Data Entry IFB – DHMH OPASS No. 1010107

Attachments

Attachment A – Sample Data Entry Documents & Document Specifications

Attachment B – Sample Batch Report

Attachment C – Sample Shipment Report

Attachment D – Consumer Price Index (CPI) Gas Price Sample

Attachment E – Directions to 201 W. Preston Street

Attachment A

Sample Data Entry Documents & Document Specifications

1. Burial Transit Permit
2. Certificate of Death
3. CMS 1500 – Breast & Cervical Cancer Program
4. UB-04 – Breast & Cervical Cancer Program
5. FMIS M40 – Expense Report
6. FMIS M42 – Goods & Services
7. FMIS M43 – Interface Payment Block
8. GES – Adult Evaluation and Review Services
9. CMS 1500 – Kidney Disease Program
10. UB-04 – Kidney Disease Program
11. MAP – Admission and Length of Stay Certification
12. STEPS/PASRR Claim and Statistical Form
13. UB-04 – Medical Assistance Program

State of Maryland / Department of Health and Mental Hygiene

Burial-Transit Permit (This permit must accompany remains to destination)

2- For State Registrar

Reg. No. 00000

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
John D. Doe	Dec. 3 2008	1:23 pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
John Hopkins Hospital	Baltimore	

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
123-45-6789	X 1 M 2 F	28 Yrs.			Jan. 1, 1980	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		Baltimore	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
123 Main Street	12345	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes X 2 No If Yes, Give Year or Dates:	1 Yes X 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Mechanic	Jiffy Lube

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John M. Doe	Sarah Lee

19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sarah DOe - Mother	123 Main Street Baltimore, MD 12345

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Memorial	Dec. 6, 2008	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Doe Funeral Home 456 Main Street Baltimore, MD 12345

To Be Completed by Funeral Director

Authority for Burial, Transportation, Removal, Cremation or Other Disposition

This burial permit, when completely filled in and bearing below the signature of the attending physician and funeral director, constitutes authority for burial, transportation, removal, cremation or other disposition of the deceased named above.

Cemetery or Crematory Authority Shall Fill Out Section Below

The deceased named above was buried ☑ cremated ☐ in the cemetery or crematory named in item 20b.

Burial was in Section Resting Lot J164 Grave 301

I have made the appropriate entry in the cemetery or crematory register.

Signature [signature] Date signed Dec. 6, 2008

Sexton or other person in charge

This burial transmit permit must be signed above by the cemetery or crematory authority. Where there is no full-time person in charge of the cemetery, the funeral director may sign as sexton.

If burial took place in Maryland this permit must be returned within **ten** days to the:
Maryland Department of Health and Mental Hygiene
Division of Vital Records
6550 Reisterstown Road Plaza
Baltimore, Maryland 21215

SAMPLE

FOR USE

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D01234	Dec. 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Janice King, MD 600 Wolfe Street, Baltimore, MD 21202

31. Date filed (Month, Day, Year)	32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Warning: The law imposes a penalty up to $200 upon any person who disposes of a dead body without a duly executed burial-transit permit.
Transportation: This permit must accompany the body to the final destination. When the body is to be shipped by common carrier, the casket containing the body or the outer case shall be constructed to prevent seepage or escape of odors.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

Record Title: BURIAL TRANSIT PERMIT
Completed By: Jerry Plummer

System: OCR
Date: September 10, 1999

Record Length: 133
Block Size: 27930

Number	Field Name	Output Position	D.E Field Number	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Range High	Special Instructions
1	Decedent's Name												
	- First and Middle	1-21	2	21	A	L	S	S					
	- Last Name	22-37	3	16	A	L	S	S					
2	Date of Death												
	- Month	38-39	4	2	N	R	Z	Z					
	- Day	40-41	5	2	N	R	Z	Z					
	- Century/Year	42-45	6	4	N	R	Z	Z					
3	Place of Disposition	46-70	7	25	A	L	S	S					
4	Date of Disposition												
	- Month	71-72	8	2	N	R	Z	Z					
	- Day	73-74	9	2	N	R	Z	Z					
	- Century/Year	75-78	10	4	N	R	Z	Z					
5	Location of Disposition	79-98	11		A	L	S	S					
6	Burial Section	99-108	12	10	A/N	L	S	S					
7	Burial Lot	109-118	13	10	A/N	L	S	S					
8	Burial Grave	119-128	14	10	A/N	L	S	S					
9	Reg. No.	129-133	1	5	N	R	Z	S					

Data Set Name: HVDP.DEATHS.BURIAL.NCRDATA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 00000

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John D. Doe
2. Date of Death Month: Dec. Day: 3 Year: 2008
3. Time of Death: 1:23 pm M
4a. Facility Name *(If not institution, give street and number)*: John Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 123-45-6789
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 28 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1980
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 123 Main Street
10f. Zip Code: 12345
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)* Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Jiffy Lube
17. Father's Name *(First, Middle, Last)*: John M. Doe
18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Lee
19a. Informant's Name/Relationship *(Type. Print)*: Sarah Doe - Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 123 Main Street Baltimore, MD 12345
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial
Date: Dec. 6, 2008
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Jimmy Doe MO1163
22. Name and Address of Facility: Doe Funeral Home 456 Main Street Baltimore, MD 12345

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):
b. Asthma

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome pf pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Janice King MD
29c. License number: D01234
29d. Date signed *(Month, Day, Year)*: Dec. 3, 2008
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janice King, MD 600 Wolfe Street, Baltimore, MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 2008
32. Registrar's Signature

