

# Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment POSITION STATEMENT

Approved by the Board of Trustees, November 2002

"Policy documents are approved by the APA Assembly and Board of Trustees...These are ... position statements that define APA official policy on specific subjects..." -- *APA Operations Manual*.

The following American Psychiatric Association (APA) position statement has been developed in response to the federal Department of Health and Human Services (HHS) final Privacy Rule's provision that health-care "providers" (health-care professionals and facilities) disclose only the "minimum necessary" information for a given purpose. The Final Rule clarifies that "providers" may make their own determination about what is the "minimum necessary" information for a specific purpose, and also invites "professional organizations, working with their members, to assess the effects of the standards and develop policies and procedures to come into compliance with them." (p. 82472) The Rule also states that this standard is "intended to reflect and be consistent with, not override, professional judgment and standards." (P 82544)

The following guidelines are based on the cumulative professional experience of APA members with respect to current practice and the necessity of privacy for effective psychiatric care. These guidelines are based on the principle that standards for "minimum necessary" disclosure of psychiatric information to third-party payers should not exceed standards generally accepted in other medical specialties.

These guidelines address the specific delimited set of information that is necessary to process a typical claim, and therefore constitutes the minimum necessary information that may be disclosed to third party payers under the HHS Privacy Rule.

This is not a policy position about how much/what information should be documented in the record about mental-health treatment and psychotherapy. Documentation guidelines, consistent with the HHS Privacy Rule, regarding general mental-health treatment records and psychotherapy notes will be addressed in a separate document. Material in psychotherapy notes, as defined in the HIPAA Privacy Rule, is not disclosed to third-party payers.

The purpose of this document is to specify the particular items of information that the APA believes fall within the "minimum necessary" criteria for routine processing of typical insurance claims for psychiatric treatment. Psychiatrists should also familiarize themselves with applicable state statutes, which may impose additional and/or different requirements with regard to the protection of confidentiality and privacy.

The APA's guidelines for "minimum necessary" are in three parts:

1. outpatient treatment that has been authorized for payment,
2. outpatient treatment requiring pre-authorization, and
3. inpatient treatment.



The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 36,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses including substance use disorders.

#### **The American Psychiatric Association**

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**#1: Outpatient treatment that has been pre-authorized for payment (including sessions that do not require any pre-authorization by payer).**

The first part of the "minimum necessary" guidelines for third-party payers, which follows below, concerns outpatient treatment that has been pre-authorized for payment or outpatient treatment that is not subject to pre-authorization.

*Minimum necessary information:*

The following information is deemed the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to process a routine claim for outpatient psychiatric services that are not subject to additional pre-authorization. The guideline is based on the current "837" Standard claim and the protocol for disclosures to third party payers mandated in the Washington DC and New Jersey third-party mental-health privacy statutes (attached). These statutes place explicit limits on disclosure to payers of information related to mental health treatment. The restriction on disclosure to payers in these statutes has been endorsed by the U.S. Surgeon General in his Report on Mental Health (December 1999, Chapter 7).

- Patient's name, address, date of birth, insurance information/ID number  
**Note:** *If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required.*
- Patient's diagnosis, by current ICD code (currently ICD-9-CM)
- Date(s), type and location of service
- Condition's date of onset (if different than date of service)
- Procedure code – CPT code
- Charges
- Clinician's name, ID number (i.e. SSN or EIN, and/or clinician's provider number)
- Clinician's address
- Facility where services were performed (i.e., office, hospital, clinic)

If a payer cannot make a determination based on the above information, it may then request the provider to disclose additional information, limited to the following:

- Patient's status (i.e., voluntary, involuntary)
- Functional status (impairment described as none, mild, moderate or severe)
- Level of distress (described as none, mild, moderate or severe)
- Prognosis – the estimated minimum duration of the treatment for which the claim has been submitted.

**#2: Outpatient treatment that requires authorization for payment.**

The second part of the "minimum necessary" guidelines for third-party payers, which follows below, concerns outpatient treatment that requires authorization for payment of outpatient treatment. This includes prospective or retrospective reviews for this purpose.

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*Minimum necessary information:*

The following information is deemed the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to authorize payment for outpatient psychiatric services. The guideline is based on the HCFA 1500 Claim Form, the Washington, DC and New Jersey peer review laws, and the current 837 Standard claim. Consistent with the Rule's "minimum necessary" provision, clinical information disclosed to payers for pre-authorization purposes will be used/disclosed by only those individuals who perform the review. The only information disclosed to payers' administrative personnel should be administrative billing information on the current 837 Standard claim. .

