4.4. Use of Other Medicare Advantage PPO Preferred Providers. Except for Emergency Services, by a Member's specific request or the unavailability of a Medicare Advantage PPO Preferred Provider, Provider shall direct Members as needed for additional health care services to, and when ordering drugs and medical items or supplies for Members, Provider shall use, only other Medicare Advantage PPO Preferred Providers. Provider shall document in the Member's records any and all reasons why a Member was directed by Provider to a non-Medicare Advantage PPO Preferred Provider, and shall inform the Member that there may be additional costs to the Member resulting from such direction.

4.5. Guidelines, Policies and Procedures. In performance of his or her responsibilities under this Amendment, Provider agrees to comply with Highmark WV's guidelines, instructions and policies and procedures, as in effect from time to time and about which Provider receives notice, and the terms of any and all applicable Evidences of Coverage as heretofore or hereafter adopted or entered into by Highmark WV each of which are incorporated into this Amendment by reference. If Provider fails to comply with any applicable policies, procedures, guidelines, billing or other instructions, or other requirements, Highmark WV shall have the right in appropriate circumstances to pursue remedial actions as appropriate including, but not limited to, rejection of claims and/or review of claims on a retrospective basis and collection of any Overpayments. In such event, Provider will hold Highmark WV and the Member harmless with respect to fees and/or charges for Provider Services, except for the collection of applicable Copayments, Coinsurance and Deductibles.

4.6. Medical, Quality Improvement and Utilization Management Policies and Programs. Provider agrees to participate in, cooperate and comply with, and abide by decisions of Highmark WV with respect to Highmark WV's medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review. Provider further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider Services for Members.

Highmark WV agrees to consult with Medicare Advantage PPO Preferred Providers such as participating physicians and other health care professionals regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines:

a. are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

b. consider the needs of the enrolled population;

c. are developed in consultation with participating physicians;

d. are reviewed and updated periodically; and

e. are communicated to Medicare Advantage PPO Preferred Providers and, as appropriate, to Members.

Highmark WV also agrees to ensure that decisions with respect to utilization management, Member education, coverage of services, and other applicable areas are consistent with the guidelines.

4.7. Prohibition of Fees For Directing Members. Provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for (a) directing a Member to another provider or (b) furnishing services to a Member directed to him or her by another provider.

4.8. Reporting to CMS. Provider shall provide to Highmark WV all data and information in Provider's possession, to the extent applicable and as necessary, for Highmark WV to meet its data reporting and submission obligations to CMS. Such information includes, but is not limited to, the following:

a. any data necessary to characterize the context and purposes of each encounter between a Member and Provider;

c. any information necessary for CMS to administer and evaluate the program; as requested by Highmark WV, any information necessary (i) to show establishment and facilitation of a process for current and prospective Members to exercise choice in obtaining Covered Services; (ii) to report disenrollment rates of Members enrolled in Highmark WV for the previous two years; (iii) to report Member satisfaction; and (iv) to report health outcomes;

d. any information and data necessary for Highmark WV to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies; and

e. any data necessary for Highmark WV to meet its reporting obligations under 42 C.F.R. § 422.516 and 42 C.F.R. § 422.257.

Further, Provider shall certify the accuracy, completeness and truthfulness of Provider generated encounter data that Highmark WV is obligated to submit to CMS.

5. PAYMENT AND BILLING

5.1. Payment. Subject to the limitations in this Section 5, Highmark WV agrees to pay Provider for Provider Services provided to eligible Members and determined to be Covered Services the lesser of: (a) payment due in accordance with Highmark WV's payment schedule(s) as applicable to Medicare Advantage PPO Program(s) and as currently in effect at the time Provider Services are rendered or (b) one hundred percent (100%) of Provider's Usual Charges. Such limitation will be calculated on a claim-by-claim basis.

All payments shall be subject to all payment terms and conditions set forth in this Section 5. In addition, all payments shall be subject to and net of applicable Copayments, Coinsurance and Deductibles. Further, all payments shall be subject to the terms of the Member's Evidence of Coverage or plan requirements, as well as to all applicable Highmark WV policies, procedures and reimbursement guidelines, as well as Medical Necessity and Appropriateness determinations, Highmark WV medical policies and, where applicable, Medicare guidelines.

5.2. Review and Adjustments to Payment Schedules. Highmark WV may review and adjust, in its sole discretion and from time to time during the Term, the payment schedule(s). Highmark WV will make payment schedules or summaries thereof and any changes thereto available by mailing notice, posting on its internet site or by other readily accessible means, and will further provide samplings of payment allowances applicable to Provider upon request.

5.3. Payment Data/Billing. Provider will submit encounter, claim and/or certain clinical data to Highmark WV or, as appropriate, to other providers, using such forms, media, format and coding structures as may from time to time be acceptable to and required by Highmark WV. Billings shall include all patient identification information and itemization of Provider Services in a standardized format acceptable to Highmark WV. Information identifying Provider Services provided to Members shall include standard references (CPT-4, HCPCS, ICD-9-CM or their successors) or such other more specific references as may be established

and required by Highmark WV. In unusual cases, a description of a Provider Service, a copy of the Member's records, or other appropriate documentation should be submitted. Over the Term of this Amendment, Medicare Advantage PPO Preferred Provider billing instructions will be issued periodically and made available to Provider to update and clarify the billing requirements of Highmark WV.

Provider shall be fully and completely responsible for all statements made on any claim form submitted to Highmark WV with respect to such services, regardless of the mode of execution or verification of such report that may be accepted by Highmark WV. If Provider misreports services to Highmark WV, Provider shall immediately notify Highmark WV in writing of such misreporting and shall be responsible for reimbursing Highmark WV for all payments which were caused by such misreporting.

5.4. Member Hold Harmless and Continuation of Benefits. Except for Copayments, Coinsurances and Deductibles, Provider shall look only to Highmark WV for the payment of Covered Services rendered to Members. In no event, including, but not limited to, nonpayment by Highmark WV, insolvency of Highmark WV or breach of this Amendment by Highmark WV or Provider, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against Member or any persons acting on Member's behalf for Covered Services provided pursuant to this Amendment. This does not prohibit the collection of Copayments, Coinsurance and Deductibles from Members, as set forth in the Evidence of Coverage. Provider agrees that in the event of Highmark WV's insolvency or other cessation of operations, benefits to Members will continue through the period for which a premium has been paid, and benefits to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their discharge. Provider further agrees that:

a. these provisions shall survive the termination of this Amendment, regardless of the cause giving rise to the termination, including, without limitation, insolvency of Highmark WV, and shall be construed for the benefit of Members; and

b. these provisions shall supersede any oral or written contrary agreement now in existence or hereafter entered into between Provider and Members or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions hereof.

5.5. Copayments, Coinsurance and Deductibles. Provider will collect Copayments, Coinsurance and Deductibles as required by the Member's Evidence of Coverage except where such collection is prohibited or restricted by applicable Laws, and Highmark WV will reduce its payment for Covered Services to Provider by such amounts. Highmark WV will provide the necessary information to Provider so that Provider can collect the appropriate Copayments, Coinsurance and Deductibles from Member. Highmark WV shall have no responsibility for the collection of any Copayment, Coinsurance and Deductibles required by any Member's Evidence of Coverage.

5.6. Restrictions on Collection of Payment. Provider shall not collect charges from Members for Covered Services, with the exception of applicable Copayments, prior to receipt of claims disposition from Highmark WV. Further, Provider shall not bill or collect from a Member or Highmark WV charges itemized and distinguished from the Provider Services provided. Such charges include, but are not limited to, insurance surcharges, charges for overhead fees or facility fees, or fees for completing claim or other forms or submitting additional information to persons requested by Member or Highmark WV.