SAMPLE
NOT FOR USE
NOT VALID

DHMH 17 Rev 1/2001

ORIGINAL

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

Record Title: DEATH ENTREX TRANSACTION RECORD
Completed By: Jerry Plummer

System: OCR
Date: August 23, 1999

Record Length: 350
Block Size: 26950

Number	Field Name	Output Position	D.E Field Number	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Range High	Special Instructions
1	Record Code	1	49	1	N				Y		2	5	2-New Rec 3-Dup 5-Corr
2	Certificate Number	2-6	1	5	N	R	0		Y		00001	99999	If missing return to Vital Recs
3	Decedent's Name												
	- First and Middle	7-26	2	20	A	L	S	S					Free Form
	- Last	27-41	3	15	A	L	S	S					Free Form
4	Date of Death												
	- Month	42-43	4	2	N						01	12	
	- Day	44-45	5	2	N						01	31	
	- Century	44-47	6	2	N						19	20	
	- Year	48-49	7	2	N						00	99	
5	Sex	50	13	1	N						1	2/9	1=Male, 2=Female, 9=Blank
6	Filler	51		1			S						
7	Age												
	- Type	52	15	1	N						0	5/9	See Attached
	- Units	53-54	14	2	N						00	99	See Attached
8	Filler	55-56		2			S						
9	Marital Status	57	27	1	N						1	4/9	Direct Entry,9-Not Checked
10	Filler	58-61		4			S						
11	Place of Death	62	39								1	6/9	Direct Entry,9-Not Checked
12	Disposition	63	34	1	N						1	5/9	
13	Filler												
14	Social Security Number	70-78	10-12	9	N			0					Direct Entry
15	Filler	79-82		4			S						
16	Autopsy	83	37	1	N						1	2/9	9-Not Checked
17	Findings	84	38	1	N						1	2/9	9-Not Checked
18	Filler	85-87					S						
19	Certifier	88	44	1	N						1	2/9	9-Not Checked
20	Date Filed												
	- Month	89-90	45	2	N						01	12	If missing return to Vital Recs
	- Day	91-92	46	2	N						01	31	"
	- Century	93-94	47	2	N						19	20	"
	- Year	95-96	48	2	N						00	99	"

Data Set Name: HVDP.DEATHS.NCRDATA.HVDJ001W

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

Record Title: DEATH ENTREX TRANSACTION RECORD
Completed By: Jerry Plummer

System: OCR
Date: August 23, 1999

Record Length: 350
Block Size: 26950

Number	Field Name	Output Position	D.E. Field Number	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Range High	Special Instructions
21	Filler	97-102		6			S						
22	Date of Birth												
	- Month	103-104	16	2	A/N						01	12/99	Space if Unknown or Blank
	- Day	105-106	17	2	A/N						01	31/99	"
	- Century	107-108	18	2	A/N						19	20/99	"
	- Year	109-110	19	2	A/N						00	99	"
23	Father's Last Name	111-125	32	15	A		S	S					Free Form
24	Residence Of Deceased												
	- Street/Number	126-146	25	21	A/N		S						Free Form - Key Abbrev.
	- Zip Code	147-151	26	5	N		0	0			00000	99999	Unknown or Blank = 00000
25	Manner of Death	152	40	1	N						1	6/9	9 if not checked
26	Injury at Work	153	41	1	N						1	2/9	9 if not checked
27	Filler	154-156					S						
28	Funeral Home Name	157-174	35	18	A/N								Free Form, FH=Funeral Ho
29	Filler	175		1			S						
30	Race	176-177	29	2	A			S					Key 1st 2 characters of race
31	Birthplace	178-185	20	8	A								Key 1st 8 characters
32	County of Death	186-193	9	8	A								Key 1st 8 characters
33	Facility Name	194-199	8	6	A								Key initial of facility name
34	Residence State	200-207	21	8	A								Key 1st 8 characters
35	Residence County	208-215	22	8	A								Key 1st 8 characters
36	Residence City	216-223	23	8	A								Key 1st 8 characters
37	Hispanic Origin	224-231	28	8	A								Key 1st 8 characters
38	Education												
	- Elementary	232-233	30	2	A/N								Key 2 Position, Space if Blank
	- College	234-235	31	2	A/N								Key 2 Position, Space if Blank
39	Place of Injury	236-243	42	8	A								Key 1st 8 characters
40	Location of Injury	244-263	43	20	A/N								Same as #24
41	Inside City Code	264	24	1	A		S				0	1/9	9 if Blank
42	Filler	265-302		38			S						
43	Batch Number	303-306	50	4	N						0001	9999	Must be numeric
44	Filler	307-311		5			S						

Data Set Name: HVDP.DEATHS.NCRDATA.HVDJ001W

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

Record Title: DEATH ENTREX TRANSACTION RECORD
Completed By: Jerry Plummer

System: OCR
Date: August 23, 1999

Record Length: 350
Block Size: 26950

Number	Field Name	Output Position	D.E Field Number	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Range High	Special Instructions
45	Maiden Name	312-326	33	15	A	L	S	S					Free Form
46	Filler	327-341		15			S						
47	Tobacco	342	36	1	A		S	S					Y=Yes, N=No, P=Probably, U=Uncertain
48	Filler	343-350		8			S						

Data Set Name: HVDP.DEATHS.NCRDATA.HVDJ001W

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

KIDNEY DISEASE PROGRAM
201 WEST PRESTON STREET
SS3
BALTIMORE MD 21201

97
KDP

CARRIER

PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM 09 DD 26 YY 19[redacted] SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) [redacted] DRIVE

