August 2010 Volume 1, Issue 4

WCH Bulletin

Welcome back our readers!

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Going Electronic is Essential

Technology can be complicated and difficult to grasp at first, but overall will improve the burden of messy offices, losing valuable documents, etc. Technology can help by simplifying your day to day operations. Software can improve patient quality of life and outcomes by making care recommendations and documenting that they were done with real-time accessibility. Technology also greatly affects the facility's financials. You simply can't ignore the fact that reimbursement is what allows you to stay in business. If your office is still working with more paper than technology it might be time that you reach the moment of enlightenment that allows you to see past the confusion and embrace technology. It will not only benefit you, but your patients and employees.

Article referred : ADVANCE for Physical Therapy & Rehab Medicine | July, 12 2010 pg. 11

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New Sections on NGSMedicare.com

Recovery Audit Contractor Section

A new Recovery Audit Contractor (RAC) section on NGSMedicare.com has been added for provider and supplier interests in the Centers for Medicare & Medicaid (CMS) RAC program. The **Recovery Audit Contractor** section answers important questions about the program, such as:

- What is the RAC Program?
- What are the RAC responsibilities?
- Who are the RACs?
- How will I know when a payment determination has been issued?
- What are my options when I receive the RAC demand letter?
- How can I contact the RAC?
- What are other RAC resources?

WCH encourages you to take interest in this section of the NGS website in order to know and understand what this program does and how it works. To access the new Recovery Audit Contractor section from the NGSmedicare.com home page, select your business type, select go. From your portal home page, select Review Process from the site's global navigation (dark blue menu), then select the **Recovery Audit Contractor** sub navigation option.

New Providers Page Sections

For providers who have recently became newly certified Medicare providers or facilities, and are wondering what your next steps are should be. – There is now a "Welcome New Providers" web page for home health, hospice, and Part B providers. The section answers questions such as:

- "How do I contact NGS?"
- "I wonder what types of education are being offered."
- "Where can I find recourses to guide me step-by-step through the Medicare Program?"

The Web page also offers valuable information such as: training events calendar, Medicare University, NGS services' free Listserv, educational manuals, local medical polices via the Medical Policy Center, electronic data interchange products and services, NGS contact information, CMS web site links.
To access the new Providers Page Sections from the NGSmedicare.com home page, select your business type, select go. From your portal home page, select Education and Support the site's global navigation (dark blue menu), then select the **Welcome New Providers** sub navigation option.

Source of Information obtained from: National Government Service News Update E-Mails

HealthFirst Website Upgrade

Health First had upgraded their website on July 30th. The upgrade will simplify the use of the site and deliver content in new ways. The website provides convenient access to claims status, authorization, enrollment roasters and members eligibility. In order to keep the system protected, all users of the website will be required to reset their passwords after logging in to the new service for the first time. Once you've changed your passwords please inform WCH of the change so that we can update our records as well. https://secure.healthx.com/publicservice/loginv1/login.aspx?bc=dff1a93d-8b41-4a99-80e4-7160440c9389&serviceid=ce229792-b95f-4508-8d8c-9329ff14d1f9
Source of information obtained from: Health First News Update E-mail

Payment Increase for Medicare Skilled Nursing Facilities

Centers for Medicare and Medicaid announce that payment rates for Medicare Skilled Nursing Facilities will increase. Payment rates for nursing homes will increase 1.7% for fiscal year 2011. The increase will result in an estimated $542 million increase in Medicare payments to nursing homes across the country during FY 2011. *Cont. on next pg.*

This rule has been published in the Federal Register on July 22nd. A Copy of the update notice is available on the CMS website at: http://www.cms.gov/SNFPPS/LSNFF/list.asp#TopOfPage

Special Enrollment for Physicians with Infrequent Reimbursement from Medicare

With the implementation of Section 6405 of the Affordable Care Act, some physicians will need to enroll in the Medicare program for the sole purpose of certifying or ordering services for Medicare beneficiaries. These physicians do not send claims to a Medicare contractor for the services they furnish. Physicians: employed by the Department of Veterans Affairs, employed by the Public Health Service, employed by the Department of Defense Tricare program, employed by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Critical Access Hospitals (CAHs), in a fellowship, and dentists, including oral surgeons are put into this special circumstance.

