

HOW TO SUBMIT OWCP - 1500 BILLS TO THE FEDERAL BLACK LUNG PROGRAM

**OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF COAL MINE WORKERS' COMPENSATION**

The services performed by the following providers should be billed on the OWCP -1500 Form:

◦ Physicians (MD, DO)	◦ DME Suppliers	◦ Independent Laboratories
◦ Ambulatory Surgical Centers	◦ Home Nursing Agencies	◦ Ambulance
◦ Pulmonary Rehabilitation	◦ Pharmacies (Optional)	◦ Nursing Homes (Limited)

BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8302
London, KY 40742-8302

HOW WE WILL PROCESS YOUR BILL:

Bills will be processed by Affiliated Computer Services, the Fiscal Agent for the Office of Worker's Compensation Programs which includes the Federal Black Lung Program. The ACS facility in London, Kentucky will receive and scan your bill. If the bill must be returned without processing, you will be notified with a Return to Provider letter giving the reason. The bill should be resubmitted with the necessary corrections to London.

After the bill is scanned and entered into the processing system, it will be reviewed to determine if it is payable under the Federal Black Lung Program. You will then be issued a Remittance Voucher (RV), approximately 1 week from date of payment, describing, if applicable, the payment made, a reason for denial, and a reason why full payment was not approved. The RV will be mailed to you from London, Kentucky. At approximately the same time, an electronic funds transfer of the approved amount will be made to your financial institution.

ELECTRONIC SERVICES

ACS is pleased to offer enhanced services on its web portal (<http://owcp.dol.acs-inc.com/portal/main.do>). To take advantage of these services, and others that may be added in the future, you will need to know the patient's information, including the claim number and the Black Lung Benefits Identification Card number, which is a 10-digit number on the reverse side of the card that every eligible beneficiary receives. The claim number is the patient's Social Security number, which does not appear on the card for security reasons.

REMITTANCE VOUCHER RETRIEVAL

Retrieving DOL remittance vouchers via electronic media offers the advantage of speed in retrieval. Providers may access reports online as well as receive paper copies of the remittance vouchers.

The Electronic Data Interchange (EDI) Support Unit assists providers who have questions about electronic bill submission. ACS's EDI Support Unit is available to all providers Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time at 800-987-6717.

EDI Support will:

- Provide information on available services.
- Assist in enrolling users for report retrieval.
- Provide technical assistance on retrieval difficulties.

CLAIMANT ELIGIBILITY INQUIRY

Because the Federal Black Lung Program is limited to coverage of treatment for the patient's pneumoconiosis and related illnesses, the web portal also allows you to help determine if a procedure or diagnosis is covered, or if the patient was covered on a specific date of service.

USING THE OWCP -1500

Physician services rendered in the treatment of a miner's pulmonary disease are reimbursable under the following categories: office visits, hospital visits, procedures at an outpatient clinic, home visits, pulmonary consultations, immunizations for flu and pneumonia, radiology for the diagnosis and/or treatment of a pulmonary disease, pulmonary therapy, and prescriptions for and administration of drugs on the lists of drugs and laboratory tests covered by the Department of Labor program. When care is rendered for an acute condition causing hospitalization, emergency room, or ambulatory care services, the acute condition must be indicated on the billing form before reimbursement can be considered.

AUTHORIZATION REQUIREMENTS

The Federal Black Lung Program pays for medical services rendered to coal miners disabled from pneumoconiosis (black lung disease). Some services, specifically home nursing services, pulmonary rehabilitation, and durable medical equipment, require prior authorization in the form of a Certificate of Medical Necessity (CM-893.) Because the Federal Black Lung Program has unique requirements and standards for authorization, the CM-893 is required. To request a Certificate of Medical Necessity, you may contact the claimant's district office or download and

print the CMN at <http://www.dol.gov/esa/regs/compliance/owcp/cm-893.pdf>. See Attachment 1 or go to <http://www.dol.gov/esa/contacts/owcp/blcontac.htm>) for the appropriate DCMWC District Office address and telephone number.

Nursing homes that provide services requiring pre-approval must also follow these procedures, and bill using the OWCP -1500. The Federal Black Lung Program does not cover room and board for nursing homes, but will pay for covered physicians' services and prescriptions in addition to pre-approved services.

