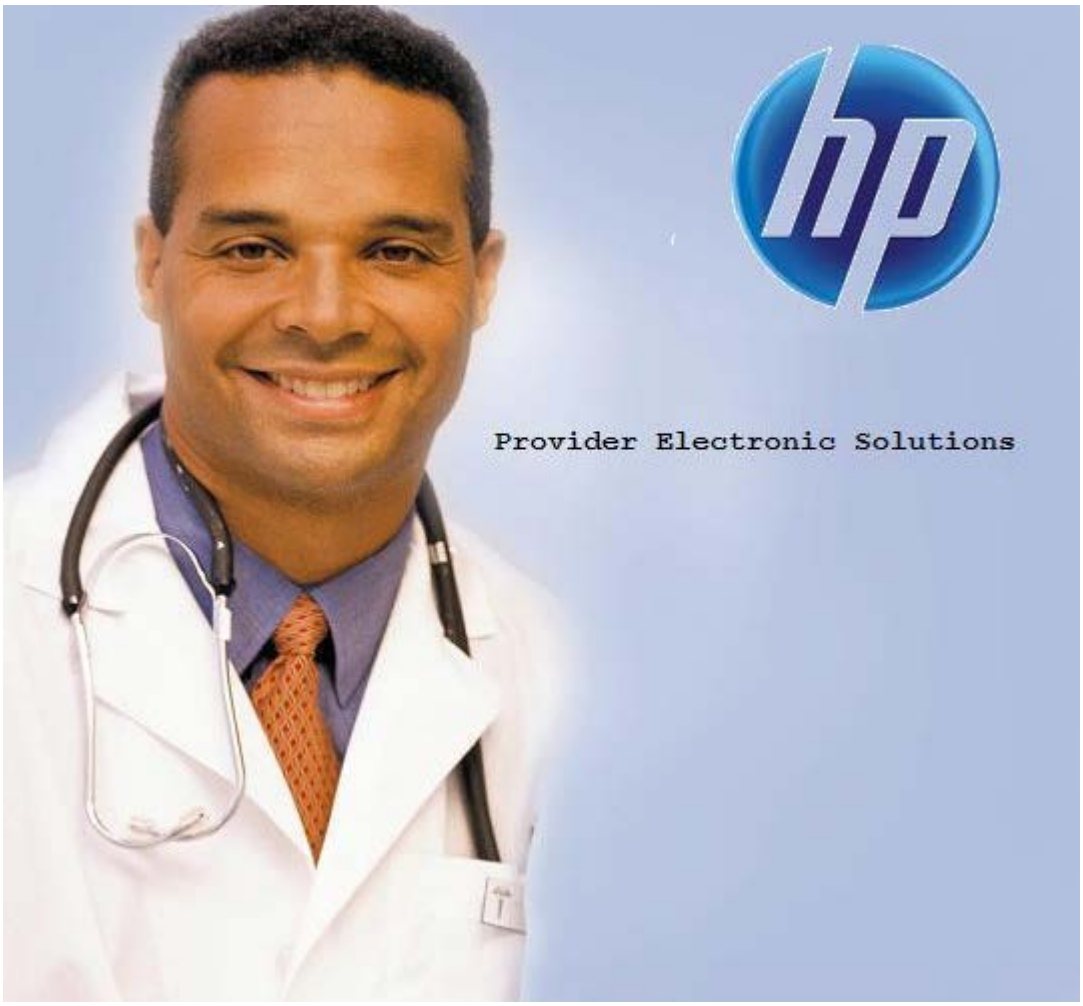
HP Provider Electronic Solutions



Billing Instructions

Professional Claims

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INTRODUCTION

Now that you have installed and become familiar with the functionality of the HP PROVIDER ELECTRONIC SOLUTIONS software, it's time to begin claims data entry.

The claim entry screen consists of nine sections: Four Header, Three Service, Other Insurance and Crossover screens. The following instructions detail requirements and general information for each of these sections.

In the following sections, each data entry field is defined with the appropriate requirements. Edits have been built into the software to assist you in correct data entry, however, READ THESE SECTIONS CAREFULLY. Payment or denial of your claims depends on the data you supply to HP.

Please reference your billing manual for detailed Connecticut Medical Assistance Program billing requirements unique to your provider type.

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit screens. For example, you can enter lists of common diagnosis codes, procedure codes, and modifiers. All of the lists are available from the data entry section as a drop-down list where you can select previously entered data to speed the data entry process and help ensure accuracy of the form.

There are several lists that you are required to complete prior to entering a transaction. Because this software uses the HIPAA-compliant transaction format, there is certain information which is required for each transaction. To assist you in making sure that all required information is included and save time entering your information, some of the lists are required. These lists are:

- Client
- Provider
- Other Provider
- Taxonomy
- Policy Holder

If these lists are not completed prior to keying your transaction, the list will open in the transaction form.

Some of the lists contain preloaded information that is available for auto-plugging as soon as you install Provider Electronic Solutions. Other lists require you to enter the information you will use for auto-plugging. You should enter your data in these lists soon after you set up Provider Electronic Solutions to take advantage of the auto-plug feature. To create or edit a list, select List from the Main Menu and then select the appropriate item.

Working with Lists

From the Lists option on the menu bar, select the list you want to access.

Perform one of the following:

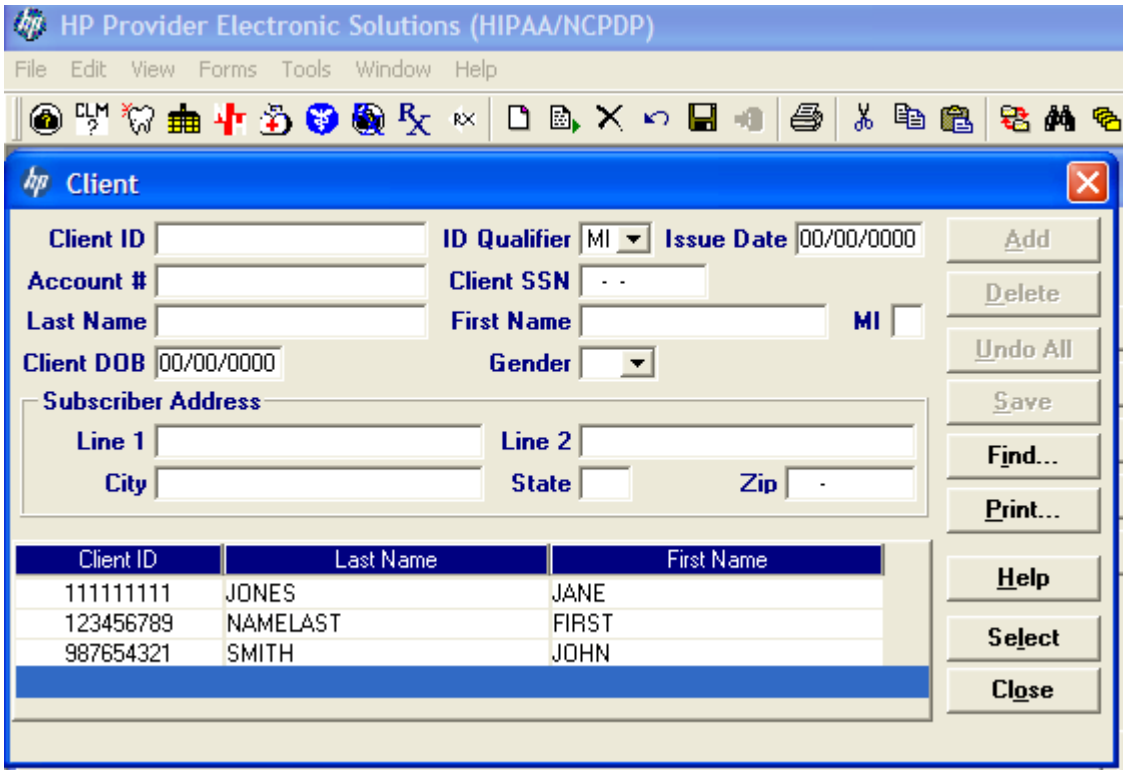
· To add a new entry, select Add.

· To edit an existing entry, select the entry and then enter your changes.

· The command buttons for Delete, Undo All, Find, Print, and Close work as titled.

Note: The Select command button is not visible on the List window unless it has been invoked by double-clicking an auto-plug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

CLIENT SCREEN



The Client list requires you to collect detailed information about your clients, which are then automatically entered into forms. All of the fields are required except Issue Date, Middle Initial and Subscriber Address Line 2.

CLIENT ENTRY INSTRUCTIONS

Client ID:
Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

ID Qualifier:
This field has been preloaded with the information which identifies the type of client. This field will be by-passed.

Issue Date:
Enter the issue date found on the patient's Medical Assistance Program Identification Card.

Account #:
Enter the unique number assigned by your facility to identify a client.

Client SSN:
Enter the client's social security number.

Last Name:
Enter the last name of the client who received services.

First Name:

Enter the first name of the client who received services.

MI:

Enter the middle initial of the client who received services.

Client DOB:

Enter the date the client was born.

Gender:

Select the appropriate value from the drop-down list to enter the client's gender.