Source of information: https://www.highmarkmedicareservices.com/bulletins/all/news-07152010.html

A New Way to Submit Electronic Medical Record to NGS

National Government Service (NGS) has announced that they are now able to accept medical records submitted on a CD-ROM! They state that their preference is that if the documents are loaded onto the CD-ROM using WinZip. The records submitted should be only for NGS business department; records intended for the Medical Review Department should not be on the same CD-ROM as records submitted for the Appeals Department.

A cover sheet must be included with each CD-ROM, which should include: 1. The business department who receives the CD-ROM (Medical Review, Appeals, etc.); 2. The specific claim(s) information (beneficiary name, Medicare number, dates of service, and claim number) for each claim on the CD-ROM; 3. The reasons records are being submitted; 4. The password, if applicable.

Source of Information obtained from: National Government Service News Update E-Mails

Update Your PECOS

WCH had previously informed you that **beginning July 6, 2010** - Medicare requires that all referring/ordering physicians and suppliers must be enrolled in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS).

CMS in several of their publications has noted that many health care providers are making an effort to update PECOS records. WCH wants to ensure that **your records** are up-to-date and accurate, so that your billing privileges and ordering/referring will be covered. Even though the regulation of July 6, 2010 was implemented, CMS is continuing to process claims with the understanding that Medicare providers are making the effort now to update their files in PECOS. Please keep in mind that Medicare can retroactively request refund of payments if your record has not been updated in PECOS.

Beginning July 6th: Medicare requires that all referring/ordering physicians and suppliers must be enrolled in PECOS

Reasons to update your PECOS records:

If you are still receiving paper checks, changed locations but have not informed Medicare or changed your corresponding address - all these changes can delay your reimbursement and ordering/referring privileges with Medicare. Those providers who will not be enrolled in PECOS and will refer patients to your office, this will also impact you, as you will not be reimbursed for the services or supplies you provided to the referred patients.

The application process takes from 45 to 90 days; therefore, you should not wait to update PECOS records. WCH can help you by processing your updates and ensure that you will not lose your reimbursement.

Right now it must be your priority to update your Medicare files! Please contact our general manager Olga Khabinskaya at (718) 934-6714 ext 1201 or via email at OlgaK@wchsb.com to start your update today.

President Signs "Improper Payments Elimination" Bill

President Obama signed the Improper Payments Elimination and Recovery Act (IPERA) July 22. The bill is designed to cut waste, fraud, and abuse due to improper payments by federal government agencies. Areas with a history of improper payments, such as chiropractic services, will be targeted. In 2009, improper payments totaled nearly $110 billion—the highest amount to date. This includes tens of billions of dollars in payments made in error or because of fraudulent claims by contractors and organizations as well as more than $180 million in improper payments sent to individuals who are dead and $230 million in improper payments to prisoners and fugitives—none of whom qualify for benefits.

The president has instructed his administration to reduce these improper payments by $50 million by 2012 and to create a "Do Not Pay" list—a consolidated database of every individual and company that is ineligible for federal payments.
"Before checks are mailed, agencies will be required to check this list to make sure the payment is going to the right person, in the right amount, for the right reason." , said President Obama, before signing the bill in the White House.

The bill outlines steps federal agencies will need to take to reduce and recover improper payments, including:

- **Identification and Estimation of Improper Payments.** IPERA requires federal agencies to conduct annual risk assessments, and if a program is found to be susceptible to significant improper payments, then agencies must measure improper payments in that program. Further, over time, IPERA lowers the threshold for determining if a program is susceptible to improper payments.
- **Payment Recapture Audits.** The bill expands the types of programs that are required to conduct payment recovery audits (from contracts to all types of programs and activities, including grants, benefits, loans, and contract payments), and lowers the threshold for programs and activities that must conduct these reviews, if cost-effective (from $500 million to $1 million in annual outlays).
- **Use of Recovered Improper Payments.** IPERA also authorizes agency heads to use recovered funds for additional uses than what is currently allowed, including improving their financial management, supporting the agency's Office of Inspector General (OIG), and for the original intent of the funding.
- **Compliance and Non-Compliance Requirements.** Currently, if an agency does not reduce improper payments or implement the existing law, there are no repercussions. Under IPERA, there is a list of actions that an federal agency must take to be in compliance with the law, and the agency Inspector General is responsible for determining whether the agency is in compliance with the law. If the agency is found not to be in compliance with the law, then IPERA contains a series of actions that the agency must implent to improve its error reduction efforts.

