Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

## Health and Recovery Services Administration


# Medical Nutrition Therapy

**(Formerly known as Nutritional Counseling Services)**

**Billing Instructions**

**WAC 388-550-6300**

# About this publication

This publication incorporates the previous *Medical Nutrition Therapy Billing Instructions*.

Published in coordination with Washington State's:

Health and Recovery Services Administration
Department of Social and Health Services
**AND**
Maternal and Infant Health
Department of Health

**Note:** The effective date and publication date for any particular page of this document may be found at the bottom of the page.

# Copyright Disclosure



# HRSA's Billing Instructions and Numbered Memoranda

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

# Table of Contents

# Table of Contents (cont.)

# Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs.

## How can I use the Internet to…

### Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

Click ***Sign up to be a DSHS WA state Medicaid provider*** and follow the on-screen instructions.

### Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

- Click ***Sign up to be a DSHS WA state Medicaid provider***
- Click ***I want to sign up as a DSHS Washington State Medical provider***
- Click ***What happens once I return my application?***

### Submit a change of address or ownership?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***I want to make a change to my provider information***

### Payments, denials, claims processing, or HRSA managed care organizations?

Visit the Customer Service Center for Providers at:
http://maa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***Frequently Asked Questions***

or call/fax:
800.562.3022, Option 2 (toll free)
360.725.2144 (fax)

or write to:
HRSA Customer Service Center
PO Box 45562
Olympia, WA 98504-5562

## If I don't have access to the Internet, how do I find information on…

### Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (toll free)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

**If I don't have access to the Internet, how do I find information on… (cont.)**

**Private insurance or third-party liability, other than HRSA managed care?**

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

**How do I find out about Internet billing (electronic claims submission)?**

Visit:
WinASAP and WAMedWeb:
http://www.acs-gcro.com

Click ***Medicaid*** then ***Washington State***.

All other HIPAA transactions:
https://wamedweb.acs-inc.com

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:
http://www.acs-gcro.com

Click ***Medicaid***, then ***Washington State***, then ***Enrollment***.

or call ACS EDI Gateway, Inc. at:
800.833.2051 (toll free)
After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 800.833.2051.

**How do I check on a client's eligibility status?**

Call ACS at:
800.833.2051 (toll free)

or call HRSA at:
800.562.3022 (toll free) and choose option #2

You may also access the WAMedWeb Online Tutorial at:
http://maa.dshs.wa.gov/wamedwebtutor

**Where do I send paper claims?**

Claims Processing
PO Box 9248
Olympia WA 98507-9248

**How do I obtain copies of billing instructions or numbered memoranda?**

To view an electronic copy, visit:
http://hrsa.dshs.wa.gov

Click ***Billing Instructions/Numbered Memoranda***

## How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:
Phone: 360.664.6047
Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

**This page intentionally left blank.**

# Definitions & Abbreviations

**This section defines terms and abbreviations (includes acronyms) used in these billing instructions. Please refer to HRSA's *General Information Booklet* for other definitions.**

**Certified Dietitian** – Certified dietitians in Washington State are:

- Dietitians or nutritionists who:
  - ✓ Have met the national educational standards of the American Dietetic Association;
  - ✓ Are designated as a Registered Dietitian; and
  - ✓ Have met additional specific health education requirements of the Washington State Department of Health, Division of Licensing;

**Note:** Registered Dieticians licensed in the State of Oregon may be assigned an HRSA-Certified Dietician provider number.

- Recognized by the medical profession as legitimate providers of nutrition care; and
- Healthcare professionals who translate scientific information about nutrition and diet into relevant terms for individuals.

**Client** – An applicant for, or recipient of, a DSHS medical care program.

**Code of Federal Regulations (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office(s) (CSO)** - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

**Core Provider Agreement** - A basic contract that the [DSHS] Health and Recovery Services Administration (HRSA) holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation with Medical Assistance.