BILLING REQUIREMENTS

1. **All bills must contain the 9-digit Social Security number of your patient and your 9-digit DCMWC provider number. Your patient's SSN is not shown on the Black Lung Benefits Identification Card for privacy reasons.**
2. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).

The following modifiers must be used for services requiring anesthesia:

Anesthesia	AA
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3. For surgical procedures, no modifier is necessary. If an assistant surgeon is needed, services must be coded with modifier 80:

Surgical Assistant	80
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4. Drugs dispensed/administered at the physician's office:

Oral medication: Bill using the appropriate NDC and HCPC Code J8499

Injectable medication: Bill using the specific HCPCs injection code and optionally CPT 4 code 90782

5. When billing for services over a period of time, use the "From" and "Through" dates with the appropriate units for each CPT code billed.

The following modifiers must be used for procedures billed as professional or technical components if a full fee is not billed:

Professional	26
Technical	TC

The following modifiers must be used for durable medical equipment billed as purchase or rental:

Purchase	1B
Rental	RR

6. For additional instructions, please refer to Attachment 2, a detailed OWCP -1500 listing with the required fields.

Attachment 1 - Black Lung District Office List

<p><u>JOHNSTOWN, PENNSYLVANIA</u></p> <p>U.S. Department of Labor ESA/OWCP/DCMWC 319 Washington Street, Second Floor Johnstown, Pennsylvania 15901 Commercial: (814) 533-4323 Toll-Free: (800) 347-3754</p>	<p>Virginia</p> <p>Thirty-seven counties in Pennsylvania: Adams, Bedford, Berks, Blair, Bucks, Cambria, Cameron, Centre, Chester, Clearfield, Clinton, Cumberland, Dauphin, Delaware, Elk, Franklin, Fulton, Huntingdon, Indiana, Jefferson, Juniata, Lancaster, Lebanon, Lycoming, McKean, Mifflin, Montgomery, Montour, Northumberland, Perry, Philadelphia, Potter, Somerset, Snyder, Tioga, Union, and York.</p>
<p><u>GREENSBURG, PENNSYLVANIA</u></p> <p>U.S. Department of Labor ESA/OWCP/DCMWC 1225 South Main Street, Suite 405 Greensburg, Pennsylvania 15601 Commercial: (724) 836-7230 Toll-Free: (800) 347-3753</p>	<p>Maryland</p> <p>Sixteen counties in Pennsylvania: Allegheny, Armstrong, Beaver, Butler, Clarion, Crawford, Erie, Fayette, Forest, Greene, Lawrence, Mercer, Venango, Warren, Washington, and Westmoreland</p>
<p><u>WILKES-BARRE, PENNSYLVANIA</u></p> <p>U.S. Department of Labor ESA/OWCP/DCMWC 100 N. Wilkes-Barre Blvd., Room 300 A Wilkes-Barre, PA 18702 Commercial: (570) 826- 6457 Toll-Free: (800) 347-3755</p>	<p>Connecticut, Delaware, District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, Puerto Rico, Rhode Island, Vermont</p> <p>The following fourteen counties in Pennsylvania: Bradford, Carbon, Columbia, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Wayne, and Wyoming.</p>
<p><u>CHARLESTON, WEST VIRGINIA</u></p> <p>U.S. Department of Labor ESA/OWCP/DCMWC Charleston Federal Center - Suite 110 500 Quarrier Street Charleston, West Virginia 25301 Commercial: (304) 347-7100 Toll-Free (800) 347-3749</p>	<p>Fifteen counties in West Virginia including Boone, Cabell, Fayette, Kanawha, Lincoln, Logan, McDowell, Mercer, Mingo, Monroe, Putnam, Raleigh, Summers, Wayne and Wyoming.</p>
<p><u>PARKERSBURG, WEST VIRGINIA</u></p> <p>U.S. Department of Labor ESA/OWCP/DCMWC, Suite 3116 425 Juliana Street Parkersburg, West Virginia 26101 Commercial: (304) 420-6385 Toll-Free: (800) 347-3751</p>	<p>All counties in West Virginia not under the jurisdiction of the Charleston Office.</p>

Continued on following page

PIKEVILLE, KENTUCKY

**U.S. Department of Labor
ESA/OWCP/DCMWC
164 Main Street, Suite 508
Pikeville, Kentucky 41501
Commercial: (606) 432-0116
Toll-Free: (800) 366-4599**

All claims from Kentucky. This office is part of the Jacksonville Region

MOUNT STERLING, KENTUCKY

**U.S. Department of Labor
ESA/OWCP/DCMWC
402 Campbell Way
Mount Sterling, Kentucky 40353
Commercial: (859) 498-9700
Toll-Free: (800) 366-4628**

Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee. This office is part of the Jacksonville Region.