The IPERA is available for viewing on The Library of Congress website.

Chiropractors Targeted

According to WPS Medicare, chiropractic services fall within the list of four supplemental measures listed in the strategy developed by the federal government. Chiropractic physicians throughout the Medicare administrative contractor's (MAC's) jurisdiction 5 (Iowa, Kansas, Missouri, and Nebraska) will be part of the national review aimed at eliminating payment error, waste, fraud and abuse in federal programs.
Beginning August 2010, Comprehensive Error Rate Testing (CERT) contractors will begin requesting records from chiropractic offices as part of a Special Studies request. Unlike traditional CERT requests, Special Studies requests use targeted samples, focused scripts and allow only 30 days for submission of requested medical records. Other measures include those for power wheelchairs, inpatient hospital short stays, and pressure reducing support surfaces. For additional information, refer to the Medicare Fee-for-Service portion of the Payment Accuracy website by clicking on "High Error Programs" at the top of the page.

Article directly obtained from: http://news.aapc.com/index.php/2010/07/president-signs-%E2%80%9Cimproper-payments-elimination%E2%80%9D-bill/

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The Federal and New York State Implementation of the Health Care Reform

Federal Health Reform Laws for 2010
No discrimination against children with pre-existing conditions
Help for uninsured Americans with pre-existing conditions
End rescissions: ban insurances for dropping people from health insurance coverage after they get sick due to an unintentional mistake on their paperwork (effective September 2010)
Extends coverage for young people up to the age 26 on their parents' insurance
Bans lifetime limits on coverage
Regulates annual limits on insurance coverage
Help for early retirees
Small business tax credits
No cost-sharing for preventive care under new private plans
Prohibits discrimination based on salary
Medicare Part D donut hole rebate checks: Starting mid-June a tax free, onetime $250 rebate check will be automatically sent to Medicare Part D enrollees who reach the coverage gap (also known as "donut hole")
Web portal: U.S. Department of Health and Human Services (HHS) has developed a website through which individuals and small businesses can identify affordable health insurance coverage options. The website, www.HealthCare.gov provides information on health insurance coverage, Medicaid, CHIP, Medicare, Pre-existing condition insurance, small group coverage (including early retirees, tax credits, and other)
Choice of primary care provider
Direct access for OB/GYN services

New York State is Impacted stronger by reform than other States
Guaranteed Issue: health insurance companies must issue a health insurance policy to anyone who applies for it.
Adjusted community rating: New York has pure community rating, which means that in the individual and small group market, people are charged the same health insurance premiums regardless of age, sex, health status or occupation. Federal health reform introduces "adjusted community rating," which would permit limited differences in rating based on age and tobacco use. It is our understanding that because New York's standards exceed federal standards, New York can maintain its current requirements.
Affordability
Pre-existing Condition Waiting Periods
Coverage Extension to Age 26
Ensures Value For Premium Payments
No Copayments For Preventive Care Under New Private Plans

To read more about the Health reform please visit the source of information.
Source of information obtained: http://www.healthcarereform.ny.gov/summary/

Seven Things You Should Check in Your Charts

1. Do you have the right patient? – Confusion can take place when patients have similar names, be sure to check the address and date of birth to verify that you are billing the correct individual.
2. Have you charged for the correct tests, procedures/services that were given or received? – Review the charge slip to verify how many tests were ordered on the day in question.
3. Are the hospitals' days, rooms, and services billed accurate? – Charges should be for the actual department in which the patient was seen. For example: if the patient was charged for an operating room, but was seen in a regular exam room.
4. Are the times correct? – Review that the increments of time are accurate.
5. Have you over-coded? – Review that the correct level of treatment is coded.
6. Are the quantities and items correct? – Watch out for the numbers, most often, too many zeros.
7. Are there overcharges or unbundles? – Make sure you aren't charging for items that can be included in the cost of something else.

Source of information obtained from: AAPC Coding Edge| Pg. 24

ICD-10 Q&A

Q: ***Is the October 1, 2013 compliance date for ICD-10 implementation flexible? Will the go-line date be delayed?***
A: All covered entities of HIPPA MUST implement the new code sets on October 1, 2013.