*Administrative billing information:*

- Patient's name, address, date of birth, insurance information/ID number  
**Note:** *If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required.*
- Patient's diagnosis by current ICD code (currently ICD-9-CM)
- Clinician's name, ID number (i.e., SSN or EIN, and/or clinician's provider number) and address
- Facility where services were performed (i.e. office, hospital, clinic)
- Date(s), type and location of service – current and planned
- Condition's date of onset (if different than date of service)
- Procedure code–CPT code
- Charges

*Clinical information for authorization of benefits:*

- Treatment planned – CPT code(s), including recommended/expected frequency
- Currently on psychiatric medications? Y/N
- Patient's status (i.e., voluntary, involuntary)
- Functional status (impairment: none, mild, moderate or severe) or Axis V (GAF)
  - Current
  - Highest in past year
  - Estimated GAF at treatment's completion (would address treatment goal)
- Level of distress (none, mild, moderate or severe) or Axis IV rating
- Prognosis – the estimated minimum duration of the treatment for which authorization is sought

**#3: Minimum necessary information for inpatient psychiatric treatment.**

The third part of the "minimum necessary" guidelines for third-party payers, which follows below, concerns inpatient treatment that requires authorization for payment.

*Minimum necessary information:*

The following information is deemed the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to authorize payment for inpatient psychiatric services. Consistent with the Rule's "minimum necessary" provision, clinical information disclosed to payers for pre-authorization purposes will be used/disclosed by only those individuals who perform the review. The only information disclosed to payers' administrative personnel should be administrative billing information on the Current 837 Standard claim.

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### *Administrative Billing Information*

- Patient's name, address, date of birth, insurance information/ID number.  
**Note:** *If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required.*
- Patient's diagnosis, by current ICD code (currently ICD-9-CM)
- Condition's date of onset, (if different than date of service)
- Clinician's name, ID number (i.e. SSN or EIN, and/or provider number) and address
- Facility where services were performed (i.e., office, hospital, clinic)
- Date(s), type and location of service – current and planned
- Procedure code – E&M code(s), or CPT code for ECT
- Charges

### *Clinical Information for Review*

- Patient's status (i.e., voluntary, involuntary)
- Functional status (impairment: none, mild, moderate or severe) or Axis V:
  - Current
  - Highest in past year
  - Estimated GAF at discharge
- Level of distress (none, mild, moderate or severe) or Axis IV:
- Current Risk Factors
  - At risk for harm to self Y/N
  - At risk for harm to others Y/N
  - Currently on psychiatric medications Y/N
  - At risk for medical complications Y/N
  - Other--specify
- Treatment planned: E&M code(s), or CPT code for ECT, including recommended/expected frequency and duration
- Response to treatment, patient's progress, or revision in treatment plan (for authorization of additional treatment). Describe briefly:
- Inpatient treatment goal(s)
- Prognosis – the estimated minimum duration of inpatient treatment for which authorization is sought

### **Procedure for requesting additional information:**

The preceding guidelines should be sufficient in providing the necessary information to the insurer in almost every case for the purposes previously described. In rare cases, following disclosure of the above information, if the third-party payer 1) questions the patient's entitlement to benefits, or the amount of payment requested, or 2) has reasonable cause to believe the treatment in question may be neither usual, customary nor reasonable, the APA recommends the following procedure:

The disputed question/issue should be referred for an independent review by a qualified psychiatrist who is independent of the insurer, whose cost will be borne by the insurer. This reviewer will be given access to the clinical information necessary for the review. However, only the reviewer's determination (and no additional clinical

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information) shall be disclosed by the treating psychiatrist or the reviewer to the insurer for this purpose. Privacy statutes in New Jersey and the District of Columbia (as interpreted and implemented in D.C. through year 2000) provide a long-standing, workable model for such a procedure.

**References:**

NJ REV STAT. secs. 45:14B-31, et. seq.  
Surgeon General's Report on Mental Health (Chapter 7) December 1999.  
D.C. CODE sec. 7-1202.07 (as in effect through September 30, 2002)

**Further Reading:**

Hennessy & Hennessy, An Economic and clinical rationale for changing utilization review practices for outpatient Psychotherapy, v24(3): 340.

**New Jersey Revised Statute**

**45:14B-31. Definitions**

As used in this act:

- a. "Administrative information" means a patient's name, age, sex, address, educational status, identifying number, date of onset of difficulty, date of initial consultation, dates and character of sessions (individual or group), and fees;
- b. "Diagnostic information" means therapeutic characterizations which are of the types that are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM III), of the American Psychiatric Association, or other professionally recognized diagnostic manual;
- c. "Disclose" means to communicate any information in any form;
- d. "Independent professional review committee" means that group of licensed psychologists established pursuant to section 14 of this act by the State Board of Psychological Examiners;
- e. "Third-party payor" means any provider of benefits for psychological services, including but not limited to insurance carriers and employers, whether on an indemnity, reimbursement, service or prepaid basis, but excluding governmental agencies;
- f. "Usual, customary or reasonable." In applying this standard the following definitions are applicable:
  - (1) "Usual" means a practice in keeping with the particular psychologist's general mode of operation;
  - (2) "Customary" means that range of usual practices provided by psychologists of similar education, experience, and orientation within a similar geographic or socioeconomic area;
  - (3) "Reasonable" means that there is an acceptable probability that the patient will realize a significant benefit from the continuation of the psychological treatment.