Code	Description
F	Female
M	Male
U	Unknown

Subscriber Address Line 1:

Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

Line 2:

Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:

Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

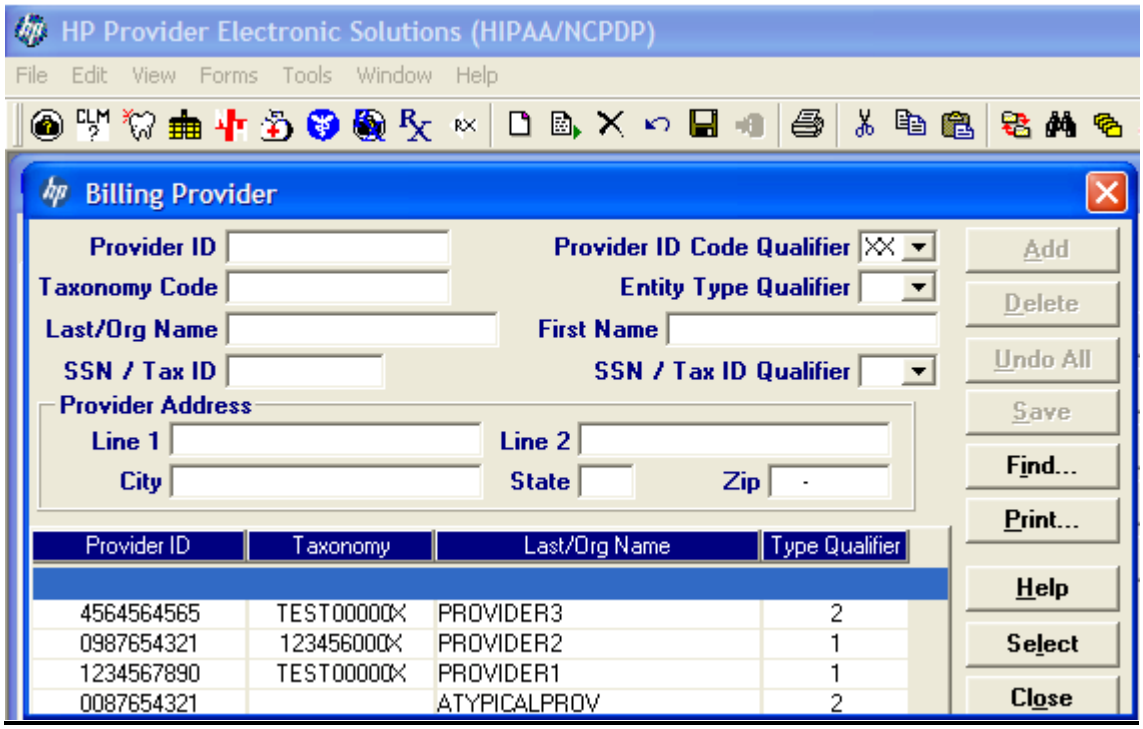
State:

Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip:

Enter the nine-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

BILLING PROVIDER SCREEN



The Provider list requires you to collect information about service providers, which are then automatically entered into forms. These can be individual providers or organizations. Use this list to enter all billing, referring, rendering, facility identification, Medicare rendering and Medicare referring provider numbers. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

BILLING PROVIDER ENTRY INSTRUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or a corporation.

Last/Org Name:
Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Entity Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop-down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

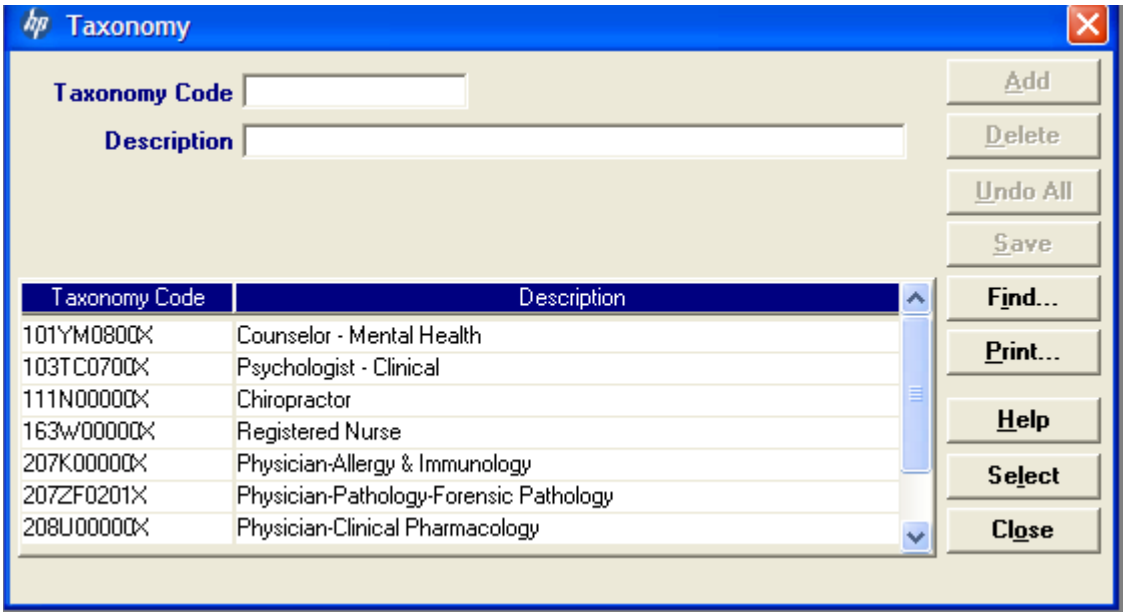
Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the nine-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

TAXONOMY SCREEN



The Taxonomy list requires you to list the taxonomy code, which is then automatically entered into the Provider List. All fields are required.

TAXONOMY BILLING INSTRUCTIONS

Taxonomy Code:

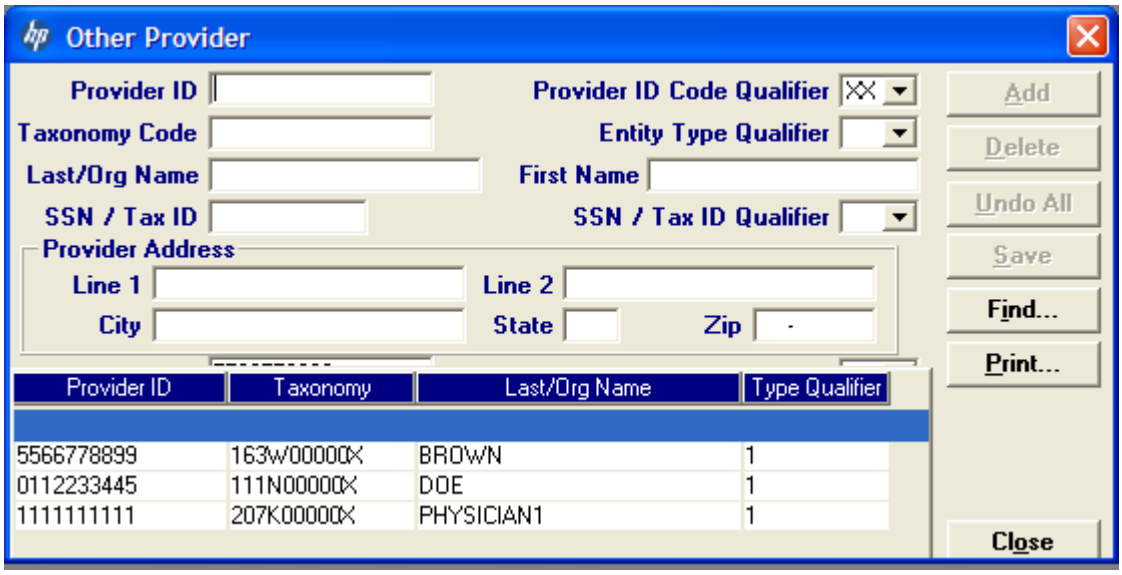
Enter the alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Description:

Enter the description of the code listed.

OTHER PROVIDER SCREEN



The Other Provider list requires you to collect information about non-billing providers, which is then automatically entered into forms. Enter the performing, attending, operating and other Medical Assistance provider numbers in this list. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

OTHER PROVIDER ENTRY INSTUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

> **NOTE**: Acquired Brain Injury (ABI) and Personal Care Assistance (PCA) providers: enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) in this field.

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or a corporation.

Last/Org Name:

Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Entity Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop-down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

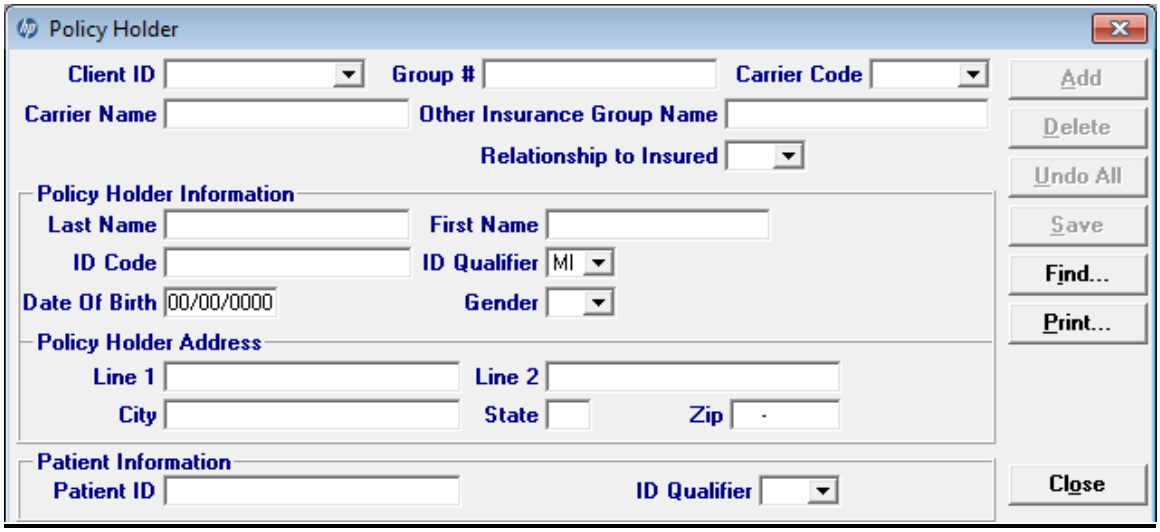
Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the nine-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

POLICY HOLDER SCREEN



The Policy Holder list requires you to list the information for the policyholder of the other insurance policies and Medicare policies. As with the Provider and Client lists, this list must be completed before completing a claim with other insurance or Medicare. Complete a separate list for each policy when a client has both other insurance and Medicare. Like the other lists, once the code is entered into the list, it may be accessed by the drop-down window and will automatically populate into the claim. All fields are required except Policy Holder Address Line 2.

