gray **Print Quality:** Standard
Color Adjustments: Customized Automatic Setup

CSF # 87487

Georgia Provider Solutions CSF Verification List

Question #	Question	Response		Additional Instructions
#1	Did you include the CSF Purpose?	YES	N/A	
#2	Did you include the applicable Tax Id(s)?	YES	N/A	If this update applies to multiple tax id's, please indicate multiple and use the special instructions field to indicate what documentation is provided to indicate the tax ids; i.e. a spreadsheet or roster.
#3	Has the Business Intent been completed?	YES	N/A	
#4	Is this a retro?	YES	N/A	If N/A, skip to Question #11
#5	Do you have a signed LOA?	YES	N/A	
#6	Does the end date on your LOA meet the processing time requirements?	YES	N/A	
#7	Does your retro require adjustments?	YES	N/A	
#8	Did you include the retro # and copy of approval?	YES	N/A	
#9	Did you include the retro reason?	YES	N/A	
#10	Did you include the prompt pay form?	YES	N/A	
#11	Did you include the Image/File Net Number?	YES	N/A	
#12	Did you indicate if PDO updates are required?	YES	N/A	
#13	Did you indicate the number of individual providers and records to be updated?	YES	N/A	
#14	Have you included the name of the Provider (First and Last) or the name of the Group/Facility?	YES	N/A	
#15	Did you include the NPI?	YES	N/A	
#16	Is this a group agreement?	YES	N/A	
#17	Does PHO designation apply?	YES	N/A	
#18	Does your Agreement/Amendment include mid-level providers?	YES	N/A	
#19	Should a center record be created?	YES	N/A	
#20	Did you include the provider's telephone number?	YES	N/A	
#21	Have you included the Tax name of the Provider, Group or Facility?	YES	N/A	
#22	Have you included the Tax NPI for the Provider, Group or Facility?	YES	N/A	
#23	Did you indicate the Provider type?	YES	N/A	
#24	Did you include all applicable physical and mailing locations?	YES	N/A	
#25	Did you include the Specialty?	YES	N/A	
#26	Did you include the Credentialing sheet or Non-Cred application (applies to new providers)?	YES	N/A	
#28	Did you indicate the Contract type?	YES	N/A	

Question #	Question	Response		Additional Instructions
#29	Did you indicate all applicable Networks and the Contract ID for each Network?	YES	N/A	
#30	Did you indicate effective date?	YES	N/A	
#31	Is this an individually Negotiated Contract?	YES	N/A	If N/A, skip to #46
#32	Does Lesser of Language Apply?	YES	N/A	
#33	Does Site of Service Language Apply?	YES	N/A	
#34	Are Drugs reimbursed at Corporate Methodology?	YES	N/A	
#35	Is this a Medicare Based Fee? What Year?	YES	N/A	
#36	If not priced by Medicare, is the fee based on RBRVS (Resource Based Relative Value Schedule)?	YES	N/A	
#37	Did you include the Medicare Rate Sheet?	YES	N/A	
#38	Did you include the Medicare Advantage GNT(s)	YES	N/A	
#39	Did you include the Medicare Advantage IRF(s)	YES	N/A	
#40	Does Lab Pricing apply (applies only to HMO)?	YES	N/A	
#41	Does the Statewide In office lab list apply (applies only to HMO)?	YES	N/A	
#42	Did you include the Reimbursement Attachment/Rate Sheet?	YES	N/A	
#43	Did you include a Fee Schedule [for new contract or newly negotiated contract; if there are more than 20 codes]	YES	N/A	
#44	Did you include the QHIP Scorecard (only for QHIP rate increases)	YES	N/A	
#45	If the Contract has to be built, is the effective date more than 25 days from current date? (if not it is a retro)	YES	N/A	
#46	Did you indicate TOF for all Networks?	YES	N/A	
#47	Does this request include Medicare? Did you provide the Medicare Advantage Contract Code?	YES	N/A	
#48	Do you have Special Instructions? If so, they should be aligned to the Business Intent.	YES	N/A	
#49	Is Network Management Director Signature Required?	YES	N/A	
#50	Is Healthcare Analytics Signature required?	YES	N/A	
#51	Is Legal's Signature required?	YES	N/A	
#52	Did you include the signed Contract or Amendment?	YES	N/A	
#53	Did you include the PCS (Plan Compensation Schedule) and PCS Attachment?	YES	N/A	
#54	Should this CSF go to Contract Compliance?	YES	N/A	

Completed By: SONIA FERRIS

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LML000A69NM1	YES [ ] NO [X]	
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	YES [ ] NO [X]	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
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