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street) [redacted] DRIVE

CITY BALTIMORE STATE MD

8. PATIENT STATUS Single [X] Married Other Employed Full-Time Student Part-Time Student

CITY BALTIMORE STATE MD

ZIP CODE 21225-1306 TELEPHONE (Include Area Code) (410) [redacted]

ZIP CODE 21225-1306 TELEPHONE (Include Area Code) (410) [redacted]

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 [X] NO

a. INSURED'S DATE OF BIRTH MM 09 DD 26 YY 19[redacted] SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME RETIRED

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME KIDNEY DISEASE PROGRAM

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE 107693

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06 19 2008

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 01 YY 2007 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [redacted] MD

17a. 1GF23848

17b. NPI [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 585.6

2.

3.

4.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 16 08	05 16 08	65		90935		1	168 03	1	N N	NPI	[redacted]
2	05 23 08	05 23 08	65		90935		1	168 03	1	N N	NPI	[redacted]
3	05 28 08	05 28 08	65		90935		1	168 03	1	N N	NPI	[redacted]
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER [redacted] SSN EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE $ 504 09

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 504 09

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.)

[redacted] MD

SIGNED 06/19/2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DAVITA. HARBOR PARK
111 CHERRY HILL ROAD
BALTIMORE MD 21225

a.

33. BILLING PROVIDER INFO & PH. # (410) 5365400

MID-ATLANTIC NEPHROLOGY ASSOC
PO BOX 64694
BALTIMORE MD 21264-4694

a. [redacted]

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M 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 Employed Full-Time Student Part-Time Student

CITY BALTIMORE 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? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

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. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

Fold

Fold

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09) DATE: 2/5/2009

COMPLETED BY: TIM McGINN RECORD LENGTH: 1130 PAGE: 1 OF 6

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
	BATCH NUM	1 – 4	4	A/N	R			Y			
	FISCAL YEAR	5-8	4	N	R			Y			
	REC SEQ NUM	9-11	3	N	R			Y			
1A	SOC SEC NUM	12-20	9								
33A	NPI	21-30	10		L						
25	FED TAX ID NUM	31-45	15	N	L						FIRST 9 numbers in FTI
	FLLLER	46-50	5								
25	PROV/STORE /SUFFIX NUM	51-56	6		L						All numbers that exceed 9 in box 25 - FTI
	SERV-TYPE	57	1								
	EOB FLAG	58	1								
	MED REC FLAG	59	1								
	FILLER	60-63	4								
21-1	DIAGNOIS CD - 1	64-68	5								
21-2	DIAGNOIS CD - 2	69-73	5								
21-3	DIAGNOIS CD - 3	74-78	5								
21-4	DIAGNOIS CD - 4	79-83	5								
24-1-SHADED	DESCRIPTOR 1	765-825	61	A/N	L						
24-1-A	DATE SER FROM #1	84-91	8								
24-1-A	DATE SER TO # 1	92-99	8								
24-1-B	PLACE SER #1	100-101	2								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09) DATE: 2/5/2009

COMPLETED BY: TIM McGINN RECORD LENGTH: 1130 PAGE: 2 OF 6

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24- 1-D	CPT/HCP # 1	102-106	5								
24-1-D	SER 1 MOD1	107-108	2								
24-1-D	SER-1 MOD2	109-110	2								
24-1-D	SER-1 MOD3	111-112	2								
24-1-D	SER-1 MOD4	113-114	2								
24-1-F	SER-1 CHARGES	115-121	7								
24-1-G	UNIT -1	122-126	5								
24-2-SHADED	DESCRIPTOR 2	826-886	61	A/N	L						
24-2-A	DATE SER FRM # 2	127-134	8								
24-2-A	DATE SER TO # 2	135-142	8								
24-2-B	PLACE SER # 2	143-144	2								
24-2-D	CPT/HCP # 2	145-149	5								
24-2-D	SER 2 MOD1	150-151	2								
24-2-D	SER-2 MOD2	152-153	2								
24-2-D	SER-2 MOD3	154-155	2								
24-2-D	SER-2 MOD4	156-157	2								
24-2-F	SER-2 CHARGES	158-164	7								
24-2-G	UNIT-2	165-169	5								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09) DATE: 2/5/2009

COMPLETED BY: TIM McGINN RECORD LENGTH: 1130 PAGE: 3 OF 6

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24-3-SHADED	DESCRIPTOR 3	887-947	61	A/N	L						
24-3-A	DATE SER FRM # 3	170-177	8								
24-3-A	DATE SER TO # 3	178-185	8								
24-3-B	PLACE SER # 3	186-187	2								
24-3-D	CPT/HCP # 3	188-192	5								
24-3-D	SER 3 MOD1	193-194	2								
24-3-D	SER-3 MOD2	195-196	2								
24-3-D	SER-3 MOD3	197-198	2								
24-3-D	SER-3 MOD4	199-200	2								
24-3-F	SER-3 TOTAL	201-207	7								
24-3-G	UNIT -3	208-212	5								
24-4-SHADED	DESCRIPTOR 4	948-1009	61	A/N	L						
24-4-A	DATE SER FRM # 4	213-220	8								
24-4-A	DATE SER TO # 4	221-228	8								
24-4-B	PLACE SER # 4	229-230	2								
24-4-D	CPT/HCP # 4	231-235	5								
24-4-D	SER 4 MOD1	236-237	2								
24-4-D	SER-4 MOD2	238-239	2								
24-4-D	SER-4 MOD3	240-241	2								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09) DATE: 2/5/2009