POLICY HOLDER ENTRY INSTRUCTIONS

This tab is required if an indicator of "Y" is entered in the other insurance indicator field on the Header Three screen. The information on this screen must be entered before you enter the Group Number from the Other Insurance screen.

Client ID:
Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

Group Number:
Enter group number for the other insurance or Medicare. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Carrier Code:
Select the three-digit other insurance carrier code from the drop-down box.

Note: Provider must maintain an Explanation of Benefits (EOB) on file for audit purposes.

Carrier Name:
This field is auto-plugged by the system once the carrier code is entered and contains the name of the other insurance company listed for the client.

Other Insurance Group Name:
Enter the name of the group that the other insurance is listed under and coincides with Group number.

Relationship to Insured:
Select the appropriate value from the drop-down box that identifies the client's relationship to the policy-holder for the other insurance or Medicare listed. If the client is the policyholder, self will be listed.

Last Name:
Enter the last name of the policyholder of the other insurance or Medicare.

First Name:
Enter the first name of the policyholder of the other insurance or Medicare.

ID Code:
Enter the policyholder's identification number assigned by the other insurance company.

ID Qualifier:
Select the appropriate value from the drop-down box that identifies the ID that is being used.

Date of Birth:
Enter the date the policyholder was born.

Gender:
Select the appropriate value from the drop-down box that identifies the sex of the individual.

Policy Holder Address Line 1:
Enter the street address of the party being referenced. The address is required for providers, subscribers and policyholders.

Line 2:
Enter additional address information of the party being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the party being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the party being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the nine-digit zip code of the party being referenced. The address is required for providers, clients and policyholders.

Patient ID:
Enter the other insurance identification number of the Connecticut Medical Assistance Program client being billed.

ID Qualifier:
Select the appropriate value from the drop-down box that identifies the ID that is being used.

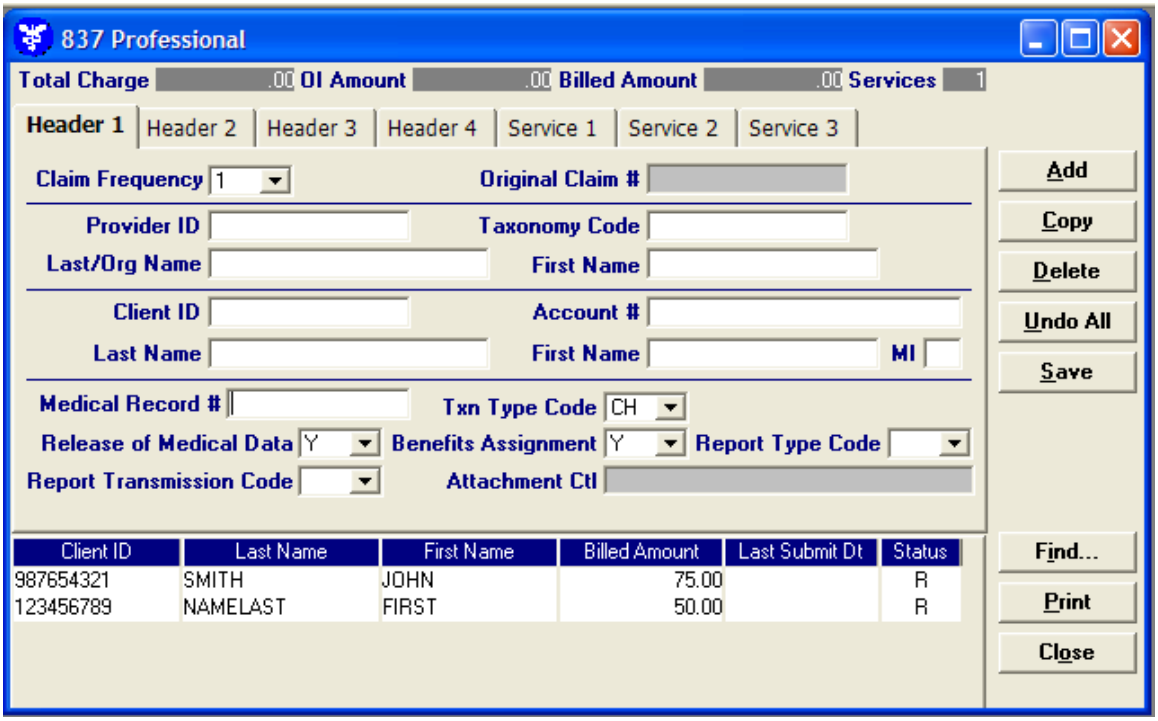
CLAIM ENTRY INSTRUCTIONS

Use the following instructions to complete the claim screens. When data entry is complete, click **SAVE.** The saved claim will appear in the list below the data entry screen. If the claim data hits edits, a message window will appear with error messages. Click **SELECT** to move to the highlighted error and correct the data. Once all error messages have been resolved, you can save the claim.

Newly saved claims are in Status R (Ready). Status R claims can be edited and saved multiple times prior to submission. Be sure to click **ADD** before beginning to enter the data for each new claim.

Note: The Select command button is not visible on the List window unless it has been invoked by double-clicking an auto-plug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

PROFESSIONAL HEADER ONE



PROFESSIONAL HEADER ONE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
CLAIM FREQUENCY	1	R	N
ORIGINAL CLAIM #	13	S	N
PROVIDER ID	10	R	N
TAXONOMY CODE	10	R	X
LAST/ORG NAME	35	R	A
FIRST NAME	25	R	A
CLIENT ID	16	R	X
ACCOUNT #	38	R	X
LAST NAME	35	R	A
FIRST NAME	25	S	A
MI	1	O	A
MEDICAL RECORD #	30	O	X
TRANSACTION TYPE CODE	2	R	A
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
REPORT TYPE CODE	2	O	X
REPORT TRANSMISSION CODE	2	O	A
ATTACHMENT CTL	30	S	X

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL HEADER ONE ENTRY INSTRUCTIONS

Special Note: All data entry will default to capital letters.

Header Field Definition

$$ = Dollars
cc = Cents
A = Alpha
N = Numeric
X = Alphanumeric

Claim Frequency:

Select the appropriate code specifying the frequency of the claim to identify original, adjustment or void.

Code	Description
1	Original (Admit thru discharge claim)
7	Replacement (Replacement of prior claim)
8	Void (Void/Cancel of prior claim)

Note: If the claim frequency value is a "7" or "8", the Original Claim field will be required.

Remarks: Required
Format: N

Original Claim #:

This field is populated when the claim frequency value is a "7" or "8". When a claim is replaced or voided, indicate the original Internal Control Number as it appears on the remittance advice.

Remarks: Situational
Format: NNNNNNNNNNNNN

Provider ID:

Enter your NPI or Connecticut Medical Assistance Program's Provider number with two leading zeros.

Remarks: Required
Format: NNNNNNNNNN

Taxonomy Code:

This field will be auto-plugged once you enter your provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required

Format: NNNANNNNNA

Last/Org Name:

This field will be auto-plugged once you enter your provider number and contains the provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Programs.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

First Name:

This field will be auto-plugged once you enter your provider number and contains the provider's first name or the first letter of the provider's first name as enrolled in the Connecticut Medical Assistance Program. Required when the Entity Type Qualifier is a 1. There are no spaces allowed in this field.

Example: THOMPSON or 'T'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAA or A

Client ID:

Enter the client's nine-digit Connecticut Medical Assistance Program's identification number.

Remarks: Required
Format: XXXXXXXXXXXXXXX

Account #:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number and contains the patient's account number. Provider assigned, this field may be alphabetic or numeric and is used for the provider's own accounting purposes.

Remarks: Optional
Format:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Last Name:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program's identification number. This field contains the client's last name or the first two characters of the client's last name.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

First Name:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number. This field contains the client's first name or the first character of the client's first name. There are no spaces allowed in this field.

Example: JOHN or 'J'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAA or A

MI:

This field will be auto-plugged once you enter the client's Connecticut Medical Assistance Program identification number. This field contains the first character of the client's middle name.

Example: JOHN or 'J'
Remarks: Optional
Format: A

Medical Record #:

Enter the number assigned to the patient's record.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Transaction Type Code:

Select the appropriate code from the drop-down list indicating the type of transaction being sent.

Code	Description
CH	Chargeable
RP	Reporting

Remarks: Required
Format: AA

Release of Medical Data:

This code indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. Enter the value that corresponds to the release of the medical data:

Code	Description
.	
I	Informed consent to release medical information. For conditions or diagnoses regulated by federal statutes
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

Remarks: Required
Format: A

Benefits Assignment:

Code identifying that the client, or authorized person, authorizes benefits to be assigned to the provider. Enter one of the values below to indicate assignment of benefits.