5.7. Prompt Payment. Highmark WV agrees to promptly pay Provider for Clean Claims submitted

for Covered Services within thirty (30) days after receipt of an electronic Clean Claim, and forty (40) days after receipt of a manually submitted Clean Claim. If Provider has any questions or concerns regarding a submitted claim, including, but not limited to, whether the claim is a Clean Claim or why the submitted claim has not been paid, Provider hereby agrees to contact Highmark WV regarding such questions and concerns.

5.8. Timely Filing. All claim forms for Provider Services performed for Members shall be submitted as soon as possible, but in no event later than three hundred sixty-five (365) days after the date of service. Fees and/or charges for Provider Services rejected as being over the applicable time limit shall not be collected from the Member.

5.9. Assignability of Accounts Receivables. Provider may assign his or her rights to payment for Covered Services performed for Members only in accordance with such procedure as Highmark WV may prescribe.

5.10. Overpayments. If Provider receives an Overpayment, Highmark WV shall be entitled to setoff any such Overpayment against any future payments due Provider and/or take any other action against Provider authorized under this Amendment or as otherwise permitted by Law or the Agreement. If no future payments are due to Provider, Provider shall reimburse Highmark WV an amount equal to such Overpayment within thirty (30) days of demand by Highmark WV. Provider shall report the receipt of any Overpayment it receives from Highmark WV as soon as practicable after learning of such Overpayment.

The above provisions will survive the expiration or earlier termination of this Amendment regardless of the reason.

5.11. Coordination of Benefits. If a Member's Evidence of Coverage contains a provision requiring coordination of benefits or non-duplication of benefits, Highmark WV will determine, in accordance with the terms of the Member's Evidence of Coverage, whether Highmark WV's liability for payment to Provider will be either primary or secondary. Payment to Provider will be made under the terms of the Member's Evidence of Coverage. Should the Member's Evidence of Coverage not provide for coordination of benefits or non-duplication of benefits, Provider will accept Highmark WV's payments made in accordance with the terms of this Amendment in full satisfaction for Covered Services. Provider will collect and provide to Highmark WV other payor information as requested.

5.12. Subrogation. Provider will cooperate with Highmark WV in efforts to pursue subrogation claims against others where recognized Law or contractual standards indicate that a person or entity other than Highmark WV has primary responsibility for payment.

6. DATA, RECORDS, REVIEWS AND AUDITS

6.1. Records System. Provider will maintain in a current, detailed, comprehensive, accurate and timely manner an adequate system for the collection, processing, maintenance, storage, retrieval and distribution of administrative, medical and financial records of all Provider Services rendered by Provider and his or her Auxiliary Personnel to Members. Provider agrees to maintain records, documents and any other information relating to Members and this Amendment for ten (10) years or such longer period as required by Law. With respect to each Member receiving Provider Services, Provider will maintain a single standard medical record in such form containing such information as required by all applicable Laws that govern his or her operations and the performance of this Amendment.

Provider agrees to (a) abide by all federal and state Laws regarding confidentiality and disclosure for medical records, other health information, and patient information; (b) protect

and maintain the confidentiality of all information and records relative to Members; (c) safeguard the privacy of any information that identifies a particular Member in compliance with all applicable Laws and Highmark WV policies and procedures governing the use and disclosure of such information and records; and (d) abide by all confidentiality requirements established by Highmark WV and the Medicare Advantage PPO Program requirements. Provider will ensure timely access by Members to the records and information that pertain to them and not disclose such information to any third party without the consent of the Member, except for dissemination as further described in this Section 6. In all such cases, information from, or copies of, records may be released only to authorized individuals. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state Laws, court orders or subpoenas.

6.2. Protected Member Information. All Protected Member Information is subject to various statutory privacy standards, including, without limitation, the regulations of the HIPAA Privacy Rule. Provider shall treat all such information in accordance with those standards, and shall use or disclose Protected Member Information only for the purposes stated in this Amendment or to comply with judicial process or any applicable Law.

Provider further agrees that Provider will adopt such policies and procedures, will execute or has executed such written agreements, and will provide or has provided such further assurances as required to make Provider's activities under this Amendment compliant on or before the final compliance date of any regulations of the Department of Health and Human Services adopted pursuant to HIPAA, including, without limitation, the following:

Business Associate Agreements	45 C.F.R. §164.504(e);
Information Safeguards	45 C.F.R. §164.530(c);
Standard Transactions	45 C.F.R. Part 162; and
Data Security	45 C.F.R. Part 164.

If the regulations adopted pursuant to HIPAA are modified in any way that affects the terms of this Amendment, this Amendment or Provider's obligations hereunder or thereunder, Provider agrees to adopt such policies and procedures, execute such written agreements and provide such further assurances as may be required to make Provider's activities under this Amendment compliant on or before the final compliance date of any such modifications.

The parties agree that all communications between Provider and Highmark WV that are required to meet the Standards for Electronic Transactions, as defined and set forth at 45 C.F.R. Part 162, shall do so. For any other communications between Highmark WV and Provider, Provider shall use such forms, tape formats or electronic formats as Highmark WV may approve.

The parties acknowledge and agree that the HIPAA Privacy Rule permits Provider to provide Protected Member Information to Highmark WV for purposes of Treatment, Payment and Health Care Operations (each as defined by the HIPAA Privacy Rule) without a consent or authorization, except for psychotherapy notes. The definition of Health Care Operations includes, but is not limited to, quality assessment and improvement activities, activities related to improving health or reducing health care costs, case management and care coordination, credentialing of providers and evaluating provider performance. Upon request by Highmark WV, Provider agrees to provide information, including Protected Member Information, to Highmark WV for purposes of Treatment, Payment and Health Care

Operations activities, in accordance with the requirements of HIPAA, without the authorization or consent of Members who are the subject of the Protected Member Information, unless such consent is otherwise required by state or federal Law, including, but not limited to, Laws regarding disclosure of mental health records, HIV-related information, and information regarding drug or alcohol abuse or dependence. In those instances where the Member's consent is required Provider agrees to obtain any and all consents and releases from a Member necessary for the disclosure of medical or other confidential information to Highmark WV for disclosures necessary under this Amendment or the underlying Agreement.

6.3. Use of Information and Data. Provider agrees, except as required by Laws or to the extent information is otherwise publicly available, not to utilize or disclose any information gathered or provided regarding the cost and utilization of health care services by Members (whether Member specific, account specific or aggregate) or software data which is the property of Highmark WV without the prior written consent of Highmark WV. Further, Provider will not disclose or permit the disclosure of any information, including fees, expenses and utilization derived from, through or provided by Highmark WV. Notwithstanding the foregoing, during the Term, Provider, in accordance with Laws, may use data regarding Members which is not individual Member specific or account specific if such data is included with similar data in a form which will not allow the party to whom disclosure is made to identify the Member from the information. Highmark WV, in accordance with Laws, may use and/or include data generated by Provider for studies and reports (including reports to his or her customers) on a customer-specific or aggregate basis. Highmark WV may also disclose the terms of this Amendment or provide a third party with a copy of this Amendment and information regarding terms of payment where a disclosure of terms is required for an audit.