COMPLETED BY: TIM McGINN RECORD LENGTH: 1130 PAGE: 4 OF 6

24-4-D	SER-4 MOD4	242-243	2								
24-4-F	SER-4 TOTAL	244-250	7								
Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24-4-G	UNIT -4	251-255	5								
24-5-SHADED	DESCRIPTOR 5	1009-1069	61	A/N	L						
24-5-A	DATE SER FRM # 5	256-263	8								
24-5-A	DATE SER TO # 5	264-271	8								
24-5-B	PLACE SER # 5	272-273	2								
24-5-D	CPT/HCP # 5	274-278	5								
24-5-D	SER 5 MOD1	279-280	2								
24-5-D	SER-5 MOD2	281-282	2								
24-5-D	SER-5 MOD3	283-284	2								
24-5-D	SER-5 MOD4	285-286	2								
24-5-F	SER-5 TOTAL	287-293	7								
24-5-G	UNIT-5	294-298	5								
24-6-SHADED	DESCRIPTOR 6	1070-1130	61	A/N	L						
24-6-A	DATE SER FRM # 6	299-306	8								
24-6-A	DATE SER TO # 6	307-314	8								
24-6-B	PLACE SER # 6	315-316	2								
24-6-D	CPT/HCP # 6	317-321	5								
24-6D	SER 6 MOD1	322-323	2								
24-6D	SER-6 MOD2	324-325	2								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09) DATE: 2/5/2009

COMPLETED BY: TIM McGINN RECORD LENGTH: 1130 PAGE: 5 OF 6

24-6D	SER-6 MOD3	326-327	2								
24-6D	SER-6 MOD4	328-329	2								
Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24-6-F	SER-6 TOTAL	330-336	7								
24-6-G	UNIT-6	337-341	5								
28	TOTAL CHARGE	342-349	8								
29	AMUNT PAID	350-357	8								
30	BALANCE DUE	358-365	8								
2	LAST NAME	366-385	20								
2	FIRST NAME	386-400	15								
2	MIDDLE INIT	401	1								
5	PAT ADDRR	402-426	25								
5	PAT CITY	427-441	15								
5	PAT STATE	442-443	2								
5	PAT ZIP-1	444-448	5								
5	PAT ZIP-2	449-452	4								
3	PAT BIRTDATE	453-460	8								
3	PAT SEX	461	1								M, F
33	PROVDR NAME	462-491	30								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09) DATE: 2/5/2009

COMPLETED BY: TIM McGINN RECORD LENGTH: 1130 PAGE: 6 OF 6

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
33	PRVDR ADDR	492-511	20								
33	PRVDR CITY	512-526	15								
33	PRVDR STATE	527-528	2								
33	PRVDR ZIP-1	529-533	5								
33	PRVDR ZIP-2	534-537	4								
	DATE RECEIVED	538-545	8								MMDDCCYY Date Stamp
31	PHYSICAN NAME	546-565	20								
	FILLER	566-580	15								
	FILLER	581-605	25								
	FILLER	601	1								
	FILLER	607-621	15								
	FILLER	622-629	8								
	FILLER	630-654	25								
17-A	REFER PHYSICAN	655-669	15								
33	PRVR NAME EXT	670-709	40								PROVIDER NAME OVER FLOW
33	PRVDR ADDR EXT	710-759	50								PROVIDER ADDRESS OVERFLOW
33	PRVDR CITY EXT	760-764	5								PROVIDER CITY OVERFLOW

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: HCFA BCCDT CANCER FORM (CANHIC09)

DATE: 2/5/2009

COMPLETED BY: TIM McGINN

RECORD LENGTH: 1130

PAGE: 7 OF 7

1 FRESENIUS MEDICAL CARE C
12931 OAK HILL AVENUE
HAGERSTOWN, MD 21742

2 FMC OF HAGERSTOWN
P.O. BOX 64741
BALTIMORE MD 21264-4741
[redacted]

3a PAT. CNTL # [redacted]
b. MED. REC. # [redacted]

4 TYPE OF BILL: 721

5 FED. TAX NO. [redacted]

STATEMENT COVERS PERIOD FROM 030107 THROUGH 033107

7

8 PATIENT NAME a 100480
b [redacted] E

9 PATIENT ADDRESS a
b HAGERSTOWN
c MD d 21740 e

10 BIRTHDATE 120919[redacted]
11 SEX M
12 ADMISSION DATE 030107
13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 30 18 71 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE 30

31 OCCURRENCE CODE 33 DATE 061005
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38 KIDNEY DISEASE PROGRAM SC
ROOM SS-3 CLAIMS DEPT
201 WEST PRESTON STREET
BALTIMORE MD 21201

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 49	40.20	68	13800.00	A8	76.00
b A9	170.00				
c					
d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0270	ADMIN SUPPLY INJECTION -	A4657		13	6.50		
0270	ADMIN SUPPLY - IV	A4913		6	29.34		
0634	EPO 13800 UNITS	Q4081		13	132.05		
0636	ZEMPLAR 1 MCG	J2501		25	94.25		
0636	PROCHLORPERAZINE IV 10 M	J0780		1	2.04		
0821	TMT HIGH FLUX HEMODIALYS	90935		14	1914.47		
				TOTALS	2178.65		