Y – Yes
N – No
W – Not Applicable

Remarks: Required
Format: A

Report Type Code:

Code indicating the title or contents of a document, report or supporting item for this claim
Enter the two-digit value that corresponds to the report type.

Code	Description
03	Report justifying treatment beyond utilization guidelines
04	Drugs Administered
05	Treatment diagnosis
06	Initial assessment
07	Functional goals
08	Plan of treatment
09	Progress report
10	Continued treatment
11	Chemical analysis
13	Certified test report
15	Justification for admission
21	Recovery plan
A3	Allergies/sensitivities document
A4	Autopsy report
AM	Ambulance certification
AS	Admission summary
B2	Prescription
B3	Physician order
B4	Referral form
BR	Benchmark testing results
BS	Baseline
BT	Blanket test results
CB	Chiropractic justification
CK	Consent form(s)
CT	Certification
D2	Drug profile document
DA	Dental models
DB	Durable medical equipment prescription
DG	Diagnostic report
DJ	Discharge monitoring report
DS	Discharge summary
EB	Explanation of benefits
HC	Health certificate
HR	Health clinic records
I5	Immunization record
IR	State school Immunization records
LA	Laboratory results
M1	Medical record attachment
MT	Models
NN	Nursing notes
OB	Operative Notes
OC	Oxygen content averaging report
OD	Orders and treatments document
OE	Objective physical examination (including vital signs) document

OX	Oxygen therapy certification
OZ	Support data for claim
P4	Pathology report
P5	Patient medical history document
PE	Parenteral or enteral certification
PN	Physical therapy notes
PO	Prosthetics or orthotic certification
PQ	Paramedical results
PY	Physician's report
PZ	Physical therapy certification
RB	Radiology films
RR	Radiology reports
RT	Report of tests and analysis report
RX	Renewable oxygen content averaging report
SG	Symptoms document
V5	Death notification
XP	Photographs

Remarks: Optional
Format: XX

Report Transmission Code:

Code defining timing, transmission method or format by which reports are to be sent. Enter the two-digit value that defines the transmission method reports will be sent:

Code	Description
AA	Available on request at providers site
BM	By mail
EL	Electronically only
EM	E-mail
FT	File Transfer
FX	By fax

Note: If the values BM, EL, EM, FT or FX, are used the Attachment Control field will be required.

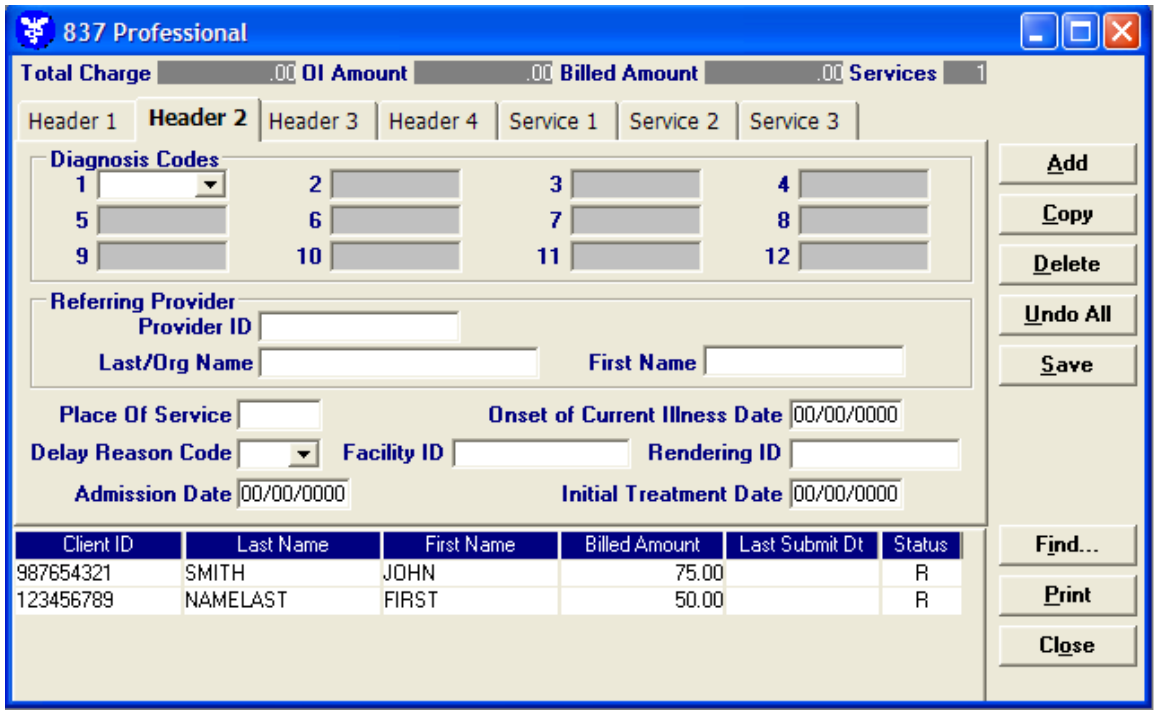
Remarks: Optional
Format: AA

Attachment Ctl:

This field is enabled when the Report Transmission Code is a "BM", "EL", "EM", "FT" or "FX". Enter the control number of the attachment.

Remarks: Situational
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROFESSIONAL HEADER TWO



HEADER TWO INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
DIAGNOSIS CODES 1-12	5	O	X
REFERRING PROVIDER ID	10	O	N
REFERRING LAST/ORG NAME	35	O	A
REFERRING FIRST NAME	25	O	A
PLACE OF SERVICE	2	R	N
ONSET OF CURRENT ILLNESS DATE	8	O	N
DELAY REASON CODE	2	O	N
FACILITY ID	10	O	N
RENDERING ID	10	O	N
ADMISSION DATE	8	S	N
INITIAL TREATMENT DATE	8	O	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL HEADER TWO ENTRY INSTRUCTIONS

Diagnosis Codes 1-12:

Enter the diagnosis code from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) manual. NOTE: DO NOT key the decimal point. It is already assumed.

Remarks: Optional

Format: XXXXX

Referring Provider ID

Select the NPI or Connecticut Medical Assistance identification number from the drop-down list of the referring physician.

Remarks: Optional
Format: NNNNNNNNNN

Last/Org Name:

This field will be auto-plugged once you enter the provider number. This field contains the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

First Name:

This field will be auto-plugged once you enter the provider number. This field contains the first name of the provider when they are an individual. Required when the Entity Type Qualifier is a 1. Cannot be used when the Entity Type Qualifier is a 2.

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAA

Place of Service:

Enter the appropriate code from the drop-down list that reflects where the services for this claim were performed. Refer to your Connecticut Medical Assistance Program Provider Manual for the valid codes.

Code	Description	Code	Description
03	School	33	Custodial care facility
04	Homeless Shelter	34	Hospice
05	Indian health service free standing facility	41	Ambulance – land
		42	Ambulance –air
06	Indian health service provider-based facility	50	Federally qualified health center
		51	Inpatient psychiatric facility
07	Tribal 638 free-standing facility	52	Psychiatric facility partial hospital
08	Tribal 638 provider based facility	53	Community mental health center
11	Office	54	Intermediate care facility/mentally retarded
12	Home	55	Psychiatric substance abuse treatment facility
13	Assisted Living Services	56	Psychiatric residential treatment center
15	Mobile unit	60	Mass immunization center
16	Temporary lodging	61	Comprehensive inpatient rehabilitation
20	Urgent care facility	62	Comprehensive outpatient rehabilitation
21	Inpatient	65	End stage renal disease treatment facility
22	Outpatient	71	State or local public health clinic
23	Emergency room	72	Rural health clinic
24	Ambulatory surgical center	81	Independent laboratory
25	Birthing center	99	Other unlisted Facility
26	Military treatment facility		
31	Skilled nursing facility		

Remarks: Required
Format: XX

Onset of Current Illness Date:

Enter the date of onset of illness or symptoms when different from the date of service if applicable.

Remarks: Optional
Format: MM/DD/CCYY

Delay Reason Code:

Select the appropriate code from the drop-down list that identifies the reason for delay in submitting the claim.

Code	Description
1.	Proof of eligibility unknown or unavailable
2.	Litigation
3.	Authorization delays
4.	Delay in certifying provider
5.	Delay in supplying billing forms
6.	Delay in delivery of custom-made appliances
7.	Third party processing delay
8.	Delay in eligibility determination
9.	Original claim rejected/denied due to reason unrelated to the billing limitation rules
10.	Administration delay in the prior approval process
11.	Other
15.	Natural Disaster

Remarks: Optional
Format: N

Facility ID:

Select the appropriate provider identification number from the drop-down list. Required when the Place of Service value is 21, 22, 31 or 35.

Remarks: Optional
Format: NNNNNNNNNN

Rendering ID

Select the NPI or Connecticut Medical Assistance identification number from the drop-down list of the rendering physician.

Remarks: Optional
Format: NNNNNNNNNN

Admission Date:

Enter the date of admission if applicable.