6.4. Reviews, Access and Audits. Provider acknowledges that, in accordance with 42 CFR §422.502(e)(4), the U.S. Secretary of Health and Human Services, the Comptroller General, or their designees have the right to audit, evaluate or inspect any books, contracts, medical records, patient care documentation, and other records of Provider or his or her subcontractors or transferees involving transactions related to Highmark WV's Medicare Advantage PPO contract(s) and Members thereunder through ten (10) years (a) from the final date of the contract period, (b) from the date of the completion of any audit or (c) for such longer period provided for in other applicable Law, whichever is later, unless (i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Highmark WV at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute or fraud or similar fault by Highmark WV, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute or fraud or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate and audit Highmark WV at any time. Provider agrees to make available Provider's premises, physical facilities, equipment, records relating to Members, and any additional relevant information that CMS may require.

Highmark WV or its designated agent or agents (herein for purposes of this Section 6.4, collectively "Highmark WV") shall have access at all reasonable times, upon reasonable demand, to the books, medical records, other records and papers of Provider relating to Provider Services rendered to Members, the records regarding the charges made by Provider for Provider Services, and payments received by Provider from Members or other third-party payers for Members. Further, Highmark WV may perform any and all reviews (on-site or otherwise) and audits of Provider that it deems necessary to include, but not be limited to, credentialing and peer review program activities, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits

and quality improvement audits. Provider agrees to permit and cooperate in such reviews and audits, participate in any special studies requested by Highmark WV, provide Highmark WV access to all records and reports and facilities related to such activities, and participate in any corrective action plan required by Highmark WV. Such records are to be provided to Highmark WV at no cost. Based on such review, Highmark WV shall have the right to deny payment, to reject claims and/or review claims on a retrospective basis and collect any Overpayments. In such event, Provider will hold Highmark WV and the Member harmless with respect to payment for Provider Services, except for the collection of applicable Copayments, Coinsurance and Deductibles.

The obligations of the Provider set out in this Section 6.4 shall extend to other Official Bodies and employees or agents of Official Bodies. Provider agrees to make available to Official Bodies: Provider's premises, physical facilities, equipment, records relating to Members, and any additional relevant information that Highmark WV or Official Body may require. The Provider understands and acknowledges that the medical records referred to in this Section 6.4 shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable Laws

6.5. Provision of Records for Treatment. In the event of (a) termination of this Amendment, (b) the selection by a Member of another provider or (c) as otherwise necessary and appropriate for treatment of a Member, Provider agrees to transfer copies of the Member's medical records, x-rays, or other data when requested to do so in writing by Highmark WV, another provider or the Member. Such records are to be provided to Highmark WV at no cost.

6.6. Survival. Obligations under this Section 6 shall survive the expiration or termination of this Amendment.

7. ADDITIONAL MEDICARE ADVANTAGE PPO REQUIREMENTS

In addition to all other terms and conditions contained in this Amendment, the following additional Medicare Advantage PPO Requirements shall apply to Provider's provision of Provider Services and Highmark WV's payment for Covered Services to Members:

7.1. Adequate Network. Both parties acknowledge and agree that Highmark WV contracts with providers to create a network of Medicare Advantage PPO Preferred Providers in order to provide adequate access to health services for Members enrolled in Medicare Advantage PPO Program(s).

7.2. Medicare Participation Requirements. Neither Provider nor Highmark WV may employ or subcontract with an individual, or with an entity that employs or contracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. Provider acknowledges that this Amendment shall be automatically terminated if Provider, or a person with an ownership or control interest in Provider, is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in any other federal health care program. Any payments received by Provider hereunder on or after the date of such exclusion shall constitute Overpayments.

7.3. Affiliated Provider Credentials. To the extent applicable and required, Provider agrees that the credentials of any of Provider's Affiliated Providers and any Auxiliary Personnel will be reviewed by Highmark WV.

7.4. Delegation. Highmark WV delegates to Provider its responsibility under its Medicare Advantage PPO contract with CMS, as applicable, to render Provider Services to Members as set forth in this Amendment. Highmark WV may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate this Amendment if CMS or Highmark WV determines that Provider has not performed satisfactorily or if Provider's reporting and disclosure obligations under this Amendment are not fully met in a timely manner. Such revocation shall be consistent with the termination provisions of this Amendment. Highmark WV shall monitor performance of Provider on an ongoing basis.

Provider acknowledges that Highmark WV shall oversee and is accountable to CMS for the functions and responsibilities described in the regulatory standards governing the Medicare Advantage PPO Program(s) on an on-going basis and is ultimately responsible to CMS for the performance of all services. Further, Provider acknowledges that Highmark WV may only delegate such functions and responsibilities in a manner consistent with the standards set forth under 42 CFR §422.502(i)(4).

7.5. Equal Access and Non-Discrimination. Provider shall not deny, limit, discriminate or condition the furnishing of Provider Services to Members on the basis of any factor that is related to race, color, national origin, ancestry, religion, sex, marital status, sexual preference, disability, age, source of payment, cost, anticipated cost, membership in a Medicare Advantage PPO Program, or health status (to include, but not be limited to, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence or disability). In accordance with the preceding sentence, Provider agrees that under no circumstance will Provider refuse to render Provider Services based on the assumption that the anticipated cost that will be incurred by Provider will be in excess of Highmark WV's payment of Covered Services. Further, Provider shall provide Members with equal access at all times during the Term to those Provider Services that are made available to other persons who are not Members.

7.6. Treatment Plans, Health Assessments, Follow-Up Care and Self-Care. Provider acknowledges that Highmark WV has or will have procedures approved by CMS to (a) identify Members with complex or serious medical conditions; (b) assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and (c) establish and implement a treatment plan appropriate to those conditions with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans. In addition, and to the extent applicable, Provider agrees to cooperate with conducting a health assessment of all new Members within ninety (90) days of the effective date of their enrollment. Further and in accordance with Highmark WV policies and procedures, Provider will, to the extent applicable, inform Members of follow-up care and/or provide Members with training in self-care.

7.7. Subcontractors. Provider agrees that if Provider enters into subcontracts to render any Provider Services to Members that are permitted under the terms of this Amendment, Provider's subcontracts shall include the following:

a. an agreement by the subcontractor to comply with all of Provider's obligations in this Amendment;

b. a prompt payment provision as negotiated by Provider and the subcontractor;

c. a provision setting forth the terms of payment and any incentive arrangements;

d. a provision setting forth the term of the subcontract (preferably one year or longer); and

e. dated signatures of all parties to the subcontract.

7.8. Interpretation of Amendment. Provider and Highmark WV agree that the terms of this Amendment, as they relate to the provision of Provider Services under the Medicare Advantage PPO Program(s), shall be interpreted in a manner consistent with applicable requirements under Medicare Laws and CMS instructions and policies.

7.9. Compliance with Laws, Contractual Obligations and Policies and Procedures. Provider agrees to comply, and to require any of his or her permitted subcontractors to comply, with all applicable Laws, including, but not limited to, Medicare Laws and CMS instructions and policies. Provider also agrees that any Provider Services or other activity performed by Provider, his or her Auxiliary Personnel or his or her permitted subcontractors on Members will be consistent with and will comply with the contractual obligations of Highmark WV as a Medicare Advantage PPO organization.

7.10. Member Grievances and Appeals. Highmark WV shall establish and maintain fair and efficient procedures in accordance with applicable Laws to handle Members' grievances and appeals. Provider agrees to comply with Medicare requirements regarding Member appeals and grievances and to cooperate with Highmark WV in meeting his or her obligations regarding Member appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner as well as compliance with appeals decisions.