RECEIVED AUG 26 2008 KIDNEY DISEASE PROGRAM

MEDICARE EOB ATTACHED

0001 PAGE 1 OF 1 CREATION DATE 082008

50 PAYER NAME
MEDICARE
KIDNEY DISEASE PROGRAM

51 HEALTH PLAN ID [redacted] 0027
52 REL INFO Y Y
53 ASG BEN Y Y
54 PRIOR PAYMENTS 1736.74
55 EST. AMOUNT DUE 441.91
56 NPI [redacted]
57 OTHER PRV. ID

58 INSURED'S NAME
[redacted] E
[redacted] E
59 P.REL 18 18
60 INSURED'S UNIQUE ID [redacted]
61 GROUP NAME
62 INSURANCE GROUP NO. N/A

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 5856 20521 58881 70701 68
67 73
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI [redacted] QUAL 62 A72082
LAST ROZA FIRST ELI
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a 03 2610E0700X
b
c
d

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

– CANCER UB-04

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME a	b	9 PATIENT ADDRESS a	b	c	d	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															
b															

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	PAGE ____ OF ____		CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57 OTHER PRV ID	A
B								B
C								C

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX										68

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
	BATCH NUM	1 – 4	4	A/N	R			Y			From Batch Sheet
	FISCAL YEAR	5-8	4	N	R			Y			From Batch Sheet
	REC SEQ NUM	9-11	3	N				Y			SYSTEM GENERATED
56	NPI	12-21	10	N	L						
	FILLER	22--25	4	A/N							
12	LAST NAME	26-45	20	A/N							
12	FIRST NAME	46-60	15	A/N							
14	BIRTHDATE	61-68	8	N							MMDDYYYY
15	SEX	69	1	A/N							M/F
	FILLER	70-78	9	N							
1	PROV NAME	79-103	25	A/N							
1	PROV ADDRESS	104-128	25	A/N							
1	PROV CITY	129-140	12	A/N							
1	PROV STATE	141-142	2	A/N							
1	PROV ZIP	143-151	9	N							
	EOB FLAG	152	1	A/N							
	MEDICAL REC	153	1	A/N							
	SERVICE TYPE	154	1	N							
5	SUFFIX	155-160	6	A/N							On Line with Fed Tax No.

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
6	BEG SER DATE	161-166	6	N							MMDDYY
	FILLER	167-168	2								
7	END SER DATE	169-174	6	N							MMDDYY
	FILLER	175-176	2								
	DATE RECEIVED	177-184	8	N							MMDDCCYY DATE STAMP
66	66-PRIN CODE	185-189	5	A/N							
66	CODE	190-194	5	A/N							
66	CODE	195-199	5	A/N							
66	CODE	200-204	5	A/N							
66	CODE	205-209	5	A/N							
66	CODE	210-214	5	A/N							
66	CODE	215-219	5	A/N							
66	CODE	220-224	5	A/N							
66	CODE	225-229	5	A/N							
66	76-ADM DIAG	230-234	5	A/N							
	FILLER	235-237	3								
74	PRINC PROC C-80	238-242	5	A/N							
74	PRINC DATE	243 - 248	6	N							
74A	OTHR PROC	249 –253	5	A/N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
74A	OTH P-DTE	254 - 259	6	N							
74B	OTHR PROC –B	260-264	5	A/N							
74B	OTH P-DTE -B	265-270	6	N							
74C	OTHR PROC -C	217-275	5	A/N							
74C	OTH P-DTE-C	276-281	6	N							
74D	OTHR PROC -D	282-286	5	A/N							
74D	OTH P-DTE -D	287-292	6	N							
74E	OTHR PROC -E	293-297	5	A/N							
74E	OTH P-DTE-E	298-303	6	N							
17	ADMISS DATE	304-309	6	N							MMDDYY
5	PROV TAX ID	310-324	15	N							
	FILLER	325-345	21								
60	INSUR ID # 1	346-356	11	N							
61	INSUR NME #1	357-369	13	A/N							
62	INSUR GRP #1	370-374	5	A/N							
60	INSUR ID # 2	375-385	11	N							
61	INSUR NME #2	386-398	13	A/N							
62	INSUR GRP #2	399-403	5	N							
60	INSUR ID # 3	404-414	11	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
61	INSUR NME #3	415-427	13	A/N							
62	INSUR GRP #3	428-432	5	A/N							
	REVENUE CODES OCCUR 23 TIMES	433-1191	759								
42	REV CODE 1	433-435	3	N							
43	DESCRIPTION 1	1458-1481	24	A/N	L						
44	HCPS RATE 1	439-440	5	N							
45	SER DTE 1	441-446	6	N							
46	SERV UNIT 1	447-451	5	N							
47	TOT CHARGES # 1	452-458	7	N							
48	NO CHARGES #1	459-465	7	N							
42	REV CODE # 2	466-468	3	N							
43	DESCRIPTION 2	1482-1505	24	A/N	L						
44	HCPS RATE 2	469-473	5	N							
45	SER DTE 2	474-479	6	N							
46	SERV UNIT 2	480-484	5	N							
47	TOT CHARGES # 2	485-491	7	N							
48	NO CHARGES # 2	492-498	7	N							
42	REV CODE 3	499-501	3	N							
43	DESCRIPTION 3	1506-1529	24	A/N	L						
44	HCPS RATE 3	502-506	5	N							
45	SER DTE 3	507-512	6	N							

DHMH DATA ENTRY JOB SPECIFICATION
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RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
46	SERV UNIT 3	513-517	5	N							
47	TOT CHARGES # 3	518-524	7	N							
48	NO CHARGES # 3	525-531	7	N							
42	REV CODE 4	532-534	3	N							
43	DESCRIPTION 4	1530-1553	24	A/N	L						
44	HCPS RATE 4	535-539	5	N							
45	SER DTE 4	540-545	6	N							
46	SERV UNIT 4	546-550	5	N							
47	CHARGES # 4	551-557	7	N							
48	NO CHARGES # 4	558-564	7	N							
42	REV CODE 5	565-567	3	N							
43	DESCRIPTION 5	1554-1577	24	A/N	L						
44	HCPS RATE 5	568-572	5	N							
45	SER DTE 5	573-578	6	N							
46	SERV UNIT 5	579-583	5	N							
47	CHARGES # 5	584-590	7	N							
48	NO CHARGES # 5	591-597	7	N							
42	REV CODE 6	598-601	5	N							
43	DESCRIPTION 6	1578-1601	24	A/N	L						
44	HCPS RATE 6	602-606	5	N							
45	SER DTE 6	606-611	6	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
46	SERV UNIT 6	612-616	3	N							
47	TOT CHARGES # 6	617-623	7	N							
48	NO CHARGES # 6	624-630	7	N							
42	REV CODE 7	631-633	3	N							
43	DESCRIPTION 7	1602-1625	24	A/N	L						
44	HCPS RATE 7	634-638	5	N							
45	SER DTE 7	639-644	6	N							
46	SERV UNIT 7	645-649	5	N							
47	TOT CHARGES # 7	650-656	7	N							
48	NO CHARGES # 7	657-663	7	N							
42	REV CODE 8	664-666	3	N							
43	DESCRIPTION 8	1626-1649	24	A/N	L						
44	HCPS RATE 8	667-671	5	N							
45	SER DTE 8	672-677	6	N							
46	SERV UNIT 8	678-682	5	N							
47	TOT CHARGES # 8	683-689	7	N							
48	NO CHARGES # 8	690-696	7	N							
42	REV CODE 9	697-699	3	N							
43	DESCRIPTION 9	1650-1673	24	A/N	L						
44	HCPS RATE 9	700-704	5	N							
45	SER DTE 9	705-710	6	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
46	SERV UNIT 9	711-715	5	N							
47	CHARGES # 9	716-722	7	N							
48	NO CHARGES # 9	723-729	7	N							
42	REV CODE 10	730-732	3	N							
43	DESCRIPTION 10	1674-1697	24	A/N	L						
44	HCPS RATE 10	733-737	5	N							
45	SER DTE 10	738-743	6	N							
46	SERV UNIT 10	744-748	5	N							
47	TOT CHARGE # 10	749-755	7	N							
48	NO CHARGES # 10	756-762	7	N							
42	REV CODE 11	763-765	3	N							
43	DESCRIPTION 11	1698-1721	24	A/N	L						
44	HCPS RATE 11	766-770	5	N							
45	SER DTE 11	771-776	6	N							
46	SERV UNIT 1	777-781	5	N							
47	CHARGES # 11	782-788	7	N							
48	NO CHARGES # 11	789-794	7	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
42	REV CODE 12	796-798	3	N							
43	DESCRIPTION 12	1722-1745	24	A/N	L						
44	HCPS RATE 12	799-803	5	N							
45	SER DTE 12	804-809	6	N							
46	SERV UNIT 12	810-814	5	N							
47	CHARGES # 12	815-821	7	N							
48	NO CHARGES #12	822-828	7	N							
42	REV CODE 13	829-831	3	N							
43	DESCRIPTION 13	1746-1769	24	A/N	L						
44	HCPS RATE 13	832-836	5	N							
45	SER DTE 13	837-842	6	N							
46	SERV UNIT 13	843-847	3	N							
47	CHARGES # 13	848-854	7	N							
48	NO CHARGES # 13	855-861	7	N							
42	REV CODE 14	862-864	3	N							
43	DESCRIPTION 14	1770-1793	24	A/N	L						
44	HCPS RATE 14	865-869	5	N							
45	SER DTE 14	870-875	6	N							
46	SERV UNIT 14	876-880	5	N							
47	CHARGES # 14	881-887	7	N							
48	NO CHARGES # 14	888-894	7	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
42	REV CODE 15	895-898	3	N							
43	DESCRIPTION 15	1794-1817	24	A/N	L						
44	HCPS RATE 15	898-902	5	N							
45	SER DTE 15	903-908	6	N							
46	SERV UNIT 15	909-913	5	N							
47	CHARGES # 15	914-920	7	N							
48	NO CHARGES # 15	921-927	7	N							
42	REV CODE 16	928-930	3	N							
43	DESCRIPTION 16	1818-1841	24	A/N	L						
44	HCPS RATE 16	931-935	5	N							
45	SER DTE 16	936-941	6	N							
46	SERV UNIT 16	942-946	5	N							
47	CHARGES # 16	947-953	7	N							
48	NO CHARGES # 16	954-960	7	N							
42	REV CODE 17	961-963	3	N							
43	DESCRIPTION 17	1842-1865	24	A/N	L						
44	HCPS RATE 17	964-968	5	N							
45	SER DTE 17	969-974	6	N							
46	SERV UNIT 17	975-979	5	N							
47	CHARGES #17	980-986	7	N							
48	NO CHARGES #17	987-993	7	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
42	REV CODE 18	994-996	3	N							
43	DESCRIPTION 18	1866-1889	24	A/N	L						
44	HCPS RATE 18	997-1001	5	N							
45	SER DTE 18	1002-1007	6	N							
46	SERV UNIT 18	1008-1012	5	N							
47	CHARGES # 18	1013-1019	7	N							
48	NO CHARGES # 18	1020-1026	7	N							
42	REV CODE 19	1027-1029	3	N							
43	DESCRIPTION 19	1890-1913	24	A/N	L						
44	HCPS RATE 19	1030-1034	5	N							
45	SER DTE 19	1035-1040	6	N							
46	SERV UNIT 19	1041-1045	5	N							
47	CHARGES # 19	1046-1052	7	N							
48	NO CHARGES # 19	1053-1059	7	N							
42	REV CODE 20	1060-1062	3	N							
43	DESCRIPTION 20	1914-1937	24	A/N	L						
44	HCPS RATE 20	1063-1067	5	N							
45	SER DTE 20	1068-1073	6	N							
46	SERV UNIT 20	1074-1078	5	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
47	CHARGES # 20	1079-1085	7	N							
48	NO CHARGES # 20	1086-1092	7	N							
42	REV CODE 21	1093-1095	3	N							
43	DESCRIPTION 21	1938-1961	24	A/N	L						
44	HCPS RATE 21	1096-1100	5	N							
45	SER DTE 21	1101-1106	6	N							
46	SERV UNIT 21	1107-1111	5	N							
47	TOT CHARGES # 21	1112-1118	7	N							
48	NO CHARGES # 21	1119-1125	7	N							
42	REV CODE 22	1126-1128	3	N							
43	DESCRIPTION 22	1962-1985	24	A/N	L						
44	HCPS RATE 22	1129-1133	5	N							
45	SER DTE 22	1134-1139	6	N							
46	SERV UNIT 22	1140-1144	5	N							
47	CHARGES # 22	1145-1151	7	N							
48	NO CHARGES # 22	1152-1158	7	N							
42	REV CODE 23	1159-1161	3	N							Always '001' for last record
44	FILLER	1162-1166	5	N							
45	FILLER	1167-1172	6	N							
46	FILLER	1173-1176	4	N							
47	TOTALS	1177-1184	8	N							