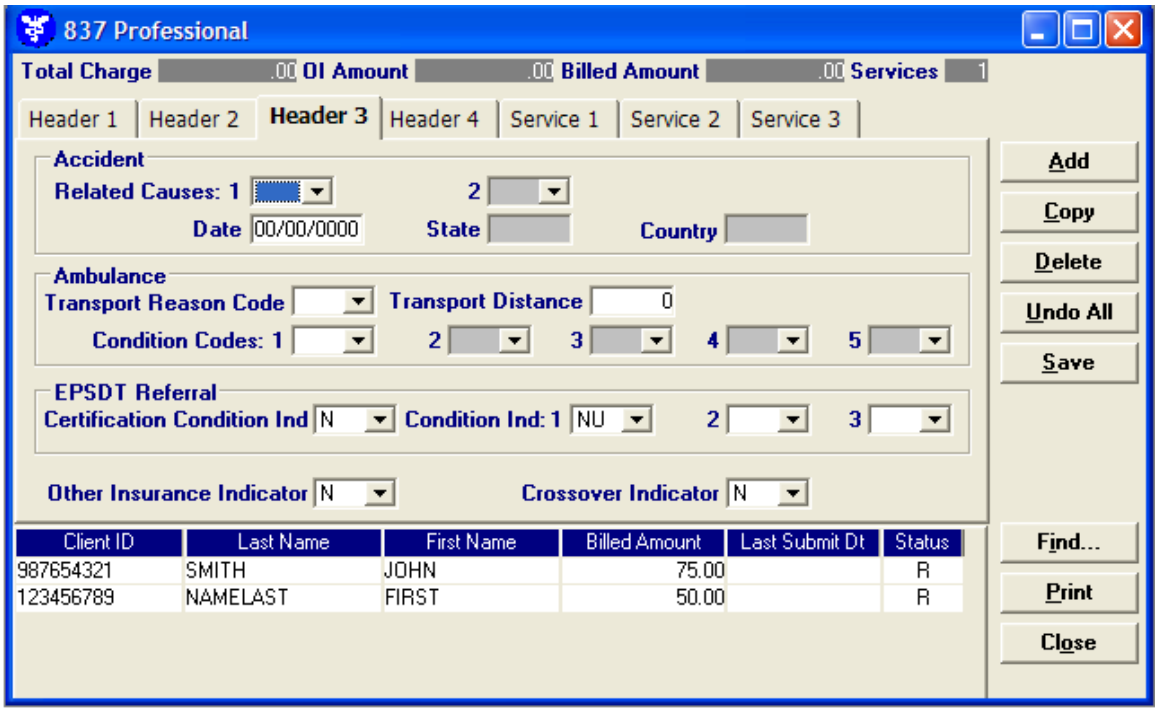
Remarks: Situational
Format: MM/DD/CCYY

Initial Treatment Date:

Enter the initial date treatment was provided.

Remarks: Optional
Format: MM/DD/CCYY

PROFESSIONAL HEADER THREE



PROFESSIONAL HEADER THREE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
ACCIDENT RELATED CAUSES 1-2	2	S	A
DATE	8	S	N
STATE	2	S	A
COUNTRY	3	S	A
AMBULANCE TRANSPORT REASON CODE	1	S	A
TRANSPORT DISTANCE	4	S	N
CONDITION CODES 1-5	2	S	N
EPSDT REFERRAL CERTIFICATION CONDITION IND	1	S	A
EPSDT REFERRAL CONDITION IND 1-3	2	S	X
OTHER INSURANCE INDICATOR	1	R	A
CROSSOVER INDICATOR	1	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL HEADER THREE ENTRY INSTRUCTIONS

Accident Related Causes 1-2:

Select the appropriate value from the drop-down box to indicate the type of accident. This field is required for all accident-related claims.

Code	Description
AA	Auto Accident
EM	Employment
OA	Other Accident

Remarks: Situational
Format: AA

Date:

Indicate the date of the accident.

Remarks: Situational
Format: MM/DD/CCYY

State:

Enter the state where the auto accident occurred. Use state postal codes (CT = Connecticut, etc). Required if Accident Related Causes value is "AA".

Remarks: Situational
Format: AA

Country:

Enter the country in which the auto accident occurred when outside of the United States. Required if the auto accident occurred outside of the United States.

Remarks: Situational
Format: AAA

Ambulance Transport Reason Code:

Select the appropriate value from the drop-down box to indicate the type of Ambulance transport. This field is required for all Ambulance claims.

Code	Description
A	Patient was transported to nearest facility for care of symptoms, complaints, or both
B	Patient was transported for the benefit of a preferred physician
C	Patient was transported for the nearness of family members
D	Patient was transported for the care of a specialist or for the availability of specialized equipment
E	Patient transferred to rehabilitation facility

Remarks: Situational
Format: A

Transport Distance:

Enter the number of miles the client was transported by ambulance. This field is required for all Ambulance claims when billing mileage.

Remarks: Situational
Format: NNNN

Condition Codes 1-5:

Select the code used to identify conditions relating to this bill that may affect Payer processing. List on Header 3 if this condition applies to the entire claim, or on Service 2 if it applies to a particular detail. This field is required for all Ambulance claims.

Code	Description
01	Patient was admitted to a hospital
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
12	Patient is confined to a bed or chair

Remarks: Situational
Format: NN

EPSDT Referral Certification Condition Ind:

Enter a "Y" or "N" to indicate if an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) referral was given to the patient.

Note: If a "N" is used the condition indicator of "NU" (Not Used) should be used.

Remarks: Situational
Format: A

EPSDT Referral Condition Ind 1-3:

Select the appropriate condition indicator from the drop-down list.

Code	Description
AV	Available – not used
NU	Not used
S2	Under treatment
ST	New services requested

Remarks: Situational
Format: XX

Other Insurance Indicator:

This field indicates whether the client has other insurance or when Medicare does not pay any portion of the claim. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Other Insurance Tab is added to the claim form for entry.

Y – Yes
N – No

Remarks: Required
Format: A

Crossover Indicator:

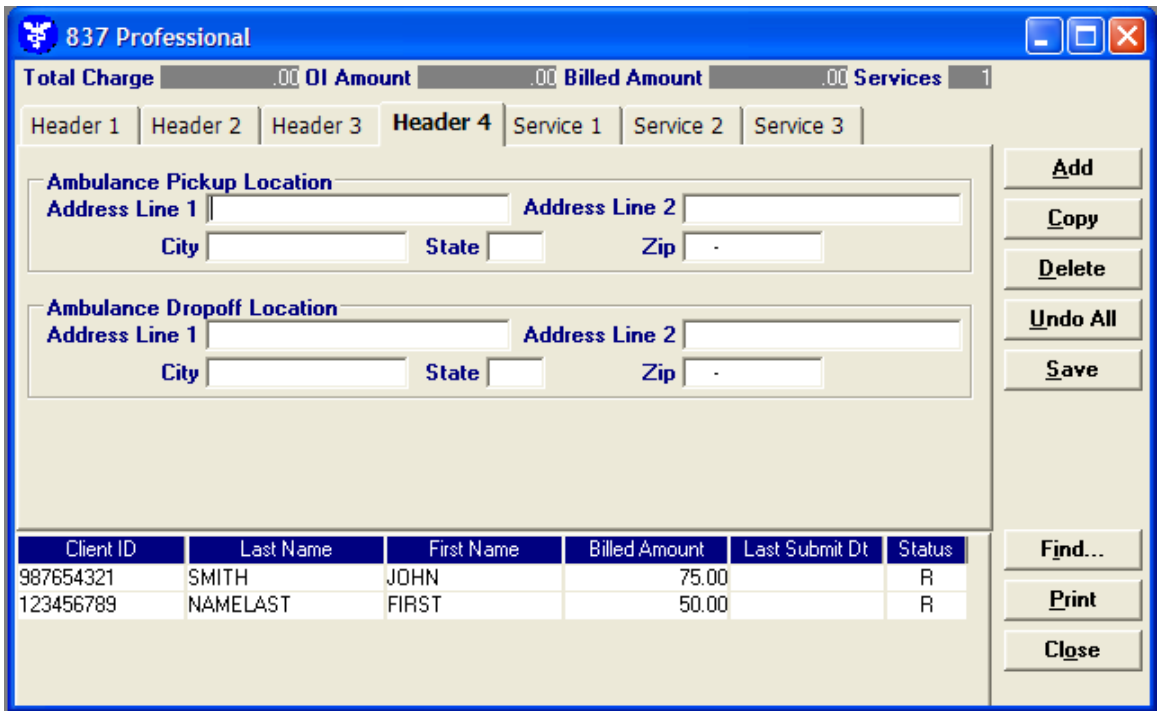
This field should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Crossover Tab is added to the claim form for entry. Use this field for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Remarks: Required
Format: A

PROFESSIONAL HEADER FOUR



PROFESSIONAL HEADER FOUR INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
AMBULANCE PICKUP LOCATION	55	S	X
ADDRESS LINE 1			
ADDRESS LINE 2	55	S	X
CITY	30	S	A
STATE	2	S	A
ZIP	9	S	N
AMBULANCE DROPOFF LOCATION	55	S	X

ADDRESS LINE 1			
ADDRESS LINE 2	55	S	X
CITY	30	S	A
STATE	2	S	A
ZIP	9	S	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL HEADER FOUR ENTRY INSTRUCTIONS

Ambulance Pickup Location Address Line 1:
Enter the street address of the location being referenced. This field is required for all Ambulance claims.

Line 2:
Enter additional address information of the location being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the location being referenced. The address is required for all Ambulance claims.

State:
Enter the state of the address of the location being referenced. The address is required for all Ambulance claims.

Zip Code:
Enter the nine-digit zip code of the location being referenced. The address is required for all Ambulance claims.

Ambulance Dropoff Location Address Line 1:
Enter the street address of the location being referenced. This field is required for all Ambulance claims.