7.11. Emergency Services. To the extent required by Law, Highmark WV provides coverage of Emergency Services for Members. Where applicable, Highmark WV shall pay Provider for Emergency Services rendered to Members without regard to prior authorization. Provider also hereby agrees to notify Highmark WV of Emergency Services provided to any Member in accordance with the terms and conditions contained in applicable Laws and Highmark WV policies and procedures.

7.12. Federal Funds. Provider acknowledges payments that Provider receives from Highmark WV for Covered Services provided to Members are, in whole or part, from federal funds. Therefore, Provider and any of his or her subcontractors are subject to certain Laws that are applicable to individuals and entities receiving federal funds, including, but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

7.13. Incentives. In the event that the compensation paid to Provider under this Amendment provides for incentives in connection with Covered Services, Provider further acknowledges and agrees as follows:

a. Highmark WV rewards decision making based on appropriateness of care and service as well as actively discourages barriers to such care and service; and

b. Highmark WV does not compensate and does not provide direct or indirect incentives to practitioners or other individuals conducting utilization review for approvals or denials of payment or coverage for the delivery of any health care service; and

c. Incentives for decision makers are in no way meant to encourage them to compromise decisions about appropriate Member care.

8. TERM AND TERMINATION

8.1. This Amendment shall be effective on the date first stated herein and shall continue in effect thereafter until terminated (a) by either party according to the following provisions of this Section 8 or (b) by termination of the underlying Amendment.

8.2. This Amendment may be terminated by either party with or without cause upon sixty (60) days prior written notice.

8.3. This Amendment may be terminated by Highmark WV immediately as follows:

a. Provider's failure to meet any or all of the general participation criteria set forth in Section 2 or Section 7.2 of this Amendment; or

b. The determination by Highmark WV, in its sole judgment, that continuation of this Amendment may negatively affect patient care or an occurrence which, in Highmark WV's sole judgment, may jeopardize the health, safety or well-being of Members or impair Provider's ability to perform his or her duties hereunder; or

c. The failure of Highmark WV to participate in the Medicare Advantage PPO Program(s) and/or withdrawal, expiration, non-renewal, suspension, modification, sanction, or termination of Highmark WV's participation in the Medicare Advantage PPO Program(s) in effect as of the date hereof; or

d. CMS or Highmark WV, in its sole discretion, determines that: (i) Provider has not performed satisfactorily or (ii) Provider's reporting and disclosure obligations under this Amendment are not fully met in a timely manner; or

e. Provider's failure to comply with the equal access and non-discrimination requirements set forth in Section 7.5 of this Amendment.

8.4. Highmark WV reserves the right to terminate this Amendment, as set forth in this Section 8 or as otherwise provided for in this Amendment, with respect to any individual Affiliated Provider, without termination of the Amendment as to either the Group Provider or other Affiliated Providers.

8.5. An existing Provider shall have the right to appeal a termination initiated by Highmark WV (other than for failure to meet initial credentialing requirements). Such appeals shall be in writing and be addressed to the Highmark WV credentialing committee as indicated in the applicable Highmark WV credentialing policies and procedures.

8.6. In addition to the rights stated herein, the non-defaulting party shall have any and all remedies otherwise available at law or in equity, including, without limitation, specific performance.

9. OBLIGATIONS UPON TERMINATION

9.1. Return of Highmark WV Documents. Subject to the any applicable continuation of benefits provisions, Provider will immediately return all forms, policies, procedures, manuals and materials of every kind, if any, provided by Highmark WV upon termination of this Amendment. Highmark WV and Provider acknowledge that any procedures, forms, policies, manuals and materials developed by Provider are the property of Provider and are not subject to this Section 9.1.

9.2. General Cooperation with Highmark WV. Subject to any applicable continuation of benefits provisions, Provider shall cooperate with Highmark WV upon this Amendment's termination with the following:

a. Highmark WV's obtaining information regarding Members that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of Provider including the name, address and identification number of affected Members; and/or

b. The orderly transfer of Members to other Medicare Advantage PPO Preferred Providers or other providers designated by Highmark WV, as applicable; and/or

c. The continued care of a Member until discharge from an inpatient facility or, for a Member undergoing an ongoing course of treatment, until clinically appropriate as designated by Highmark WV, to be provided and paid in accordance with the terms and conditions of this Amendment; and/or

d. The orderly transfer of Member records as applicable; and/or

e. The resolution of any administrative and/or financial matter related to Provider's provision of Provider Services and Highmark WV's payment for Covered Services hereunder.

10. INSURANCE

Provider shall, at his or her sole cost and expense, maintain at all times during the Term such policies of general liability and professional liability (malpractice) insurance to insure Provider against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance of any Provider Service by Provider. The amounts and extent of such insurance coverage shall be subject to the determination and approval of Highmark WV in accordance with Highmark WV's credentialing and recredentialing policies and procedures but shall not be less than the amounts required by applicable state Laws. Provider shall provide evidence of such insurance coverage to Highmark WV upon request. In addition, Provider shall notify Highmark WV at least ten (10) days in advance of any reduction or termination of such coverage.

11. RELATIONSHIP OF THE PARTIES

Both Provider and Highmark WV expressly understand and agree that no provision of this Amendment or this Amendment is intended to create, nor shall be deemed or construed to create, the relationship of agent, servant, employee, partnership, joint venture, association or any other relationship between the parties other than that of independent contractors contracting with each other hereunder solely for the purpose of effecting the provisions of this Amendment. Neither Provider nor Highmark WV shall be liable to any other party for any act, or any failure to act, of the other party. Provider when performing Provider Services for Members is not an employee of Highmark WV, and Highmark WV shall do nothing to interfere with the customary provider-patient relationship in such cases. Highmark WV shall not be liable or responsible to anyone or any person whatsoever as a result of any negligence, misfeasance, malfeasance or malpractice on the part of Provider or his or her Auxiliary Personnel when they are performing Provider Services for Members.

12. USE OF NAMES

Provider agrees to allow his or her name, office address, telephone number and similar information to be listed in Highmark WV's marketing materials and its roster and/or directory of Medicare Advantage PPO Preferred Providers that is given to Members and prospective Members or as available on internet web-sites. Provider shall not reference Highmark WV in any publicity, advertisements, notices, or promotional material or in any announcement to the Members without prior review and written approval of Highmark WV.

13. BLUE CROSS AND BLUE SHIELD ASSOCIATION LIABILITY AND DISCLAIMER

Provider hereby expressly acknowledges his or her understanding that this Amendment and the underlying Agreement constitute a contract between Provider and Highmark WV, that Highmark WV is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, permitting Highmark WV to use the Blue Cross and Blue Shield Service Marks in the State of West Virginia and Washington County, Ohio, and that Highmark WV is not contracting as the agent of the Blue Cross and Blue Shield Association. Provider further acknowledges and agrees that he or she has not entered into this Amendment or the underlying Agreement based upon any representations by any person other than Highmark WV and that no person, entity, or organization other than Highmark WV shall be held accountable or liable to Provider for any of Highmark WV's obligations to Provider as created under this Amendment and the underlying Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Highmark WV other than those obligations created under other provisions of this Amendment and the underlying Agreement.

14. ENTIRE AGREEMENT

This Amendment, all other documents incorporated by reference into this Amendment, and the Agreement contain all of the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Amendment. Any prior agreements, understandings, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Amendment are null and void and of no further force or effect, unless otherwise stated. This Amendment applies only to Members, as such term is defined herein, and shall not be deemed to replace or terminate any other agreement between the Provider, on the one hand, and Highmark WV and/or an affiliate, on the other hand, for Provider Services rendered to other subscribers or members of Highmark WV and/or such affiliate. In the case of any conflict(s) between this Amendment and the underlying Agreement, this Amendment shall take precedence.