Q: ***Is the ICD-10-CM effective date based on service date of submission date for outpatient services?***
A: For all outpatients services, including ambulatory and physician service, the date of service is the effective date.

Q: ***Non-Covered entities are not covered under the HIPPA. (Includes: workers' compensation and auto insurance companies) – are they mandated to move to ICD-10-CM/PCS?***
A: No, however because ICD-9-CM/PCS will no longer be maintained after ICD-10-CM/PCS is implemented, it is in the non-covered entities best interest to use the new coding system.

Q: ***Will there be a transition time when we will be submitting both ICD-9-CM and ICD-10-CM codes at the same time for different payers?***
A: No, there is no indication that we will use both simultaneously.

Q: ***What is the estimated timeframe for the ICD-9 to ICD-10 conversion for an EHR system?***
A: Vendors of EHR systems have the same compliance requirements as providers and health plans. They must be compliant on October 1, 2013.

Q: ***Why should a small office purchase an electronic health record?***
A: Implementation of the EHR or electronic medical record (EMR) is not mandatory. Each individual medical office will need to assess whether or not an EMR will benefit the practice with quality reporting and efficiency. Complete and thorough investigation into types of EHRs and their benefits and barriers are imperative when considering an EHR.

Source of information obtained from: AAPC Coding Edge | Pg. 42-44

94 People Arrested in One Day for Medicare Fraud

On July 16, the Department of Justice-Health and Human Services Medicare Fraud Strike Force charged 94 people for allegedly participating in different schemes to bill over $250 million is false claims to Medicare.

The defendants span across five different states (Florida, Louisiana, New York, Michigan, and Texas), and were involved in various fraudulent schemes against the Medicare program. For instance, practitioners in Miami were accused of fraudulently billing for physical therapy, home health care, and HIV infusion services and a medical biller in that state is charged with billing approximately $49 million for fraudulent services.

Cont. on next pg.

Even Medicare patients were under the microscope, with one Medicare beneficiary accused of selling her Medicare number to various clinics in New York, according to a July 16 AP article on the topic.
To read the entire DOJ press release on the initiative, visit http://stopmedicarefraud.gov/innews/dc.html#july-16-2010

Source of information directly obtained from: The Coding Institute | Pg. 208

Overpayments on KX Modifier Claims

When the HHS Office of Inspector General audited a sample of 2006 DME claims with the KX modifier, it found $127 million in estimated overpayment. Now it's looking at 2007 claims, and the results are equally grim.

Certain durable medical equipment items require a KX modifier for Medicare claims. The modifier indicates that the item in question has extra documentation requirements and that the supplier has the required documentation on file.
The problem is that of a sample of 100 claims with the KX modifier from 2007 the OIG audited, was that 55 lacked required documentation, according to the OIG. "The KX modifier was not effective in ensuring that suppliers of DMEPOS had the required supporting documentation on file," the report says.

Extrapolated to all KX claims paid by contractors Palmetto GBA and CIGNA during the period, the Medicare program paid $137 million to suppliers for KX claim that lacked required documentation, the OIG concludes. The most common missing documentation was a physician's order for 40 of the 100 claims.

Source of information directly obtained from: The Coding Institute | Pg. 208

JUST RELEASED: MLN Matters Article #SE1024 - Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted

The Centers for Medicare & Medicaid Services (CMS) has released ***MLN Matters Special Edition Article #SE1024*** as the first in a series of articles concerning RAC high-dollar improper payment vulnerabilities. These articles are intended to provide education about RAC demonstration-identified vulnerabilities in an effort to prevent these same problems from occurring in the future. This article in particular focuses on Medicare's documentation requirements and how to avoid unnecessary denial of claims. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf on the CMS website.

Source of information directly obtained from: MLN Matters Article #SE1024 | E-mail Update

Carrier Assignment of Provider Transaction Access Numbers (PTANs)

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assign an additional PTAN(s) to a physician, non-physician practitioner, or other supplier merely because the individual or entity requests one, the only exception being for hospitals that request separate billing numbers for their hospital departments in section 2C of the CMS-855B enrollment application. However, a hospital requesting an additional PTAN must associate the new PTAN with an NPI in section 4 of the CMS-855.

Source of Information directly obtained from: http://www.cms.gov/manuals/downloads/pim83c10.pdf, pg 184

Questions & Answers: IDFT Medicaid Billing

Q: Forming Article 28 by a non-physician provider to perform IDTF services and have ability to bill for both technical and professional components. Is it possible to form Article 28 which will be later submitted for approval to CMS?

A: It is important to know if you are dealing with a state facility type or federal facility type. IDTF's are a federal entity only. They are not recognized as a facility type in New York State. However, NYS is beginning to look at them much closer and may create much stricter rules. But for right now, as it stands, an IDTF can either be:

- Owned entirely by a physician and bill for both the technical and professional component OR
- Owned by a non-physician and bill for the technical component only.

These are the only two choices. It is illegal for a non-physician owner to bill for both the technical and professional components.
Article 28 facilities are a New York State entity; therefore they cannot bill Medicare nor do they need to complete a CMS-855, as both Medicare and the CMS-855 are federal in nature.
To become an Article 28 facility, you need to submit a Certificate of Need (CON) application to the Project Management Unit. If the Article 28 facility wanted to enroll as a Medicare Provider, they would need to decide which type of federal facility they would like to become.

Source of information obtained from: Nancy S. Nusca, Division of Certification and Surveillance NYS Health

Q: A practice who has group in Medicaid wants to hire a technician who has its' own equipment to perform the technical component of diagnostic services in their office under supervision of their physician; that physician will also make an interpretation (reading) – professional component of the service. The technician will be paid a certain sum for each service performed. According to the Medicaid rules they are allowed to bill diagnostic services globally under supervising physician who is participating with Medicaid?

A: Medicaid regulation 18 NYCRR 505.17 provides the regulatory authority for Medicaid coverage of radiology procedures. Medicaid reimburses physicians the global fee for radiology services provided in the office setting - both the technical and professional component. In order for a physician to be reimbursed, the following must be met:
(f) Limitations on payment for **radiology** services.
(1) In order to be paid for both the professional and the technical and administrative components of the **radiology** service, as defined in section 533.6 (b) of this Title, qualified practitioners who provide **radiology** services in their offices must perform the professional component of **radiology** services as set forth in section 533.6 of this Title and:
(i) own or directly lease the equipment and must supervise and control the **radiology** technicians who perform the **radiology** procedures; or
(ii) be the employees of physicians who own or directly lease the equipment and must supervise and control the **radiology** technicians who perform the **radiology** procedures.

The link to the regulations is: http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/16df3004782e7a3785256722007690e2?OpenDocument&Highlight=0,radiology

In the situation you have described, it appears that the technician actually owns the equipment, not the physician. I believe that arrangement would not be acceptable to Medicaid.

Source of Information obtained from: Ron Bass, Director Bureau of Policy Development and Coverage Office of Health Insurance Programs

Q: **In reference to previous questions: Are the requirements mentioned for radiology - the same for other, non-radiology services such as VNG(CPT 92540 – 92546), EMG(CPT 95860 -95872) and Nerve Conduction (CPT 95900 - 95905) as there could be different rules and regulations for these services?**

A: Radiology services would be defined/listed in the radiology section of the physician fee schedule. The provider manuals and fee *cont on next pg.*

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schedules are available on-line at www.emedny.org. The radiology payment policy described applies to all procedures/cpt codes identified in the radiology section of the physician provider manual. It does not apply to procedure/cpt codes not listed in the radiology section.

Source of Information obtained from: Ron Bass, Director Bureau of Policy Development and Coverage Office of Health Insurance Programs

Medicare Cuts Home Health Agency Pay Rates

A proposed rule that went on display in the *Federal Register* July 16 indicates home health agencies (HHAs) can expect a 4.75 percent decrease in 2011 Medicare payments. Compared to 2010 payments, this amounts to about a $900 million pay cut for HHAs across the nation.

HHAs that submit the required quality data would receive payments based on the home health market basket update of 1.4 percent for 2011. If an HHA does not submit quality data, the home health market basket percentage increase would be reduced by 2 percentage points to -0.6 percent for 2011.

The Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act, mandates that the Centers for Medicare & Medicaid Services (CMS) apply a 1 percentage point reduction to the 2011 home health market basket amount, which equates to the proposed 1.4 percent update for HHAs. Based on updated data analysis, however, instead of the planned 2.71 percent reduction for 2011, CMS proposes to reduce Home Health Prospective Payment System (HH PPS) rates by 3.79 percent in 2011 and an additional 3.79 percent in 2012.

The Affordable Care Act also changes the existing home health outlier policy through a 5 percent reduction to HH PPS rates, with total outlier payments not to exceed 2.5 percent of the total payments estimated for a given year. HHAs are also permanently subject to a 10 percent agency-level cap on outlier payments.

The proposed rule offers an approach to implement an Affordable Care Act provision, which mandates that prior to certifying a patient's eligibility for the Medicare home health benefit, the physician must document that the physician or a non-physician practitioner (NPP) has had a face-to-face encounter with the patient.

Article directly obtained from: http://news.aapc.com/index.php/2010/07/medicare-cuts-home-health-agency-pay-rates/

**"With the recently announced Medicare fraud arrests, it's more important than ever for providers to make sure their documentation, coding and billing are in compliance.
Auditing is a key component to any compliance program." – AAPC**

Patient demographic and authorization forms are available for your use, please contact your account representative for a copy!

Patient Authorization Form Today's Date __/__/__

Insurance : | Representative Name : | Authorization # : | Date from : __/__/__ Date to : __/__/__
Ins. Type : Primary ▯ : Secondary ▯

Authorized Procedure Codes, Units

CPT 1. ____ UNITS ____ CPT 4. ____ UNITS ____ CPT 7. ____ UNITS ____
CPT 2. ____ UNITS ____ CPT 5. ____ UNITS ____ CPT 8. ____ UNITS ____
CPT 3. ____ UNITS ____ CPT 6. ____ UNITS ____ CPT 9. ____ UNITS ____

Insurance : | Representative Name : | Authorization # : | Date from : __/__/__ Date to : __/__/__
Ins. Type : Primary ▯ : Secondary ▯

Authorized Procedure Codes, Units

CPT 1. ____ UNITS ____ CPT 4. ____ UNITS ____ CPT 7. ____ UNITS ____
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CPT 3. ____ UNITS ____ CPT 6. ____

Insurance : | Representative Name
Ins. Type : Primary ▯ : Secondary ▯

Authorized Procedure Codes, Units

CPT 1. ____ UNITS ____ CPT 4. ____
CPT 2. ____ UNITS ____ CPT 5. ____
CPT 3. ____ UNITS ____ CPT 6. ____

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Patient Information Form Today's Date __/__/__

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First MI) | Date of Birth __/__/__ | Sex | Marital Status | Social Security No. __-__-__
Address (Street – City – State – Zip) | Home Phone (___)___-____ | Work Phone (___)___-____
Employer Name | Employer Address (Street – City – State – Zip)
Spouse's Name (Last, First, MI) | Spouse's DOB __/__/__ | Spouse's Social Security No. __-__-__ | Spouse's Work Phone (___)___-____ Spouse's Sex: ▯ - M ▯ - F
Nearest relative not living with you | Address (Street – City – State – Zip) | Home Phone (___)___-____
Emergency Contact | Relationship | Phone (___)___-____

INSURANCE INFORMATION

Primary Insurance Name | Address Where to send claims: | Effective Date | Group No. | Authorization #
Access number | Seq Number
Deductible: Copay : | I.D. No. | Auth DATES : Date from : __/__/__ Date to : __/__/__
Name of Insured : | Relationship: Self __ Spouse__ Child__ Other__ | Authorized CPT , Units : CPT ____ Units ____
Primary Insurance Name | Address Where to send claims: | Effective Date | Group No. | Authorization #
Access number | Seq Number
Deductible: Copay : | I.D. No. | Auth DATES : Date from : __/__/__ Date to : __/__/__
Name of Insured : | Relationship: Self __ Spouse__ Child__ Other__ | Authorized CPT , Units : CPT ____ Units ____

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Comments, Feedback, or requests for future bulletins?
Please e-mail them to Alenal@wchsb.com

WCH Service Bureau, Inc

"With the increased price of cigarettes, your patients are more motivated than ever to quit." — Talk to them about quitting smoking today!

Ad obtained from: July2010 Medicaid Update

July 30th was the 45th anniversary of Medicare. Happy Birthday Medicare!

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