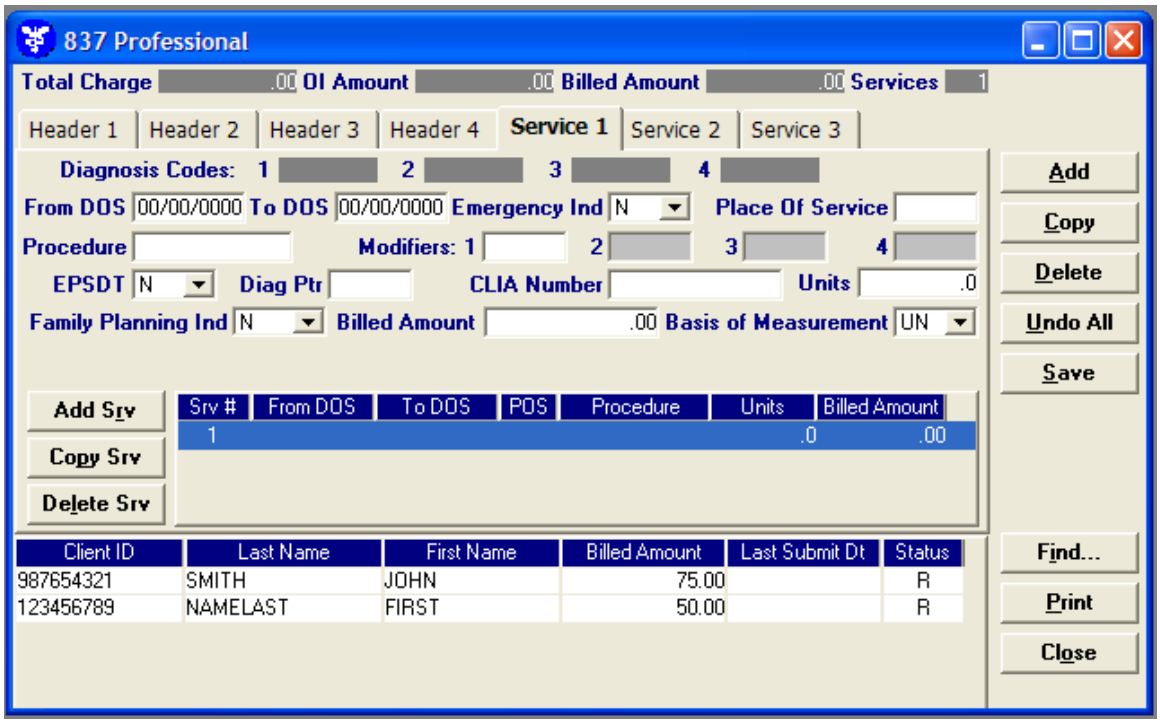
Line 2:
Enter additional address information of the location being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the location being referenced. The address is required for all Ambulance claims.

State:
Enter the state of the address of the location being referenced. The address is required for all Ambulance claims.

Zip Code:
Enter the nine-digit zip code of the location being referenced. The address is required for all Ambulance claims.

PROFESSIONAL SERVICE ONE SCREEN



PROFESSIONAL SERVICE ONE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
DIAGNOSIS CODES 1-4	5	O	X
FROM DOS	8	R	N
TO DOS	8	R	N
EMERENGY INDICATOR	1	R	A
PLACE OF SERVICE	2	R	N
PROCEDURE	5	R	X
MODIFIERS 1-4	2	O	X
EPSDT	1	R	A
DIAG PTR	2	O	N
CLIA NUMBER	10	S	X
UNITS	5	R	N
FAMILY PLANNING IND	1	R	A
BILLED AMOUNT	9	R	N
BASIS OF MEASUREMENT	2	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL SERVICE ONE ENTRY INSTRUCTIONS

Please NOTE: If the intent for this claim is to obtain coinsurance and deductible payments form a claim paid by Medicare, please complete this section as though you were submitting this claim to Medicare:

Diagnosis Codes 1-4:

The diagnosis codes entered in Header 2, positions 1 – 4 will display in these fields.

From DOS:

Enter the first date of service on which services were provided for this claim in MM/DD/CCYY format.

Remarks: Required
Format: MM/DD/CCYY

To DOS:

Enter the last date of service on which services were provided for this claim in MM/DD/CCYY format.

Remarks: Required
Format: MM/DD/CCYY

Emergency Ind:

Indicate "N" or "Y" if service provided was emergency related. The field is defaulted to an "N".

Remarks: Required
Format: A

Place of Service:

Select the appropriate code that reflects where the services for this claim were performed. This field is required if a place of service code is not entered on Header Two.

Code	Description	Code	Description
03	School	33	Custodial care facility
04	Homeless Shelter	34	Hospice
05	Indian health service free standing facility	41	Ambulance – land
		42	Ambulance –air
06	Indian health service provider-based facility	50	Federally qualified health center
		51	Inpatient psychiatric facility
07	Tribal 638 free-standing facility	52	Psychiatric facility partial hospital
08	Tribal 638 provider based facility	53	Community mental health center
11	Office	54	Intermediate care facility/mentally retarded
12	Home	55	Psychiatric substance abuse treatment facility
15	Mobile unit	56	Psychiatric residential treatment center
20	Urgent care facility	60	Mass immunization center
21	Inpatient	61	Comprehensive inpatient rehabilitation
22	Outpatient	62	Comprehensive outpatient rehabilitation
23	Emergency room	65	End stage renal disease treatment facility
24	Ambulatory surgical center	71	State or local public health clinic
25	Birthing center	72	Rural health clinic
26	Military treatment facility	81	Independent laboratory
31	Skilled nursing facility	99	Other unlisted facility
32	Nursing facility		

Remarks: Required
Format: NN

Procedure:

Enter the five (5) digit HCPCS or locally assigned non-health service procedure code which best describes the services rendered.

Remarks: Required
Format: XXXXX

Modifiers:

Enter the modifier, if applicable. Up to four (4) modifiers may be entered for each detail.

Remarks: Required
Format: XX

EPSDT:

Select a "N" or "Y" if the patient is part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

Remarks: Required
Format: A

Diag Ptr:

Enter the detail diagnosis number that references the diagnosis that relates to this service. Valid values are one (1) through eight (8) to refer to the header diagnosis codes. This field must be populated to report a diagnosis for the claim service line. Leave blank if no diagnosis code is applicable.

Remarks: Optional
Format: NN

CLIA Number:

Enter the number assigned to all certified facilities performing CLIA covered laboratory services. Required field for any laboratory or physician performing tests covered by the CLIA act.

Remarks: Situational
Format: XXXXXXXXXX

Units:

Enter the number of units performed for the service being billed.

NOTE: For Ambulance providers, if a mileage HCPC is billed, the number of units is equal to the number of miles.

Remarks: Required
Format: NNNNN

Family Planning Ind:

Select a "N" or "Y" if the procedure is due to family planning.

Remarks: Required
Format: A

Billed Amount

Enter the total amount for the services performed for this procedure. This should include the charge for all units listed.

Remarks: Required
Format: $$$$$$$cc

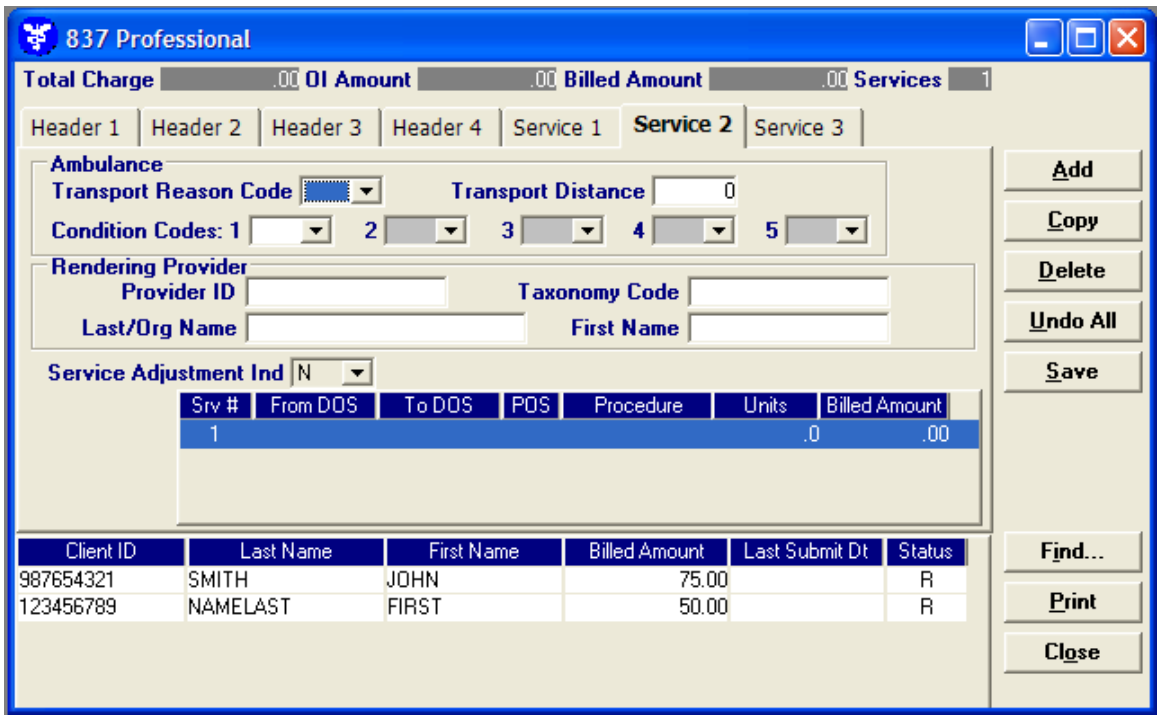
Basis of Measurement:

Select the code from the drop-down list that specifies the units in which a value is being expressed, or the manner in which a measurement has been taken. This fields defaults to 'UN'.