COLUMBUS, OHIO

**U.S. Department of Labor
ESA/OWCP/DCMWC
1160 Dublin Road Suite 300
Columbus, Ohio 43215
Commercial: (614) 469-5227
Toll-Free: (800) 347-3771**

Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.

DENVER, COLORADO

**U.S. Department of Labor-Black Lung
ESA/OWCP/DCMWC
1999 Broadway, Suite 690
P.O. Box 46550
Denver, Colorado 80201-6550
Commercial: (720) 264-3100
Toll-Free: (800) 366-4612**

Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Guam, Hawaii, Idaho, Iowa, Kansas, Louisiana, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, the North Mariana Islands, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, and Wyoming.

Attachment 2 – Detailed Instructions for Completion of OWCP-1500

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA PICA <input type="checkbox"/>																			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CIAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)									
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE						
ZIP CODE			TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE			TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNED _____										DATE _____					SIGNED _____				
14. DATE OF CURRENT: MM DD YY			ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
					17b. NPI _____														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER _____									
2. _____ 4. _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE YY	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. SPDY Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #							
1											NPI								
2											NPI								
3											NPI								
4											NPI								
5											NPI								
6											NPI								
25. FEDERAL TAX I.D. NUMBER			SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	30. BALANCE DUE \$						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()									
SIGNED _____					DATE _____					a. NPI		b. NPI							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS –1500 Claim Item	Title	Action	Required?
1	Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	No Entry Required.	N
1a	Insured's ID Number	Mandatory Field. Enter the claimant's case number.	Y
2	Patient's Name	Enter the claimant's last name, first name, and middle initial.	Y
3	<u>Patient's Birth Date, Sex</u>	Enter the claimant's 8-digit birth date (MM DD CCYY). Use an "X" to mark the appropriate box for patient sex.	Y
4	Insured's Name	Enter the claimant's last name, first name, and middle initial.	Y
5	Patient's Address	Enter the claimant's address and telephone number.	Y
6	Patient's Relationship to claimant	No Entry Required.	N
7	Insured's Address	No Entry required unless the claimant is covered by other insurance.	N
8	Patient Status	No Entry Required.	N
9a-d	Other Insured's Name	If Item Number 11d is marked, complete fields 9 and 9a-d, otherwise leave blank.	N
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the claimant.	N
9b	Other Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM DD CCYY) of the other claimant and an X to indicate the sex of the other claimant. Only one box can be marked. If gender is unknown, leave blank.	N
9c	Employer's Name or School Name	Enter the name of the other claimant's employer or school.	N
9d	Insurance Plan Name or Program Name	Enter the claimant's insurance plan or program name.	N
10a-c	Is Patient's Condition Related to:	When appropriate, enter an X in the correct box.	N
10d	Reserved for Local Use	No Entry Required.	N

11	Insured's Policy, Group, or FECA Number	Enter the claimant's policy or group number as it appears on the claimant's health care identification card. If Item Number 4 is completed, then this field should be completed.	N
11a	Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM DD CCYY) of the claimant and an X to indicate the sex of the claimant.	N
11b	Insured's Employer's Name or School Name	Enter the name of the claimant's employer or school.	N
11c	Insurance Plan Name or Program Name	Enter the insurance plan or program name of the claimant.	N
11d	Is there another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a-d.	N
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6 digit format (MMDDYY) or 8-digit format (MMDDCCYY). If there is no signature on file, leave blank or enter "No Signature on File."	Y
13	Insured's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."	Y
14	Date of current illness, injury or pregnancy	No Entry Required.	N
15	If Patient Has Had Same or Similar Illness	No Entry Required.	N
16	Dates Patient Unable to Work in Current Occupation	No Entry Required.	N
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(s) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider	N
17 a	Other ID#	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.	N
17 b	NPI #	Enter the NPI number of the referring, ordering, or supervising provider.	N