**Department** - The state Department of Social and Health Services. (WAC 388-500-0005)

**Early and Periodic Screening, Diagnosis, and Treatment ( EPSDT)** - A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. (WAC 388-500-0005)

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Health and Recovery Services Administration (HRSA)** - The administration within the Department of Social and Health Services (DSHS) responsible for providing disability determinations, medical care, mental health, and alcohol/substance abuse treatment services for Washington State's most vulnerable citizens.

**Healthy Options -** The name of the Washington State Health and Recovery Services Administration's managed care program.

**Managed Care** - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

**Maximum Allowable -** The maximum dollar amount that a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

**Medicaid -** The state and federally-funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Identification Card(s)** – The document HRSA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

**Medically Necessary** - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

**Medical Nutrition**– The use of medical nutritionals (formulas) alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet their nutritional requirements. Medical nutritionals can be given orally or via feeding tubes.

**Medical Nutrition Therapy** - A face-to-face interaction between the certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

**Medical Nutritionals** – The medical products used when providing Medical Nutrition.

**Nutritional Counseling** – See Medical Nutrition Therapy.

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each HRSA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

**Primary Care Case Management (PCCM)** The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services (WAC 388-538-050)

**Primary Care Provider (PCP)** – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. (WAC 388-538-050)

**Provider or Provider of Service -** An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

**Remittance And Status Report (RA) -** A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

**Revised Code of Washington (RCW) -** Washington State laws.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

**Title XIX** - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

**Usual and Customary Fee –** The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

**Washington Administrative Code (WAC) -** Codified rules of the state of Washington.

**Women, Infant, and Children (WIC) Program** - The United States Department of Agriculture Special Supplemental Nutrition Program for Women, Infants and Children (WIC) administered by the Department of Health. Direct client services are delivered by contracted local providers. WIC provides nutrition screening, nutrition education, breastfeeding promotion, health and social service referrals, and nutritious foods to pregnant, breastfeeding and postpartum women, infants, and children through the end of the month they turn 5 years of age. To be eligible, WIC clients must have:

- A nutrition-related health risk; and
- Income at or below 185% of the Federal Poverty Level (FPL) or be enrolled in Medicaid, Food Stamps, or Temporary Assistance for Needy Families (TANF) programs.

# About the Program

## What is the purpose of the Medical Nutrition Therapy Program?

The purpose of the Medical Nutrition Therapy Program (formerly known as Nutritional Counseling Services) is to ensure that clients have access to, and providers are reimbursed for, outpatient Medical Nutrition Therapy when:

- Medically necessary;
- Provided by a certified dietitian with an HRSA provider number; and
- Provided to HRSA-eligible clients who are 20 years of age and younger with an EPSDT referral.

**This page intentionally left blank.**

# Client Eligibility

## Who is eligible?

Medical nutrition therapy is available to Medicaid-eligible clients who meet all of the following criteria:

- Referred by an EPSDT provider;
- 20 years of age and younger; and
- Present their current Medical Identification card with one of the following identifiers:

| Medical Program Identifier | Medical Program |
|---|---|
| **CNP** | Categorically Needy Program |
| **CNP**<br>**Emergency Medical Only** | Categorically Needy Program – Emergency Medical Only – *(only when the service is related to the emergent medical condition)* |
| **CNP**<br>**Children's Health** | Categorically Needy Program - Children's Health |
| **CNP**<br>**CHIP** | Categorically Needy Program - Children's Health Insurance Program |

## Are clients enrolled in a Healthy Options managed care plan eligible for medical nutrition therapy?

Healthy Options managed care plans cover medical nutrition therapy when the client's Primary Care Provider (PCP) determines that medical nutrition therapy is medically necessary and writes a referral. The certified dietitian needs to be contracted with the Healthy Options plan and follow the plan's procedures for authorizations, referrals, and reimbursement.

**Note:** Send all claims for services covered under the client's managed care plan to that plan for payment. To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or managed care plan.