Code	Description
MJ	Minutes (Professional)
UN	Unit (Institutional and Professional)

Remarks: Required
Format: XX

PROFESSIONAL SERVICE TWO SCREEN



PROFESSIONAL SERVICE TWO INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
AMBULANCE TRANSPORT REASON CODE	1	S	A
AMBULANCE TRANSPORT DISTANCE	4	S	N
AMBULANCE CONDITION CODES 1-5	2	S	N
RENDERING PROVIDER, PROVIDER ID	10	S	N
RENDERING PROVIDER TAXONOMY CODE	10	S	X

RENDERING PROVIDER LAST/ORG NAME	35	S	A
RENDERING PROVIDER FIRST NAME	25	S	A
SERVICE ADJUSTMENT IND	1	S	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL SERVICE TWO ENTRY INSTRUCTIONS

Ambulance Transport Reason Code:

Enter the code indicating the reason for ambulance transport. This field is required for all Ambulance claims.

Code	Description
A	Patient was transported to nearest facility for care of symptoms, complaints, or both.
B	Patient was transported for the benefit of a preferred physician.
C	Patient was transported for the nearness of family members
D	Patient was transported for the care of a specialist or for availability of specialized equipment.
E	Patient transferred to rehabilitation facility

Remarks: Situational
Format: A

Transport Distance:

Enter the number of miles the client was transported by ambulance. This field is required for all Ambulance claims when billing mileage.

Remarks: Situational
Format: NNNN

Condition Codes 1-5:

Select the code used to identify conditions relating to this bill that may affect Payer processing. List on Header 3 if this condition applies to the entire claim, or on Service 2 if it applies to a particular detail. This field is required for all Ambulance claims.

Code	Description
01	Patient was admitted to a hospital
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
12	Patient is confined to a bed or chair

Remarks: Situational
Format: NN

Rendering Provider, Provider ID:

Select the NPI or Connecticut Medical Assistance Program rendering provider from the drop-down window. The other provider information will be populated once you select enter. Used only when the provider rendering services is different from the billing provider on the Header One tab.

Remarks: Situational
Format: NNNNNNNN

Rendering Provider Taxonomy Code:

Enter an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/training requirements. This field will be populated once you select a rendering provider, provider ID.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Situational
Format: NNNANNNNNA

Rendering Provider Last/Org Name:

Enter provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Program. This field will be populated once you select a rendering provider, provider ID.

Example: THOMPSON or 'TH'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

Rendering Provider First Name:

Enter the first name of the provider when they are an individual. Required when the entity type qualifier is a 1. Cannot be used when the Entity Type Qualifier is a 2. This field will be populated once you select a rendering provider, provider ID.

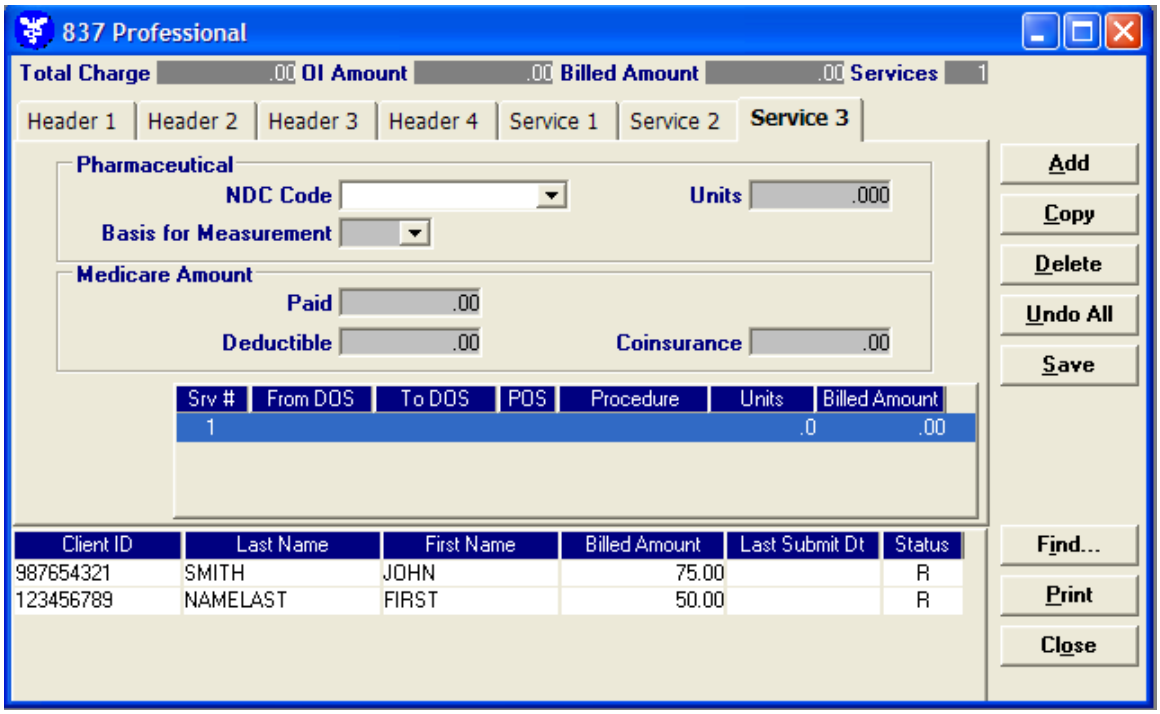
Example: THOMPSON or 'TH'
Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAA or AA

Service Adjustment Ind:

Choose the best value to indicate if the service is being adjusted.

Remarks: Situational
Format: A

PROFESSIONAL SERVICE THREE SCREEN



PROFESSIONAL SERVICE THREE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA/ NUMERIC
PHARMACEUTICAL NDC CODE	11	O	N
PHARMACEUTICAL UNITS	8	O	N
PHARMACEUTICAL BASIS FOR MEASUREMENT	2	O	X
MEDICARE AMOUNT PAID	9	S	N
MEDICARE AMOUNT DEDUCTIBLE	9	S	N
MEDICARE AMOUNT COINSURANCE	9	S	N

A = ALPHA N = NUMERIC X = ALPHANUMERIC

PROFESSIONAL SERVICE THREE ENTRY INSTRUCTIONS

Pharmaceutical NDC Code:

Enter the National Drug Code (NDC).

Remarks: Optional
Format: NNNNNNNNNNN

Pharmaceutical Units:

Enter the number of units for the drug that was dispensed.

Remarks: Optional
Format: NNNNNNNN

Pharmaceutical Basis for Measurement:

Select the appropriate value from the drop-down lists that specifies the units in which a value is being expressed, or the manner in which a measurement has been taken.

Code	Description
F2	International Unit
GR	Gram
ME	Milligram
ML	Milliliters
UN	Unit

Remarks: Optional
Format: XX

The Medicare section should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. Please see the instructions on the Other Insurance tab if Medicare did not pay any portion of the claim. Use this field for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Medicare Amount Paid:

Enter the dollar amount that Medicare paid for the service provided. Required if the crossover indicator on the Header Three tab is a "Y".

Remarks: Situational
Format: $$$$$$$cc

Medicare Amount Deductible:

Enter the amount of the deductible that applies to the claim or detail identified by Medicare. Required if the crossover indicator on the Header Three tab is a "Y".

Remarks: Situational
Format: $$$$$$$cc

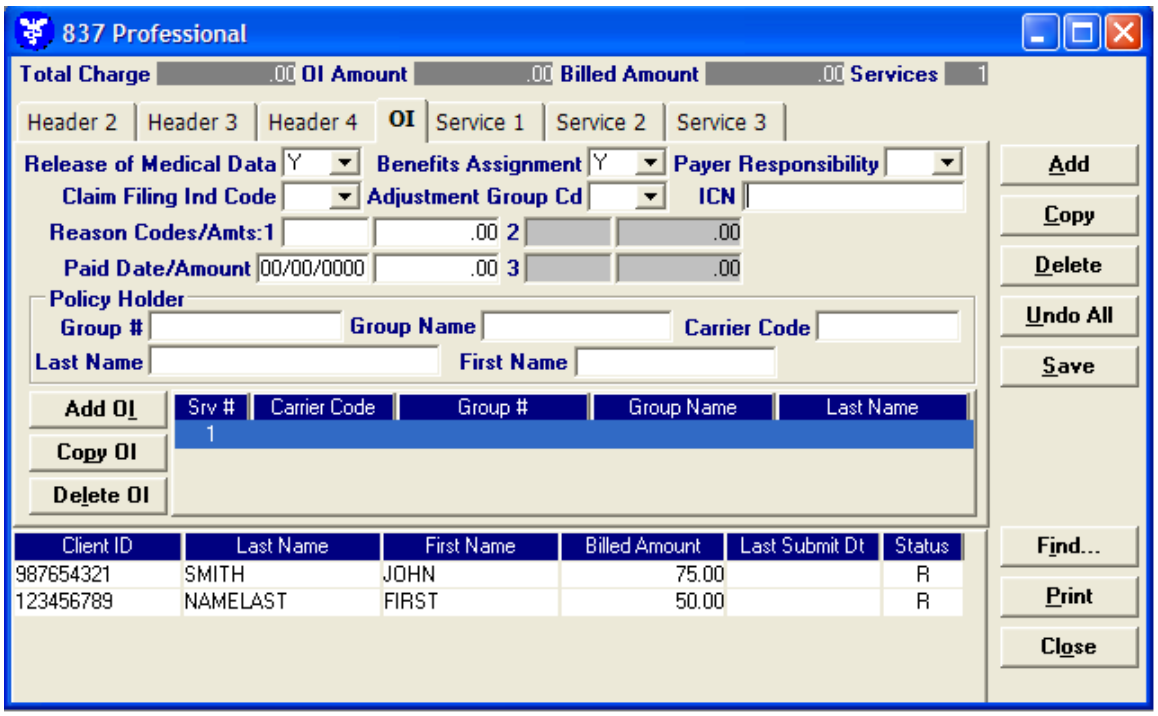
Medicare Amount Coinsurance:

Enter the amount of coinsurance applied to the claim or detail identified by Medicare. Required if the crossover indicator on the Header Three tab is a "Y".