In applying the standards of "usual, customary, and reasonable," the following guidelines are applicable: If a psychological treatment is "usual" or "customary," an inference that the treatment is also "reasonable" is warranted. If the treatment is neither "usual" nor "customary," then it shall satisfy the criterion of "reasonable."

**L. 1985, c. 256, s. 1.**

**45:14B-32. Disclosure to third-party payor**

A patient who is receiving or has received treatment from a licensed, practicing psychologist may be requested to authorize the psychologist to disclose certain confidential information to a third-party payor for the purpose of obtaining benefits from the third-party payor for psychological services, if the disclosure is pursuant to a valid authorization as described in section 6 of this act and the information is limited to:

- a. Administrative information;
- b. Diagnostic information;
- c. The status of the patient (voluntary or involuntary; inpatient or outpatient);
- d. The reason for continuing psychological services, limited to an assessment of the patient's current level of functioning and level of distress (both described by the terms mild, moderate, severe or extreme);
- e. A prognosis, limited to the estimated minimal time during which treatment might continue.

**L. 1985, c. 256, s. 2.**

**45:14B-33. Independent review**

If the third-party payor has reasonable cause to believe that the psychological treatment in question may be neither usual, customary nor reasonable, the third-party payor may request, and compensate reasonably for, an independent review of the psychological treatment by an independent professional review committee. The request shall be made in writing to the treating psychologist. No third-party payor having such reasonable cause shall terminate benefits without following the procedures set forth in section 4 of this act.

**L. 1985, c. 256, s. 3.**

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DISTRICT OF COLUMBIA OFFICIAL CODE 2001 EDITION  
DIVISION I. GOVERNMENT OF DISTRICT.  
TITLE 7. HUMAN HEALTH CARE AND SAFETY.  
SUBTITLE C. MENTAL HEALTH.  
CHAPTER 12. MENTAL HEALTH INFORMATION.  
SUBCHAPTER II. DISCLOSURES WITH THE CLIENT'S CONSENT.  
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Current through October 2, 2001

**§ 7-1202.07. Limited disclosure to 3rd-party payors.**

(a) A mental health professional or mental health facility may disclose to a 3rd-party payor mental health information necessary to determine the client's entitlement to, or the amount of, payment benefits for professional services rendered; provided, that the disclosure is pursuant to a valid authorization and that the information to be disclosed is limited to:

- (1) Administrative information;
- (2) Diagnostic information;
- (3) The status of the client (voluntary or involuntary);
- (4) The reason for admission or continuing treatment; and
- (5) A prognosis limited to the estimated time during which treatment might continue.

(b) In the event the 3rd-party payor questions the client's entitlement to or the amount of payment benefits following disclosure under subsection (a) of this section, the 3rd-party payor may, pursuant to a valid authorization, request an independent review of the client's record of mental health information by a mental health professional or professionals. Mental health information disclosed for the purpose of review shall not be disclosed to the 3rd-party payor.

CREDIT(S)

2001 Main Volume (Mar. 3, 1979, D.C. Law 2-136, § 207, 25 DCR 5055.)

HISTORICAL AND STATUTORY NOTES

Prior Codifications 1981 Ed., § 6-2017. 1973 Ed., § 6-1621.

Legislative History of Laws

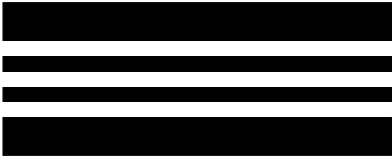
For legislative history of D.C. Law 2-136, see Historical and Statutory Notes following § 7-1201.01.

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*Minimum Necessary Guidelines for Third Party Payers (7 of 7)*

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PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 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 F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. PATIENT STATUS Single Married Other CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( ) 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 NO a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. AUTO ACCIDENT? PLACE (State) YES NO

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO 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 NO If yes, return to and complete item 9 a-d.

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. SIGNED DATE 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

14. DATE OF CURRENT: 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 PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO

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. 2. 3. 4. 23. PRIOR AUTHORIZATION NUMBER

Table with 11 columns (A-K) and 6 rows. Columns include: DATE(S) OF SERVICE, Place of Service, Type of Service, PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS MODIFIER), DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSDT Family Plan, EMG, COB, RESERVED FOR LOCAL USE.

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 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.) SIGNED DATE 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

#### **REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

#### **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

#### **MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.