**This page intentionally left blank.**

# Provider Requirements

## Which provider types may be reimbursed for medical nutrition therapy provided by a certified dietitian?

HRSA reimburses the following provider types when medical nutrition therapy is provided by certified dietitians to HRSA-eligible clients following provider types:

- Advanced Registered Nurse Practitioners (ARNP);
- Certified Dietitians;
- Durable Medical Equipment (DME)
- Health Departments;
- Outpatient Hospitals; and
- Physicians.

**Note:** When billing HRSA, the certified dietitian's provider number must be entered:

- In field #33 (PIN) and NPI number in #33bon the **1500 claim form** or;
- In the Attending Physician's I.D. form locator on the **UB-04 claim form** (see Section G.)

**Do not bill Medical Nutrition Therapy and nondietition professional services together on the same claim form. These services must be billed separately.**

## When may providers bill HRSA for medical nutrition therapy provided in WIC program locations?

Providers may bill HRSA for medical nutrition therapy provided in WIC program locations when the medical nutrition therapy is:

- Provided by a certified dietitian who has an HRSA provider number; and
- Not a WIC service and therefore is not documented or funded as a WIC service.

# Who can refer a client for medical nutrition therapy?

EPSDT providers may refer a client to a certified dietitian for medical nutrition therapy if there is a medical need for nutritional services. Information concerning the medical need and the referral must be documented in the client's chart.

# What are the responsibilities of the certified dietitian regarding the referral?

The certified dietitian must:

- Obtain all medical information necessary to do a comprehensive nutritional assessment; and

- Keep the primary medical care provider apprised of the assessment, prognosis, and progress of the client.

**Note:** When billing HRSA:
- The referring provider's name must be entered in field 17; and
- The HRSA provider number in field 17a and referring provider number in field 17b on the 1500 claim form; or
- In the appropriate form locator on the UB-04 claim form (see Section G).

# What are the appropriate conditions for referral?

HRSA covers medical nutrition therapy when ***medically necessary***. Medical conditions that can be referred to a certified dietitian include, but are not limited to, the following:

**Inadequate or Excessive Growth** - e.g., failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile.

**Inadequate Dietary Intake** - e.g., formula intolerance, food allergy, limited variety of foods, limited food resources, poor appetite.

**Infant Feeding Problems** - e.g., poor suck/swallow, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, limited information and/or skills of caregiver.

**Chronic Disease Requiring Nutritional Intervention** - e.g., congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, gastrointestinal disease.

**Medical Condition Requiring Nutritional Intervention** - e.g., iron-deficiency anemia, familial hyperlipidemia, pregnancy.

**Developmental Disability** – e.g., increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, tube feedings.

**Psycho-Social Factors** - e.g., behaviors suggesting eating disorders. Clients with eating disorders should also be referred to the Division of Mental Health or its representatives (e.g., Regional Support Network) for treatment.

**Obesity** – Use diagnosis codes 278.00, 278.01 or 278.02 on your claim.

**Note: The following Information for certified dieticians** when billing for clients (generally adults) who are completing the approval process for bariatric surgery:

Clients receive an approval letter with an authorization number for dietician visits; four units for the initial visit (97802) and two units for subsequent visits twice a month for 6 months (97803.) You must bill with the authorization number on the claim. If you have questions about the authorization number and the span of dates approved, call 1-800-562-3022 option 2. For dietitian visits billed in the outpatient setting, use the appropriate revenue code, however do not use revenue code 942 which is used only for diabetic education only.

**This page intentionally left blank.**

# Coverage/Fee Schedule

## What is covered?

HRSA covers the procedure codes listed below.

| Procedure Code | Brief Description | Policy/Limits |
|---|---|---|
| 97802 | Medical nutrition, indiv, initial | 1 unit=15 minutes<br>Maximum of 2 hours (8 units) per year |
| 97803 | Med nutrition, indiv, subseq | 1 unit=15 minutes<br>Maximum of 1 hour (4 units) per day |
| 97804 | Medical nutrition, group | 1 unit=15 minutes<br>Maximum of 1 hour (4 units) per day |

## Fee Schedule

You may view HRSA's Medical Nutrition Therapy Fee Schedule on-line at:
http://maa.dshs.wa.gov/RBRVS/Index.html

**This page intentionally left blank.**

# Billing

**Note:** HRSA will not reimburse for medical nutrition therapy services when billed on the same claim as nondietitian professional services.

**Do not bill a physician office call and a Medical Nutrition Therapy and visit together on the same claim form. These services must be billed separately.**

## What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

**Eligibility Established After Date of Service but Within the Same Month -** If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

- ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

- **Resubmitted Claims**

  - ✓ Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

**Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the designated time periods listed above.

- The designated time periods do not apply to overpayments that the provider must refund to DSHS. After the designated time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument, such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ HRSA does not pay the claim. **(See WAC 388-502-0160 for more information.)**

# What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

# How do I bill for services provided to PCCM clients?

For clients who have chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." The PCCM is responsible for coordination of care including the referral for medical nutrition therapy services. Please refer to the client's Medical ID card for the PCCM.

> **Note:** To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCCM.

When billing for services provided to Primary Care Case Management (PCCM) clients:

- Enter the referring physician or PCCM name in field 17 and referring provider's number in field 17b on the 1500 claim form or the Other Physician's I.D. form locator on the UB-04 claim form (see Section G); and

- Enter the seven-digit HRSA provider number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a on the 1500 claim form or the Other Physician's I.D. form locator on the UB-04 claim form (see Section G) when you bill HRSA, the claim will be denied.

- All services should be billed to HRSA.

> **Note:** Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborns.

# What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.**

# What additional records must be kept when providing medical nutrition therapy?

Enrolled providers must keep a copy of:

- Documentation that the WIC program is unable to provide all or part of the medically necessary medical nutritionals (formula);
- The referral from the EPSDT provider;
- The comprehensive medical nutrition therapy evaluation;
- Any correspondence with the referring provider; and
- Information concerning the medical need and the referral must be documented in the client's file.

# What additional information should be included in the

# medical nutrition evaluation when clients are receiving medical nutritionals that are reimbursed by HRSA?

Include determination and documentation of the following:

- The amount of oral and/or enteral nutrition required; and
- The reason why traditional foods alone will not meet an individual's nutritional requirements.

* See the current edition of HRSA's **Enteral Nutrition Billing Instructions** for a list of criteria and modifiers.

**This page intentionally left blank.**

# Completing the 1500 Claim Form

**Attention! HRSA now accepts the new 1500 Claim Form.**

- **On November 1, 2006,** the HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

**Note: HRSA encourages providers to make use of electronic billing options.** For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's web site at: http://maa.dshs.wa.gov (click ***Billing Instructions/Numbered Memoranda***, ***Accept*** the agreement, and then click ***Billing Instructions***). You may also request a paper copy from the Department of Printing (see Important Contacts section).

## Instructions Specific to Medical Nutrition Therapy Providers

The following 1500 Claim Form instructions relate to Medical Nutrition Therapy:

| Field No. | Name | Entry |
|---|---|---|
| 24B | Place of Service | Use the appropriate code(s):<br><br>**Code Number** — **To Be Used For**<br>2 — Outpatient Hospital<br>3 — Office<br>4 — Home |
| 24G | Days or Units | Enter:<br><br>• 97802, not more than 8 units per year.<br>• 97803, not more than 4 units per day.<br>• 97804, not more than 2 units per day. |

**This page intentionally left blank.**

# UB-04 Claim Form

**Attention! HRSA accepts only the new UB-04 Claim Form.**

- **On March 1, 2007**, HRSA began accepting both the new UB-04 and the old UB-92 claim forms.
- **As of May 23, 2007**, HRSA accepts only the new UB-04 claims form. HRSA will return all claims submitted on the UB-92 claim forms.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.

For more information, read # Memorandum 06-84.

**This page intentionally left blank.**