18	Hospitalization Dates Related to Current Services	No Entry Required.	N																								
19	Reserved for Local Use	No Entry Required.	N																								
20	Outside Lab? \$Charges	Complete this field when billing for purchased services.	N																								
21	Diagnosis or Nature of Illness or Injury	Enter the diagnosis/condition. List up to four ICD-9-CM diagnosis codes.	Y																								
22	Medicaid Resubmission Code	No Entry Required.	N																								
23	Prior Authorization Number	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. (Optional)	N																								
24a	Date(s) of Service	Mandatory Field. Enter the beginning date of service in month, day, year format. Services rendered in one calendar month may be billed on one line with a "From Date" and a "To Date."	Y																								
24b	Place of Service	Mandatory Field. Enter the two-digit place of service (POS) code for each procedure performed.	Y																								
24c	EMG	No Entry Required.	N																								
24d	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) <u>and</u> modifier(s) (if applicable) from the appropriate code set in effect on the date of service. <table style="margin-left: auto; margin-right: 0;"> <thead> <tr> <th colspan="2" style="text-align: right;">Modifier</th> </tr> </thead> <tbody> <tr><td>DME Rental</td><td style="text-align: right;">RR</td></tr> <tr><td>Purchase</td><td style="text-align: right;">1B</td></tr> <tr><td>Determination</td><td style="text-align: right;">1D</td></tr> <tr><td>Home Nurse</td><td style="text-align: right;">1N</td></tr> <tr><td>Professional Component</td><td style="text-align: right;">26</td></tr> <tr><td>Determination Professional</td><td style="text-align: right;">1Q</td></tr> <tr><td>Technical Component</td><td style="text-align: right;">TC</td></tr> <tr><td>Determination Technical</td><td style="text-align: right;">1V</td></tr> <tr><td>Pulmonary Rehab</td><td style="text-align: right;">1X</td></tr> <tr><td>Anesthesia</td><td style="text-align: right;">AA</td></tr> <tr><td>Surgical Assistance</td><td style="text-align: right;">80</td></tr> </tbody> </table>	Modifier		DME Rental	RR	Purchase	1B	Determination	1D	Home Nurse	1N	Professional Component	26	Determination Professional	1Q	Technical Component	TC	Determination Technical	1V	Pulmonary Rehab	1X	Anesthesia	AA	Surgical Assistance	80	Y
Modifier																											
DME Rental	RR																										
Purchase	1B																										
Determination	1D																										
Home Nurse	1N																										
Professional Component	26																										
Determination Professional	1Q																										
Technical Component	TC																										
Determination Technical	1V																										
Pulmonary Rehab	1X																										
Anesthesia	AA																										
Surgical Assistance	80																										
24e	Diagnosis Pointer	Enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis.	Y																								
24f	\$ Charges	Enter number right justified in the dollar area of the field. Do not use commas. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	Y																								

24g	Days or Units	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.	Y
24h	EPSDT/Family Plan	No Entry Required.	N
24i	ID Qualifier	Enter in the shaded area of 24i the qualifier identifying if the number is a non-NPI.	N
24j	Rendering Provider ID #	Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the un-shaded area of the field.	N
25	Federal Tax ID Number	Enter the provider of service or supplier federal tax ID (employer identification number) or Social Security number. Enter an X in the appropriate box to indicate which number is being reported.	Y
26	Patient's Account No.	Enter the patient's account number assigned by the provider of services or supplier's accounting system.	N
27	Accept Assignment	No Entry Required.	N
28	Total Charge	Enter total charges for the services (i.e., total of all charges in 24f).	Y
29	Amount Paid	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	N
30	Balance Due	Enter total amount due.	N
31	Signature of Physician or Supplier Including Degrees or Credentials Bill Date	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit or 8 digit date, or alphanumeric date (e.g., January 1, 2003) that the form was signed.	Y
32	Service Facility Location Information	Enter the name, address, city, state, and zip code of the location where the services were rendered.	Y
32 a	NPI#	Enter the NPI number of the service facility location in 32a.	N
32 b	<u>Other ID#</u>	Enter the two digit qualifier identifying the non-NPI number followed by the ID number.	N

33	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, zip code, and phone number.	Y
33 a	NPI#	Enter the NPI number of the billing provider.	N
33 b	Other ID#	ACS Provider Number is required <i>You may also see a two digit qualifier identifying the non-NPI number followed by the ID number.</i>	Y

Attachment 3 – Place of Service Codes

Place of Service Codes (POS)

Code	Description
11	Office
12	Patient Home
15	Mobile Unit
20	Urgent Care
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
50	Federally Qualified Health Center
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service