Remarks: Situational
Format: $$$$$$$cc

NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

OTHER INSURANCE



OTHER INSURANCE INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED/ OPTIONAL/ SITUATIONAL	ALPHA/ NUMERIC
RELEASE of MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
PAYER RESPONSIBILITY	1	R	A
CLAIM FILING IND CODE	2	R	X
ADJUSTMENT GROUP CD	2	R	X
ICN	30	O	X
REASON CODES 1-3	5	R	X
REASON AMTS 1-3	9	R	N
PAID DATE 1-3	8	R	N
PAID AMOUNT 1-3	9	R	N
POLICY HOLDER GROUP #	17	O	X
POLICY HOLDER GROUP NAME	14	R	A
POLICY HOLDER CARRIER CODE	5	R	X
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

OTHER INSURANCE ENTRY INSTRUCTIONS

Providers are required to submit other insurance information when another payer is known to potentially be involved in paying or denying a claim. This tab should also be used when Medicare does not pay any

portion of the claim and all dollar fields below will contain zero amounts. Please use the crossover tab when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare.

The following fields are required when a "Y" is indicated in the Other Insurance Indicator field on the Header Three Screen.

Release of Medical Data:

Select the appropriate value from the drop-down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop-down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

Payer Responsibility:

Select the code that describes the order of insurance carrier's level of responsibility for a payment of a claim.

Remarks: Required
Format: A

Claim Filing Ind Code:

Select the appropriate value from the drop-down box that identifies the type of other insurance claim that is being submitted. Select MB when the denial is from Medicare.

Remarks: Required
Format: XX

Adjustment Group Cd:

Select the appropriate value from the drop-down box that identifies the general category of payment adjustment by the other insurance company.

Remarks: Required
Format: XX

ICN:
Enter the original claim number, as assigned by the other insurance.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Reason Codes:

Enter the code identifying the reason the adjustment was made by the other insurance carrier. At least one reason code and amount is required or use this field to indicate the reason Medicare denied the claim. The

reason code can be found in the Implementation Guide by clicking on the following site**:** http://www.wpc-edi.com/ Follow the instructions below to retrieve the reason codes.

- Click on Code Lists
- Click on Claim Adjustment Reason Codes

Use this list of codes to indicate if a payment was made by OI or denied by OI.

Remarks: Required
Format: XXXXX

Reason Amounts:

Enter the amount associated with the reason code. At least one reason code and amount is required.

Remarks: Required
Format: $$$$$$$cc

Paid Date:

Enter the date that the other insurance carrier paid the claim (remittance advice date). Use this field to enter the date Medicare denied the claim.

Remarks: Required
Format: MM/DD/CCYY

Paid Amount:

Enter the amount paid by the other insurance carrier. An amount of zero (0) may be entered. This field is required if a value is entered in the Reason Code field on the other insurance screen and a payment has been received towards the claim from a third party.

Remarks: Required
Format: $$$$$cc

Policy Holder Group #:

Select the group number for the other insurance from the drop-down list. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Remarks: Optional
Format: XXXXXXXXXXXXXXXX

Policy Holder Group Name:

This field is auto-plugged when a group number is selected and contains the name of the group that the other insurance is listed under and coincides with Group number.

Remarks: Required
Format: AAAAAAAAAAAAA

Policy Holder Carrier Code:

This field is auto-plugged when a group number is selected and contains the carrier code identifying the Other Insurance carrier from the drop-down list.

Remarks: Required
Format: XXXXX

Policy Holder Last Name:

This field is auto-plugged when a group number is selected and contains the last name of the policyholder of the other insurance.

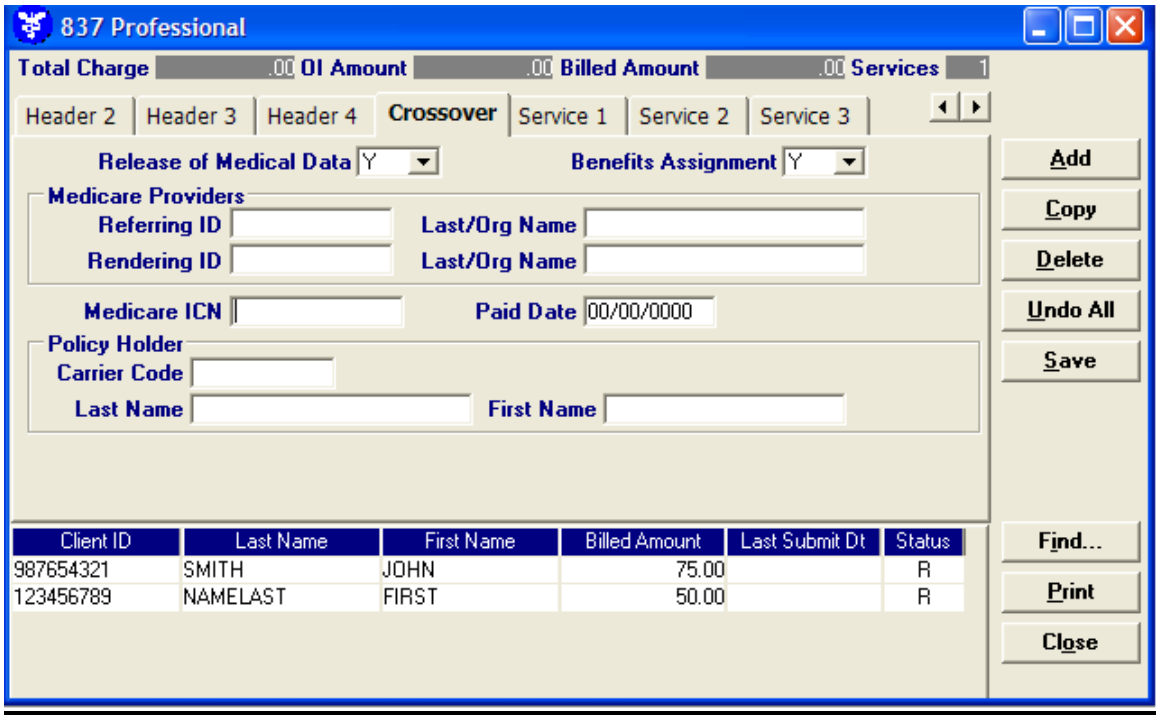
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:

This field is auto-plugged when a group number is selected and contains the first name of the policyholder of the other insurance.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAA

CROSSOVER SCREEN



CROSSOVER INFORMATION

DESCRIPTION	FIELD LENGTH	REQUIRED/ OPTIONAL/ SITUATIONAL	ALPHA/ NUMERIC

RELEASE of MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
MEDICARE PROVIDER REFERRING ID	10	S	N
MEDICARE PROVIDER LAST/ORG NAME	35	S	A
MEDICARE PROVIDER RENDERING ID	10	R	N
MEDICARE PROVIDER LAST/ORG NAME	35	R	A
MEDICARE ICN	14	R	N
PAID DATE	8	R	N
POLICY HOLDER CARRIER CODE	5	R	N
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

A = ALPHA N = NUMERIC X = ALPHANUMERIC

CROSSOVER ENTRY INSTRUCTIONS

Providers are required to submit other insurance information when another payer is known to potentially be involved in paying or denying a claim. This tab should also be used when Medicare does not pay any portion of the claim and all dollar fields below will contain zero amounts. Please use the crossover tab when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare.

NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Release of Medical Data:

Select the appropriate value from the drop-down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to a 'Y' (yes).

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop-down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to a 'Y' (yes).

Remarks: Required
Format: A

Medicare Providers Referring ID:

Select the appropriate identification number of the Medicare referring provider from the billing provider list.

Remarks: Required
Format: NNNNNNNNNN

Medicare Providers Last/Org Name:

This field is auto-plugged once you select the referring provider identification number.

Remarks: Required

Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Medicare Providers Rendering ID:

Select the appropriate identification number of the Medicare rendering provider from the billing provider list.

Remarks: Situational
Format: NNNNNNNNNN

Medicare Providers Last/Org Name:

This field is auto-plugged once you select the Rendering provider identification number.

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Medicare ICN:

Enter the claim number assigned to the claim by Medicare.

Remarks: Required
Format: XXXXXXXXXXXXXX

Paid Date:

Enter the date of the Medicare remittance advice on which these services are listed.

Remarks: Required
Format: MM/DD/CCYY

Policy Holder Carrier Code:

Select the carrier code that corresponds to the policyholder for this claim.

Remarks: Required
Format: XXXXX

Policy Holder Last Name:

This field is auto-plugged once you select the carrier code.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:

This field is auto-plugged once you select the carrier code.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAA