CMS-1500 Billing Guide for PROMISe™ Healthy Beginnings Plus (HBP) Providers

About HBP Program

The Healthy Beginnings Plus (HBP) Program is an enhanced, comprehensive package of services for pregnant women which includes, in addition to medical services, a variety of health promotion and counseling services, as well as home and community-based services. To be eligible to bill the Department for Services, as well as home and community-based services, a provider must apply to be enrolled and approved as a "Qualified Provider" in the Healthy Beginnings Plus Program. For qualified provider requirements, refer to MA bulletin 31-90-01 – Provider Participation Requirements for Healthy Beginnings Plus – at the following site:

http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=1198

Providers are advised that the definitions of the expected level of service from the HBP manual are still in effect. The newly mapped National Codes and modifiers have been utilized due to the lack of equivalent National Codes for trimester services and other HBP local codes. In order to bill the National codes with the HD modifiers, which the local codes are cross walked from, it is the expectation of the Department; that providers will continue to perform the described services reflected by the HBP Manual's description of the equivalent local code(s).

Payment and Billing Policies

This section contains the payment and billing policies for services covered under the Healthy Beginnings Plus Program.

Providers may bill the **Intake Package** in any trimester that care is initiated. An invoice for the HBP intake package may only be submitted after the intake package in completed. Providers need not wait until the end of the trimester to bill for the intake package. If a Healthy Beginnings Plus recipient transfers from one HBP provider to another, the second provider should obtain the comprehensive prenatal care record from the first provider. The Department will not pay for a second intake package for the same pregnancy.

Providers may bill for the appropriate **maternity care packages** at the end of each respective trimester. Trimester packages may only be billed 91 days from the completion of the previous package. The provider bills trimester packages by indicating the last day of the trimester in the Dates of Service Field (24a). The payment for any of the trimester package includes all the obstetrical visits during the trimester. (Excluding home visits). Service with no direct bearing on the outcome of the pregnancy may be billed in addition to the trimester packages in accordance with the MA Regulations, Chapter 1150, Medical Assistance Payment Policies and the MA Fee Schedule. Individual visits may be billed when a recipient withdraws from HBP, or, for any reason, the provider cannot complete all the components of the package. Billing for individual trimester visits may not exceed the payment for the trimester package, regardless of the actual number of visits provided. Payment for the basic and high-risk third trimester packages include the post-partum visit. Billing should not occur until the post-partum visit is rendered. **The third trimester date of service should be the date of the postpartum visit or, in cases of non-compliance, the last day of the month in which the 60th post-partum day occurs. For example, if the child is born on January 15th, 2006, the last date for service is March 31, 2006.**

Physicians who receive payment for deliveries through the HBP providers and billing the Third Trimester Basic or High Risk Packages or the Second Trimester Early Delivery Package; must ensure that the admitting hospital is aware they may not bill Medical Assistance for a delivery charge on the inpatient claim. Additionally, providers may not bill for a HBP delivery on a professional claim via a standard delivery code for a delivery billed under the HBP Third Trimester Basic or High Risk Packages or the Second Trimester Early Delivery Package codes. In these cases, the later submitted HBP trimester claim may not be paid.

Payment and Billing Policies

A designated **HBP provider who performs a second trimester delivery** should bill one of the following procedure code modifier combinations (In these cases, the provider who performs the delivery will bill the delivery using the appropriate Medical Assistance Program Fee Schedule code):

59400 U7 HD	Second Trimester Maternity Care Package with a Vaginal Delivery
59510 U7 HD	Second Trimester Maternity Care Package with a Cesarean Delivery
59610 UB HD	Trimester Maternity Care Package with a Vaginal Birth After Cesarean (VBAC) Delivery

If for any reason the **Delivery is not performed by HBP provider**, but all other third trimester package requirements have been completed, including the post-partum visit, bill one of the following procedure code modifier combinations. (Please be advised the HBP Manual requires a minimum of 5 visits for the third trimester package to be considered complete):

59425 U7 HD	Basic third trimester package with 5 to 6 visits – Delivery not performed by HBP provider.
59426 U7 HD	Basic third trimester package with 7 or more visits – Delivery not performed by HBP provider
59425 U8 HD	High Risk third trimester package with 5 to 6 visits – Delivery not performed by HBP provider
59426 U8 HD	High Risk third trimester package with 7 or more visits – Delivery not performed by HBP provider

Providers may bill for the outreach bonus (code 99429 with the HD modifier) for each recipient recruited into the Healthy Beginnings Plus Program **during the first trimester and receiving services from the same provider site through the third trimester.** The outreach bonus cannot be billed until the recipient has completed the third trimester and the package has been billed and paid. The Outreach Bonus may be billed for either basic or high-risk services. The date of service for the Outreach Bonus is to be the same date of service used for the third trimester package**. The Third trimester date of service should be the date of the postpartum visit, or, in cases of non-compliance, the last day of the month in which the 60th postpartum day occurs. For example, if the child is born on January 15th, 2006 the last date for service is March 31, 2006.**

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Payment and Billing Policies

For the following procedure code modifier combinations, units are equal to 45 minutes. The limit for each of these codes is 1 visit per day.

G0154 U9 HD	Post-Partum Home Nursing Care
G0156 U9 HD	Post-Partum Home Health Aide Care
G0156 U9 HD	Home Health Aide Care
99500 HD	Prenatal Home Care

The following procedure code modifier combination codes are limited to billing 2 units per visit and 2 visits per week:

99050 HD	Post-Partum Home Care
99501 HD	Post-Partum Home Assessment/Client Education
99509 HD SC	Post-Partum Personal Care
99509 HD	Personal Care
T1028 HD	Home Assessment/Client Education

Additional medically <u>necessary</u> home care beyond the limits of the HBP Program will require program exception. Program exception requests must be submitted to the department using the MA-97 (Outpatient Services Authorization Request) form, which is available on the Web site.

Payment and Billing Policies

The following procedure code modifier combination codes are limited to billing once during each pregnancy:

T1001 U9 HD	Healthy Beginnings Plus Intake Package
S9444 HD	Parenting Program
S9451 HD	Prenatal Exercise Series
S9436 HD	Comprehensive Childbirth Preparation
	-OR-
S9437 HD	Childbirth Preparation Review

Payment and Billing Policies for Counseling Services

Providers billing for Counseling Services must meet the qualifications outlined in the HBP manual. The need for these services must be identified in the Healthy Beginnings Plus Care Coordination Package (MA-403), which consists of the Care Coordination Record, the Comprehensive Problem List, and the Health Promotion Log, which are part of the medical record.

Genetic Risk Assessment, information and referral counseling is billable under the following procedure code modifier combination and is limited to twice during each pregnancy (This service must be provided by a qualified HBP obstetric care practitioner or other qualified DPW-approved staff member and include referral to appropriate clinical genetics center or specialist for the genetic disorder/risk identified.)

99205 TF HD	Genetic Risk Assessment, information and referral counseling (each unit of service is 15 minutes)

Payment and Billing Policies

Psychosocial Counseling is billable under the following procedure code modifier combination if provided by a social worker, psychologist, psychiatrist, or other DPW-approved mental health worker.

H0004 U8 HD	General Counseling and Support (Psychosocial Counseling) (each unit of service is 15 minutes)

Payment and Billing Policies

Nutrition Counseling is billable under the following procedure code modifier combination.

S9470 U7 HD	Nutrition Counseling (each unit of service is 15 minutes)

Payment and Billing Policies

Substance Abuse Problem Identification and Referral Counseling is billable under the following procedure code modifier combination if this service is provided by or under the direction of the social worker in charge of psychosocial services

H0004 U9 HD	Substance Abuse Problem Identification and Referral Counseling (each unit of service is 15 minutes)

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Payment and Billing Policies for Counseling Services

Smoking (Tobacco) Cessation Counseling is billable under the following procedure code modifier combination if provided by the medical provider, care coordinator, or other qualified staff person.

G9016 HD	Smoking (Tobacco) Cessation Counseling (each unit of service is 15 minutes)

Payment and Billing Policies

Trans-portation

Reimbursement for **Recipient Transportation** under the HBP program is billable for *urgent* transportation where the HBP provider must see the pregnant woman to assess her immediate condition. Mileage is reimbursed if transported by private vehicle or public carrier transportation for which the provider has maintained a receipt for transportation in the medical record.

A0425 U9 HD	Urgent Transportation Only-Car (1 unit of service is equal to 1 mile.)
T2003 U9 HD	Urgent Transportation Only Public Carrier (1 unit of service is equal to 1 round trip)

HBP provider may bill for **Provider Transportation** under code A0425 with HD modifier only after the rendering and billing of one of the following procedure code modifier combination visit home codes (1 unit of service is equal to 1 mile.):

T1028 HD	Home Assessment/Client Education
G0154 U9 HD	Post Partum Home Nursing Care
G0156 U9	Home Health Aide Care **or** Post Partum Home Health Aide Care
99050 HD	Post Partum Obstetric Home Care (rendered by the OB practitioner)
99500 U9 HD	Prenatal Obstetrical Home Care (rendered by the OB practitioner)
99500 HD	Prenatal Home Care
99501 HD	Post Partum Home Assessment/Client Education
99509 HD SC	Post Partum Personal Care
99509 HD	Personal Care

CMS-1500 Claim Form Completion for PROMISe™ HBP Providers

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:

- **Healthy Beginnings Plus (HBP) Providers**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:
  - **M** – Indicates that the claim block must be completed.
  - **A** – Indicates that the claim block must be completed, if applicable.
  - **O** – Indicates that the claim block is optional.
  - **LB** – Indicates that the claim block should be left blank.
  - * **–** Indicates special instruction for block completion.
  - **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

CMS-1500 Claim Form Completion for PROMISe™ HBP Providers

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24F ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24F, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is thirty-five dollars, enter:

24F	
$CHARGES	
35	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

CMS-1500 Claim Form Completion for PROMISe™ HBP Providers

You must follow these instructions to complete the CMS-1500 claim when billing the Department of Public Welfare. **Do not imprint, type, or write any information on the upper right-hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit recipient number found on the ACCESS card. If the recipient number is not available, access the Eligibility Verification System (EVS) by using the recipient's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit recipient number to use for this block.
2	Patient's Name	O	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.
3	Patient's Birthdate and Sex	O	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to the Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.

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Block No.	Block Name	Block Code	Notes
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.
8	Patient Status	O	Place an **X** in the appropriate blocks to describe the patient's status.
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy and Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a-d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9a-d, if you have completed Blocks 11a-d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Other Insured's Date of Birth	A	If a secondary insurance exists, enter the other insured's date of birth. Please make sure the date is in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and indicate the patient's gender by placing an **X** in the appropriate box.
9c	Employer's Name or School Name	A	Enter the name of the other insured's employer.
9d	Insurance Plan Name or Group Name	A	Enter the other insured's insurance plan name or group name.

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Block No.	Block Name	Block Code	Notes
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's 2-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for Pennsylvania).
10d	Reserved For Local Use	A	It is optional to enter the nine-digit social security number of the policyholder if the policyholder is not the recipient.
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3.
11b	Employer's Name or School Name	A	Enter the name of the other insured's employer for the primary insurance.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9a-d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The patient's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.)

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Block No.	Block Name	Block Code	Notes
			Note: Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current:	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).
15	If Patient Has Had Same or Similar Illness	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Physician or Other Source	A	Enter the name and degree of the referring or prescribing practitioner, when applicable.
17a	I.D. Number of Referring Physician	A	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number **1D** = 13-digit Provider ID number (Legacy Number) In the second portion, enter the **license number** of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456).

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Block No.	Block Name	Block Code	Notes
			If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.
17b	NPI #	M	Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Reserved For Local Use	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**", followed by a two-digit number (i.e., **AT05**). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**", indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form. When using "**AT10**", indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form. Attachment Type Code "**AT99"** indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the recipient's number on the top left-hand corner of the page (i.e., Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's recipient number. On the remarks sheet, include the mother's full name, date of birth, and social security number.).

CMS-1500 Claim Form Completion for PROMISe™ HBP Providers

Block No.	Block Name	Block Code	Notes
			If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook. *For additional information on completing CMS-1500 claim form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*
		A	**Qualified Small Businesses** Qualified small businesses must always enter the following message in Block 19 (Reserved for Local Use) of the CMS-1500, in addition to any applicable attachment type codes: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
***Note:** If the recipient has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim.			
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	Enter the most specific three-, four-, or five-digit ICD-9-CM code that describes the diagnosis. The primary ICD-9-CM code block (21.1) must be completed. The second, third, and fourth diagnosis codes must be completed if applicable. Pregnancy diagnosis code should be the first code listed on all HBP claims including for the post-partum period.

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Block No.	Block Name	Block Code	Notes
22	Medicaid Resubmission	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Dates of Service	M/A	Enter the applicable date(s) of service. For first and second maternity care packages use the last day of the trimester as the date of service. For third trimester packages use the date of the post partum visit as the date of service.
24b	Place of Service	M	Enter the two-digit place of service code that indicates where the service was performed. **11** – Office **12** – Home **21** – Inpatient Hospital **22** – Outpatient Hospital **25** – Birthing Center **49 –** Independent Clinic **50** – Federally Qualified Health Center **72** – Rural Health Clinic **99** – Other Unlisted Facility (Community)
24c	EMG	A	Enter **1** if the service provided was in response to an emergency, **2** if urgent. Otherwise, leave this item blank.

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Block No.	Block Name	Block Code	Notes
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/M/A	List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to three additional informational modifiers, when applicable. If no pricing modifier is required, enter up to four additional / informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial. Please refer to the HBP crosswalk bulletin 01-05-03 for required modifiers at the following Web address: http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?AttachmentId=1033
24e	Diagnosis Code	M	This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 21), enter **1**. If provided for the secondary diagnosis, enter **2**. If provided for the third diagnosis, enter **3**, and for the fourth diagnosis, enter **4.**
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is thirty-five dollars, enter **3500**.
24g	Days or Units	M	Enter the number of units, services, or items provided. Please refer to the unit limits previously stated in this billing guide.

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Block No.	Block Name	Block Code	Notes
24h	EPSDT/Family Planning	A	Enter the two-digit Visit Code, if applicable. Visit Codes are especially important if providing services that do not require copay (i.e., for a pregnant recipient or long-term care resident.) HBP providers must include the "09" *Pregnant Recipient* visit code on all HBP claims. *For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **1D** = 13-digit Provider ID Number (legacy #)
24j	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	M	Enter the 10-digit NPI number of the rendering provider.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to ten alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect patient number is listed.
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
29	Amount Paid	A	If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. **Do not enter copay in this block.**
30	Balance Due	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, except for abortions, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004).
32	Service Facility Location Information	LB	Do not complete this block.
32a		LB	Do not complete this block.
32b		LB	Do not complete this block.
33	Billing Provider Info & Ph.#	A/A& M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)