15. PARTIES TO THE AMENDMENT/AGREEMENT: GROUP PROVIDER AND AFFILIATED PROVIDERS

If Provider is a Group Provider, then it represents and warrants that it has the authority to act on behalf of any Affiliated Providers of that Group Provider. Group Provider further represents and warrants that all Affiliated Providers of that Group Provider shall be bound by, agree to, and shall comply with all terms and provisions of this Amendment and the Agreement. If a Provider is a Group Provider, any reference in this Amendment or Agreement to Provider shall be interpreted as applying to both the Group Provider and all individual Affiliated Providers of that Group Provider. A Group Provider may add additional Affiliated Providers by submitting a credentialing application and other documents/information as required by Highmark WV, including a designation of the Group Provider-Affiliated Provider relationship. The Group Provider represents and warrants that this Amendment and Agreement shall apply to such additional Affiliated Providers to the same extent as they apply to existing Affiliated Providers of that Group Provider.

16. AMENDMENTS

This Amendment may be amended by the mutual written consent of the parties. In addition, Highmark WV may amend any provision of this Amendment upon forty-five (45) days prior written notice to Provider. Notwithstanding the foregoing, this Amendment may be amended from time to time upon written notice to Provider in order to comply with applicable Laws or the directives of CMS or other Official Bodies or applicable accrediting bodies, with such amendment being effective immediately upon written notice.

17. GOVERNING LAWS AND VENUE

This Amendment shall be governed in all aspects by the Laws of the State of West Virginia and, where applicable, federal Law. Exclusive venue for any action arising from this Amendment shall be before the courts of Wood County, West Virginia.

18. NOTICES

Any notice which either party must give under this Amendment shall be given in writing and shall be faxed or sent by first class mail, postage prepaid and shall be sent to the other party at its respective place of business as designated pursuant to the Agreement.

19. ASSIGNMENT

No assignment of this Amendment or the rights, duties or obligations under this Amendment shall be made by Provider, without the written consent of Highmark WV, which consent shall not be unreasonably withheld. Highmark WV may, in its sole discretion, assign this Amendment or any of its rights, duties or obligations hereunder without the consent of Provider. Highmark WV does hereby assign this Amendment, and its rights, duties and obligations hereunder, to Highmark Health Insurance Company ("HHIC") to be effective as of the date of execution. HHIC may, at its sole discretion, assign this Amendment or its rights, duties or obligations under this Amendment without consent of the Provider.

(Signatures on Next Page)

This Amendment may be executed in duplicate, each of which shall be deemed an original and which shall constitute one and the same instrument. Upon acceptance of this Amendment by Highmark WV, a fully executed copy of this Amendment shall be sent to Provider.

By signing hereunder, I certify that I have full authority to bind all members of the group practice referenced above, if applicable.

PREFERRED PROVIDER

Signature

1821471319
NPI Number

Muhammad Amjad, PhD
Printed name

Director
Title, if signing as the authorized representative of a group practice

PO Box 4100
Barboursville, WV 25504-4100
Mailing Address:

PO Box 4100
Barboursville, WV
Check Address:

08/15/2016
Execution Date

ACCEPTED BY:

HIGHMARK WEST VIRGINIA INC. d/b/a HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA

Signature

Thomas J. Fitzpatrick, Senior Vice President, Provider Contracts and Relations
Printed name Title

Provider Information Management
PO Box 898842
Camp Hill, PA 17089-8842

Execution Date

Agreement Effective Date

Name: MedTest Laboratories LLC
Vendor Number: 3404189
Federal Tax ID: 47-4213978

Exhibit B

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF REGISTRATION

LABORATORY NAME AND ADDRESS
MEDTEST LABORATORIES LLC
3860 TEAYS VALLEY ROAD
HURRICANE, WV 25526

CLIA ID NUMBER
51D2085204

EFFECTIVE DATE
07/02/2016

EXPIRATION DATE
07/01/2017

LABORATORY DIRECTOR
MUHAMMAD AMJAD PHD

Pursuant to Section 353 of the Public Health Service Act (42 U.S.C. 263a), as amended by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown on this Certificate is authorized to accept human specimens for the purpose of performing laboratory tests or procedures.

This certificate shall be valid until the expiration date shown, but is subject to revocation for cause, limitations, or other restrictions for violation of the Act or regulations governing these procedures.

Kathleen W. Dyer, Acting Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS-1-072115

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal determination of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS
MEDTEST
400 D PRESTIGE PARK
HURRICANE, WV 25526

CLIA ID NUMBER
51D2098204

EFFECTIVE DATE
04/10/2017

LABORATORY DIRECTOR
MICHAEL CHEN Ph.D.

EXPIRATION DATE
04/09/2019

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Karen W. Dyer, Acting Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

71 Certs2_091917

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)	EFFECTIVE DATE	LAB CERTIFICATION (CODE)	EFFECTIVE DATE
ROUTINE CHEMISTRY (310)	04/10/2017		
TOXICOLOGY (340)	04/10/2017		

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Exhibit C

https://wwwn.cdc.gov/clia/resources/Lab-Search.aspx#SearchResultsTop

Clinical Laboratory Improvement Amendments (CLIA)

CDC

Laboratory Search

This search provides demographic information about CLIA-certified laboratories, including CLIA number, facility name and address, and the type of CLIA certificate. For additional information about a particular laboratory, contact the appropriate State Agency or CMS Regional Office CLIA contact.

Search Criteria

CLIA Number:
51D2098204
Laboratory Name:

Advanced Search Show

Search

Options for displaying result:

Export | Print

Results per page: 20 Go

Displaying rows: 1 to 1 of 1

51D2098204	Independent	Certificate Of Compliance	**Medtest** 400 D Prestige Park, Hurricane, WV, 25526- Tel: (304) 757-9982

Displaying rows: 1 to 1 of 1

For CLIA-related questions please contact:

CDC does not issue CLIA certificates or process fee payments. Please contact your state agency for assistance. To obtain their contact information, please visit the state agency & regional office CLIA contacts web page.

- Email: LabExcellence@cms.hhs.gov
- Phone Line: 404-498-2290 (Voice mail)

- Page last reviewed:February 27, 2019
- Page last updated:February 27, 2019
- Content source:
- Office of the Associate Director for Communications, Division of Public Affairs

Exhibit D

Carefirst Bluecross Blueshield [US] | https://member.carefirst.com/mos/#/fadpublic/search/standard

CareFirst

Find a Doctor

Show Map

Back to Search Results

Share

Previous Result Next Result

Medtest Laboratories LLC
Labs

In-Network Provider

National Provider

5.2 Miles Get Directions

400D Prestige Dr
Hurricane , WV 25526

(405) 285-0102

Medtest Laboratories LLC

Independent Laboratory

Print Share

OFFICE LOCATION

4000 Prestige Dr, Hurricane, WV 25526
Get Directions

Contact

Phone: 405-285-0102

Highlights

Specialties

- Independent Laboratory

Networks Accepted

- Indemnity
- PPO (Participating Provider Organization)

Awards

Medtest Laboratories LLC has no accreditations.

Medtest Laboratories LLC has no awards.