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UB-04 BCCDT CANCER FORM (CANUBDES) DATE: 2/5/2009

COMPLETED BY: Tim McGinn RECORD LENGTH: *1985*

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
48	FILLER	1185-1191	7	N							
50-A	PAYER NAME # 1	1192-1216	25	A/N							
51-A	PAYER PROV #1	1217-1237	15	A/N							
54-A	PRIOR PYMT # 1	1232-1239	8	N							
55-A	EST AMT # 1	1240-1247	8	N							
50-B	PAYER NAME # 2	1248-1272	25	A/N							
51-B	PAYER PROV #2	1273-1287	15	A/N							
54-B	PRIOR PYMT # 2	1288-1295	8	N							
55-B	EST AMT # 2	1296-1303	8	N							
50-C	PAYER NAME # 3	1304-1328	25	A/N							
51-C	PAYER PROV #3	1329-1343	15	A/N							
54-C	PRIOR PYMT # 3	1344-1351	8	N							
55-C	EST AMT # 3	1352-1359	8	N							
1	PROVIDER NAME EXTEND	1360-1404	45								PROVIDER NAME OVERFLOW
1	PROVIDER ADDR EXTEND	1405-1449	45								PROVIDER ADDRE OVERFLOW
1	PROVIDER CITY EXTEND	1450-1457	8								PROVIDER CITY OVERFLOW

BATCH HEADER SHEET

EXPENSES

DATE __/__/____

BATCH AGENCY - M40

TOTAL _____

STD. JOB : FMIS - EXP (PGM-03 new format)

BATCH NAME : FEXP - M40 __ __

EXPENSE REPORT

PLEASE CHECK APPROPRIATE BLOCK, IF APPLICABLE

NEW NAME ☐

NEW ADDRESS ☐

FIRST TIME SUBMISSION ☐

RECEIVED D.H.M.H.

2008 OCT -7 P 12:54

DIVISION GENERAL ACCOUNTING

NOTE: SEE BACK FOR INSTRUCTIONS ON COMPLETION OF FORM

NAME	[redacted]
SOCIAL SEC. NO.	[redacted] 000
VENDOR NO	
ADDRESS	[redacted]
CITY STATE	Baltimore MD 21218

EA 381668

STATE OF MARYLAND
DEPARTMENT OF HEALTH & MENTAL HYGIENE

FROM 9 / 18 / 08 THRU 9 / 18 / 08
MO. DAY YR. MO. DAY YR.

I hereby certify that all expenditures listed hereon are true and correct and were necessary and reasonable to accomplish the objectives of the trip.