Ratings & Reviews

RECOMMENDATIONS

No recommendations yet

Overall Rating

No ratings yet

Limitations

Age From: 0
Age To: 99

Identifiers

- NPI: 1621471319
- BCA: 443;WVB1003404189;;04

https://bcbsneweb.healthsparq.com/healthsparq/public/#/one/city=omaha&state=ne&postalCode=&country=&insurerCode=BCBSNE_I&brandCode=BCBSNE/results/allRemote=false&alphaPrefix=&isPromotionSearch=

Return to
BlueCross BlueShield Nebraska

Home Settings

Choose a network: All Networks

Choose search location: Hurricane, WV

Start your search here: medtest

Search
Advanced Search

Redo Search in Map

Save & Print

Sort: Best Match

Showing 1 of 1 result

Medtest Laboratories LLC
Independent Laboratory

400D Prestige Dr
Hurricane, WV 25526
5.1 miles Get directions

(405) 285-0102

Today 8:00 AM - 5:00 PM

16 Networks Accepted
at this location

Compare

Refine your results

Miles from starting point

25

Return to

BlueCross BlueShield Nebraska

Home

Settings

Choose a network
All Networks
Choose search location

Start your search here

Search SearchAdvanced Search

Redo search when map moved

Medtest Laboratories LLC accepts 16 network

Select a network type:

Medical and Dental Plans

Medical and Dental

Network	Accepting New Patients	Network Tier
Network Blue Premier Select BlueChoice Select BlueChoice		**$$** Tier 2
Antelope Memorial BlueChoice		**$$**

Network	Accepting New Patients	Network Tier
Aurora Mem Comm BlueChoice		Tier 2 $$
Blueprint Health Boone County BlueChoice		Tier 2 $$
Brodstone Memorial BlueChoice		Tier 2 $$
Bryan Health BlueChoice		Tier 2 $$
Cozad BlueChoice		Tier 2 $$
Faith Regional BlueChoice		Tier 2 $$
Fillmore BlueChoice		Tier 2 $$
Pender Community BlueChoice		Tier 2 $$
Phelps Memorial BlueChoice		Tier 2 $$
Saunders Med Cntr BlueChoice		Tier 2 $$
West Holt BlueChoice		Tier 2 $$

- Nondiscrimination Notice and Translations
- Explore Plans
- Resources
- Contact Us
- About Us

Last updated: 06/27/2018

This directory is based upon information available at the time of creation and is subject to change without notice Read More
How accurate is the information shown above? Our information is based on data from your health insurance company and selected real world claims from 34 million customers. Read More

Secure | https://web.healthsparq.com/healthsparq/public/#/one/city=Providence&state=RI&postalCode=&country=&insurerCode=BCBSRI_I&productCode=&brandCode=BCBSRI/details/provider/providerId=1395765&locationId=191466&locatio

Blue Cross Blue Shield of Rhode Island

<< Go to the Blue Cross & Blue Shield of Rhode Island Home Page

Home Settings

Choose a health plan: All Plans

Choose search location: Providence, RI

Start your search here: Search for a doctor, hospital name or specialty

Search

Advanced Search

Medtest Laboratories LLC

400D Prestige Dr
Hurricane, WV 25526

Compare

Main: (405) 285-0102

5.1 mi away
Directions

Today 8:00 AM - 5:00 PM

Specialties: Independent Laboratory

30 Plans Accepted

Provider ID: 1821471319

Languages Spoken: English

Locations

Locations for *Medtest Laboratories LLC*:

400D Prestige Dr
Hurricane, WV 25526

Show Info

Medtest Laboratories LLC

400D Prestige Dr
Hurricane, WV 25526
Main: (405) 285-0102

5.1 mi. away
Directions

Today 8:00 AM - 5:00 PM

Specialties: Independent Laboratory

30 Plans Accepted

Medtest Laboratories LLC accepts 30 plans

Select a plan type:

Medical - Through Employer

BasicBlue

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
BASICBLUE				

BlueSolutions

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
BLUESOLUTIONS FOR HSA				
BLUESOLUTIONS SELECTRI			Tier 2	

Bryant University

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
HEALTHMATE COAST TO COAST				

Classic Blue

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
CLASSIC BLUE				

Gilbane Plans

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
BLUESOLUTIONS FOR HSA				
HEALTHMATE COAST TO COAST				

Healthmate Coast to Coast

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
HEALTHMATE COAST TO COAST				
HEALTHMATE C2C DEDUCTIBLE PLAN				

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
HEALTHMATE C2C STANDARD PLAN				
HEALTHMATE COAST TO COAST				

South County Health

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
SOUTH COUNTY HEALTH VANTAGEBLUE				

VantageBlue

Plan	Accepting New Patients	Primary Care Physician (PCP)	Network Tier	Contract Status
VANTAGEBLUE VANTAGEBLUE SELECTRI			Tier 2	

Provider ID: 1821471319

Languages Spoken: English

Locations

Primary Locations

Additional Locations

Exhibit E

CMS.gov
Centers for Medicare & Medicaid Services

Place of Service Code Set

Place of Service Codes for Professional Claims

Database (updated November 2016)

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

NOTE: Please direct questions related to billing place of service codes to your Medicare Administrative Contractor (MAC) for assistance, and not to posinfo@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy **	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03	School	A facility whose primary purpose is education. (Effective January 1, 2003)
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (Effective January 1, 2003)
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective January 1, 2003)
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (Effective January 1, 2003)
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (Effective January 1, 2003)

08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (Effective January 1, 2003)
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective July 1, 2008)
10	Unassigned	
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective October 1, 2003)
14	Group Home *	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). (Effective October 1, 2003)
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. (Effective January 1, 2003)
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective January 1, 2008)
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)

19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective January 1, 2003)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other

		Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective October 1, 2003)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (Effective October 1, 2003)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

* Revised, effective April 1, 2004.

** Revised, effective October 1, 2005

Downloads

Place of Service Codes for Professional Claims [PDF, 73KB]

Page last Modified: 11/17/2016 3:26 PM

Help with File Formats and Plug-Ins

Exhibit F

CHAPTER 5: CLAIM SUBMISSIONS

UNIT 3: 1500 HEALTH INSURANCE CLAIM FORM SUBMISSION

IN THIS UNIT

What Is My Service Area?

The *Highmark Blue Shield Office Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania (PA), Delaware (DE), West Virginia (WV), and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to only two states. **Where no symbol is present, the information is relevant to all states.**

The PA symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties

The DE symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties

The WV symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties

5.3 THE 1500 HEALTH INSURANCE CLAIM FORM

Background

The 1500 Health Insurance Claim Form ("1500 Claim Form") answers the needs of many health care payers. It is the basic claim form required by many payers for paper claims submitted by physicians and other professional providers. And now that electronic claim submission has become integral to health care, many of the software/hardware systems used by providers for submitting electronic claims depend on the existing 1500 Claim Form in its current image.

Prior to the development of the 1500 Claim Form, there was no standardized form for physicians and other health care providers to report health care services. In the 1980's, the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS; formerly known as HCFA), and many other payer organizations worked together through a group called the Uniform Claim Form Task Force to standardize and promote the use of a universal health claim form. As a result of this joint effort, the 1500 Claim Form is accepted nationwide by most insurance entities as the standard claim form/attending physician statement for submission of medical claims.

The Uniform Claim Form Task Force was replaced by the National Uniform Claim Committee (NUCC) in the mid-1990s. The NUCC continues to be responsible for the maintenance of the 1500 Claim Form. The official 1500 Health Insurance Claim Form data specifications are available through NUCC at www.nucc.org.

1500 Claim Form - 02/12 Version

Highmark accepts only the 02/12 version of the 1500 Claim Form. Photocopies, discontinued, or outdated versions of the 1500 Claim Form, including the 08/05 version, will not be accepted and will be returned to providers.

Please remember that **only original red claim forms** will be accepted. **Photocopies of the 1500 Claim Form will not be accepted and will be returned to providers.**

Electronic claims submission

Highmark encourages providers who are submitting paper claims to consider electronic claims submission. Electronic transactions and online communications have become integral to health care. Today's technology can help you simplify business operations, cut costs, and increase efficiency in your office.

Electronic claims submission is a valuable method of streamlining claim submission and processing, and results in faster payment. Highmark supports a variety of HIPAA compliant electronic claims and inquiry transactions. Please refer to Chapter 5, Unit 1, Benefits of Electronic Communication, for information on how to take advantage of the electronic solutions available to you.

Continued on next page

5.3 THE 1500 HEALTH INSURANCE CLAIM FORM, Continued

Electronic claims submission (continued)

You may also want to consider NaviNet® for submitting claims to Highmark. NaviNet is provided to Highmark network participating providers at no cost. This Internet-based service seamlessly integrates all insurer-provider transactions into one system – HIPAA-compliant claims submission, claim status inquiry, claim investigation, eligibility, benefits, and much more! NaviNet even provides access to Highmark's tools for real-time claim estimation and adjudication. For more information about NaviNet, please see Chapter 1, Unit 2 of the *Highmark Blue Shield Office Manual.*

5.3 OCR SCANNING OF PAPER CLAIMS

OCR scanner improves paper claims processing time

Highmark uses an OCR (Optical Character Recognition) scanner for direct entry of paper claims into its claims processing system, OSCAR (Optimum System for Claims Adjudication and Reporting). OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and "reads" the printed data, and then translates it into a format for direct entry into OSCAR. The scanner can "read" both computer-prepared and typewritten claim forms but **only if the data is within the borders of each box.**

Direct entry of claims by the OCR scanner is an advantage to you because it requires less human intervention in preparing and entering your claims. The scanner reads, numbers, and images your paper claims in one step. OCR scanning reduces claim entry time as well as entry errors. However, OCR claims do not receive the same priority processing as do electronically submitted claims.

For the most efficient processing, please use *only* original red 1500 Health Insurance Claim Forms. The OCR scanner is programmed to read this form. Highmark will not accept photocopies or discontinued versions of the 1500 Claim Form and will return claims received on these invalid forms. Providers will need to resubmit returned claims on valid, original forms for the claims to be entered into Highmark's claims processing system.

If you use computer billing software to complete the 1500 paper claim forms, please remember to use original, current versions of the form and not photocopies or older versions of the claim form.

How to obtain claim forms

To obtain a supply of the current version of the 1500 Health Insurance Claim Form, please contact:

- Your current forms supplier; or
- TFP Data Systems: e-mail 1500form@tfpdata.com , or telephone 1-800-482-9367, ext. 58029; or
- The Government Printing Office: http://bookstore.gpo.gov/catalog/government-forms-phone-directories, or telephone 1-866-512-1800.

5.3 GUIDELINES FOR SUBMITTING PAPER CLAIMS

Overview

In today's business world, there are no requirements to submit claims on paper. In fact, Highmark's claim system places higher priority on processing and payment of claims filed electronically. However, if you are submitting paper claims, the guidelines provided below must be followed when completing the 1500 Health Insurance Claim Form. By following these guidelines, you can be assured that your claims will be scanned as quickly as possible, processed accurately, and paid without delay.

Note: Please be sure to reference Chapter 5, Unit 2 for general guidelines and reporting tips that apply to claims submissions in both paper and electronic formats.

Be sure to use the correct forms

Highmark will accept only the Version 02/12 1500 Health Insurance Claim Form. Always provide Highmark with the **original red** 1500 form. Do not send copies or forms printed in black ink on a laser printer – they cannot be scanned. **Photocopies, discontinued, or outdated versions of the 1500 Claim Form will not be accepted and will be returned to providers.** Resubmission on a valid form will be required.

ICD-10 compliance

Highmark will accept only ICD-10-CM diagnosis codes on claims for dates of service October 1, 2015, and after. Please see the next section of this unit for tips on reporting diagnosis codes.

Appropriate printing of forms

Always print or type all information on the claim form. Clear, concise reporting on the form helps us to interpret the information correctly.

- Use computer-printed forms or type the data within the boundaries of the boxes provided. **DO NOT HAND WRITE.**
- Use black ink. **Do not use red ink.** The OCR image scanner cannot read red ink.
- Printing Specifications:
  - Use **10-pitch PICA** type.
  - Submit all claims on 20 pound paper.
- **Do not use highlighters** to emphasize information on the claim form or attachments. Highlighted information becomes blackened out when imaged and is not legible.

Continued on next page

5.3 GUIDELINES FOR SUBMITTING PAPER CLAIMS, Continued

If multiple forms are necessary

In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.

Complete the claim form in its entirety. Our claims examiners review each claim individually. If you submit several claim forms for the same member but fill in only essential details on one form, Highmark will reject the claim forms.

We must have complete information before we can process the claim. If details are missing, Highmark will reject the claim.

Use the appropriate mailing address

Mail the claim forms to the appropriate P.O. Box address. A complete listing of addresses can be found in Chapter 1, Unit 1: Quick Reference Directory.

Why blue italics?

Adjustment claim changes effective January 1, 2018

Effective January 1, 2018, providers must submit corrected (replacement) claims electronically for claims filed electronically; Highmark will not accept requests for claim corrections via telephone or NaviNet® Claim Investigation.

However, if the original claim was submitted on paper, the replacement claim must also be submitted on paper. In Box 22 of the 1500 Claim Form, enter the Frequency Type code in the ***Resubmission Code*** *field and the original claim number in the* ***Original Ref. No.*** *field. Please see detailed instructions for Box 22 in the* ***1500 Claim Form (02/12) Completion Instructions*** *section of this unit.*

Reminder: *The original claim number is required for all Frequency Type adjustment claims. This requirement also applies to claims already adjusted that now require a second (or subsequent) adjustment.*

5.3 DIAGNOSIS CODE REPORTING

ICD-10 compliance

Highmark will accept only ICD-10-CM diagnosis codes on claims for dates of service October 1, 2015, and after.

Diagnosis code reporting guidelines for the 1500 Claim Form (02/12)

The following diagnosis code reporting guidelines are for all lines of business:

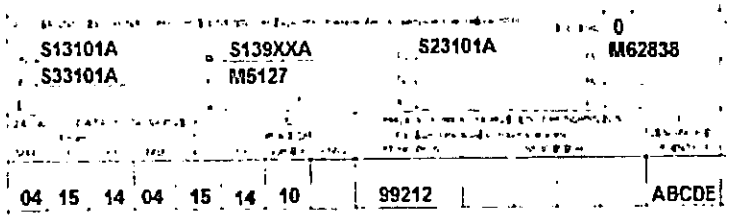
1. Enter the codes to identify the patient's diagnosis and/or condition.
2. Report diagnosis codes to the **highest level of specificity** available.
3. The "**ICD Indicator**" identifies the version of the ICD code set being reported. Enter **0** (zero) for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. See example below.
4. The lines allow for diagnosis codes at a maximum of seven (7) characters.
5. You may report a maximum of twelve (12) diagnosis codes.
6. Report only one diagnosis code on each line (labeled A-L) in Box 21 of the 02/12 1500 Claim Form.
7. Enter the diagnosis codes **left-justified** on each line.
8. **Do not** include the decimal point within the diagnosis code.
9. **Do not** provide narrative description in this field.
10. Relate lines A - L to the lines of service in 24E by the **letter** of the line.
11. Substantiate all member diagnoses in the medical record.

For Medicare Advantage Freedom Blue PPO Members in Pennsylvania:
In addition to above, include all diagnosis codes that impact the patient's evaluation, care, and treatment for the current problems.

What Is My Service Area?

1500 Claim Form (02/12) reporting example

This is an example of reporting **ICD-10-CM** diagnosis codes on the 02/12 version of the 1500 Claim Form.



5.3 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS

Overview

The additional tips provided here will help to assure your claims submissions are completed accurately and to avoid any delays in processing. If you have a question about how to complete a claim form, contact Highmark's Provider Services.

Before you begin...

Always verify the patient's information via NaviNet® or the HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction before completing the claim form. NaviNet's Eligibility and Benefits function and the HIPAA 270/271 allow you to quickly confirm the member's coverage and the member information needed on the claim form.

General tips for completing the claim form

- Please do not staple over the Quick Response (QR) code symbol at the top of the Version 02/12 1500 Claim Form. Highmark's scanners read the symbol to identify that the 1500 Claim Form is the 02/12 version.
- Be certain to enter information within the correct fields on the form.
- Make sure that the member's identification number is correctly reported on the claim form (*including the alphabetical prefix*).
- Use an 8-digit format for reporting date of birth (MMDDYYYY).
- Submit a separate claim for each patient even when they are members of the same family. When a patient has had multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include coordination of benefits or Medicare information on the claim form when the patient qualifies.
- Always report your 10-digit NPI in Item Number 33a.
- Regularly change your printer's ink cartridge or typewriter ribbon to ensure print readability. Light print cannot be read by the scanner.
- Avoid using special characters such as dollar signs, hyphens, slashes, or periods.
- Avoid extra labeling in fields on claim form.
- Use X's for marking Yes or No blocks. Do not use other alphabetical indicators such as Y for Yes, N for No, F for Female, or M for Male.
- Do not use correction fluid on the claims.
- Leave the upper right-hand corner of the claim form blank for internal purposes. If you need to print information at the top of the form, use the open space in the center.
- If using a rubber stamp, do not stamp information in or over fields one through 33 or in the upper right hand corner of the claim form. Any stamps used should be in black ink only.
- Claims and other documents (inquiries, referrals, etc.) should never be taped or glued in any way. Staples should be avoided unless absolutely necessary.

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5.3 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS, Continued

When completing service lines...

- Include the date each service was provided in 6-digit format (MM|DD|YY).
- Be certain the total charge equals the service line charges.
- Do not fill in blank fields or space with unnecessary data. For example, if hospitalization dates are not required, leave the field blank rather than entering 00/00/00 or XX/XX/XX.
- Include HCPCS codes to identify the service or services rendered. Other coding manuals may use the same code number to describe a different service.
- The claim form can only accommodate six lines of service. The top area of the six service lines is shaded and is the location for reporting supplemental information. Supplemental information can only be entered with a corresponding, completed service line. It is not intended to allow the billing of 12 lines of service.
- Report all information about a service on one line. If the service dates, diagnosis code, charge, etc., are reported on separate lines, the scanner "creates" an extra line. This may cause the claim to be returned to you for correction and re-submission.
- Use the procedure code that most closely describes the service. Written descriptions are only necessary if using NOC codes or when no procedure code is available. Unnecessary descriptions are problematic for OCR scanned claims.
- Not Otherwise Classified (NOC) Codes: When reporting NOC procedure codes, provide a written description of the item or service above the code in the shaded area of the service line on the claim form. When more than one NOC is submitted, provide an individual description and charge for each item.

Tips for specific reporting needs

- Surgical procedures do not require operative notes unless:
  - An "individual consideration" (IC) or "unlisted procedure" code is reported.
  - The service performed is a new procedure.
  - The service performed is potentially cosmetic.
  - Multiple primary surgeons participated in a surgical procedure.
  - The terminology for the reported code indicates, "by report" (BR).
  - A pre-authorization letter advised you to submit specific reports.
  - The service involves unusual circumstances. Remember to also report modifier 22. If this modifier is not reported, the special circumstances will not be considered.
- When reporting circumcision for a baby boy, report the service on the baby's claim, not the mother's.
- When reporting services involving a multiple birth, report the services under the babies' names, not as Baby A, Baby B, etc.

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5.3 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS, Continued

Avoid including unnecessary attachments

- Do not submit a photocopy of the member's identification card.
- Do not routinely send "Release of Information" forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Avoid the use of Post-It Notes on claims or inquiries. (Full sheets of paper are preferable.)
- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims. We will request this information if it is necessary to process the claim.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment.
- The OCR scanner is designed to read computer prepared or typewritten claim forms. Claims with superbill attachments cannot process through the OCR scanner. Type data from the superbill directly onto the claim form. Do not attach superbills for the same services you have reported on the claim form.

Mailing tips

- Use flat envelopes for mailing claims.
- Do not fold claim forms. Folded or wrinkled claim forms cannot be effectively read by the scanner.

Examples of how to submit information correctly

INSURED'S ID NUMBER	
Correct: YYZ123456789001	
Incorrect: YYZ-123-456-789001; ID # YYZ123456789001	
CHARGES	
Correct: 20.00	
Incorrect: $20.00	
DATE OF BIRTH: 8-digit format	ALL OTHER DATES: 6-digit format
Correct: 12271949	**Correct:** 122713; 021414
Incorrect: 12/27/49; 12-27-1949	**Incorrect:** 12/27/13; 2-14-14
INSURED'S POLICY GROUP NUMBER	
Correct: 123456; NAS123	
Incorrect: GRP # 123456; GRP # NAS123	

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5.3 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS, Continued

FOR MORE INFORMATION

For instructions on how to begin to submit claims electronically, please visit the EDI Trading Partner website via the Provider Resource Center, or by clicking the applicable link below to access the site directly:

- In Pennsylvania and Delaware: www.highmark.com/edi
- In West Virginia: www.highmark.com/edi-wv

Or, you may call EDI Operations at **1-800-992-0246.**

5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS

Overview

The National Uniform Claim Committee (NUCC) released the 02/12 version of the 1500 Health Insurance Claim Form ("02/12 1500 Claim Form") in January 2014.

The instructions for completing the 1500 (02/12) paper claim form begin below. Please refer to page 26 in this unit for an example of a completed 02/12 1500 Claim Form.

IMPORTANT! 02/12 1500 Claim Form required

Highmark will accept only the 02/12 version of the 1500 Claim Form. Please remember that **only original red claim forms** will be accepted. Photocopies, discontinued, or outdated versions of the 1500 Claim Form will not be accepted and will be returned to providers.

Instructions for completing the 1500 Claim Form version (02/12)

Any data (e.g., diagnosis codes, charges, NPIs, etc.) used in the instructions and sample claim form is demonstrating how to enter data in the field and is not providing instruction on how to bill for certain services.

Note: Please refer to Chapter 5, Unit 2 of the *Highmark Blue Shield Office Manual* for additional information about specific claim reporting situations.

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
TOP OF FORM	CARRIER BLOCK	Report name and address in the center of the open space. Do not report above Item #1a (this is where Highmark prints the claim number). **Please do not staple over the Quick Response (QR) code symbol.** Highmark's scanners read the symbol to identify that the 1500 Claim Form is the 02/12 version.
1	TYPE OF HEALTH INSURANCE COVERAGE	For Highmark products, place an X in the "Other" box.
1a	INSURED'S ID NUMBER	Enter insured's identification number exactly as shown on the insured's identification card. Be sure to include any alpha prefixes.

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