[redacted] 9/29/08
SIGNATURE DATE

[redacted] 9-28-08
APPROVED DATE

PCA	INDEX	AG/OBJ	AMOUNT	FED. GRANT TRACKING #	MILEAGE	AC
X 7 9	1 0 7 0 0	0 4 0 5	9.00	0 9 2 3 2 8		

Yrtt the 10/06

PRIVATELY OWNED VEHICLES ONLY

DATE	ODOMETER READINGS START	ODOMETER READINGS FINISH	LESS COMMUTE MILES	OFFICIAL MILES TRAVELED
TOTAL MILEAGE				

DATE	STARTING TIME / ENDING TIME	MILEAGE / PARKING / TOLLS	BREAKFAST / LUNCH / DINNER	LODGING / REGISTRATION / TIPS	TAXI / PHONE	*	DAILY TOTAL	EXPLANATION OF EXPENSE AND/OR PURPOSE OF TRAVEL
9/18/08	8:00am / 12:00pm	M / P 9.00 / T	B / L / D	L / R / T	T / P / *	* / * / *	9.00	UofM Oncology Social Work Meeting Pl. Inter.
		M / P / T	B / L / D	L / R / T	T / P / *	* / * / *		
		M / P / T	B / L / D	L / R / T	T / P / *	* / * / *		
		M / P / T	B / L / D	L / R / T	T / P / *	* / * / *		
		M / P / T	B / L / D	L / R / T	T / P / *	* / * / *		
		M / P / T	B / L / D	L / R / T	T / P / *	* / * / *		
		M / P / T	B / L / D	L / R / T	T / P / *	* / * / *		
		$	$	$	$	$	$ 9.00	TOTAL EXPENSES
							(0)	Deduct Advance (If Applicable)
							9.00	Amount Due Employee / (DHMH)

FOR ACCOUNTING USE ONLY

INV. DATE	DUE DATE	REC. DATE
10 / 07 / 08	10 / 18 / 08	10 / 16 / 08

PROCESSED BY TH DATE 10-16-08

EXPENSE REPORT

PLEASE CHECK APPROPRIATE BLOCK, IF APPLICABLE

NEW NAME ☐

NEW ADDRESS ☐

FIRST TIME SUBMISSION ☐

NOTE: SEE BACK FOR INSTRUCTIONS ON COMPLETION OF FORM

NAME	
SOCIAL SEC. NO.	
VENDOR NO.	
ADDRESS	
CITY STATE	ZIP

EA 422677

STATE OF MARYLAND

DEPARTMENT OF HEALTH & MENTAL HYGIENE

FROM ____/____/____ THRU ____/____/____
MO. DAY YR. MO. DAY YR.

I hereby certify that all expenditures listed hereon are true and correct and were necessary and reasonable to accomplish the objectives of the trip.

EMPLOYEE DATE

SUPERVISOR DATE

FISCAL APPROVAL DATE

PCA	INDEX	AG/OBJ	AMOUNT	FED. GRANT TRACKING #	MILEAGE	AC

PRIVATELY OWNED VEHICLES ONLY				
DATE	ODOMETER READINGS		LESS COMMUTE MILES	OFFICIAL MILES TRAVELED
	START	FINISH		
TOTAL MILEAGE				

DATE	STARTING TIME / ENDING TIME	MILEAGE / PARKING / TOLLS	BREAKFAST / LUNCH / DINNER	LODGING / REGISTRATION / TIPS	TAXI / PHONE / *	*	DAILY TOTAL	EXPLANATION OF EXPENSE AND/OR PURPOSE OF TRAVEL
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		M	B	L	T	*		
		P	L	R	P	*		
		T	D	T	*	*		
		$	$	$	$	$	$	

TOTAL EXPENSES

( )

Deduct Advance (If Applicable)

Amount Due Employee / (DHMH)

FOR ACCOUNTING USE ONLY

INV. DATE	DUE DATE	REC. DATE	PROCESSED BY	DATE

COMPTROLLER'S COPY

DHMH — 1 (Rev. 3/03)

New 2/3/2005

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 40* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 02 / 03 / 2005 PAGE: 1 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
1	BATCH AGENCY	1 – 3	3	A/N								'M40'
2	FILLER	4 – 5	2									SPACES
3	BATCH DATE	6 – 11	6	N								CURRENT DATE (YMD)
4	BATCH TYPE	12	1	N	R	0	0					'4'
5	BATCH NUMBER	13 – 15	3									'002'
6	BATCH SEQUENCE NUMBER	16 – 20	5	N	R	0	0					OUTPUT PGM INCREMENT BY '1'
7	OPERATOR ID	21 – 28	8	A/N								'INTERM00'
8	FILLER	29 – 44	18									SPACES
9	TRANSACTION CODE	45 – 47	3									'242'
10	FILLER	48 – 49	2									SPACES
11	FINANCIAL AGENCY	50 – 52	3									'M00'
12	FILLER	53 – 58	6									SPACES
13	INDEX	59 – 63	5		L	0	BLANK					
14	FILLER	64 – 72	9									SPACES
15	PCA	73 – 77	5	A/N	L	BLANK	BLANK					
16	FILLER	78 – 81	4									SPACES
17	AG/OBJ	82 – 85	4	N	R	0	BLANK					
18	FILLER	86-151	55									SPACES
19	VENDOR NUMBER	152-161	10	N	R	0	0					

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 40* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 02 / 03 / 2005 PAGE: 2 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
20	MAIL CODE	162-164	3	N	R	0	0					
21	FILLER	165	1									SPACES
22	INVOICE PREFIX	166-167	2	A	L	BLANK	BLANK					'EA'
23	INVOICE NUMBER	168-179	12	N	L	BLANK	BLANK					
24	INVOICE DATE											
	YEAR	180-183	4	N	R	0	BLANK					
	MONTH	184-185	2	N	R	0	BLANK					
	DAY	186-187	2	N	R	0	BLANK					
25	FILLER	188-195	10									SPACES
26	DOC NUMBER PREFIX	196-197	2									'VZ'
27	DOCUMENT NUMBER	198-203	6	N	R	0	BLANK					
28	DOCUMENT SUFFIX	204-206	3									'001'
29	FILLER	207-217	11									SPACES
30	DUE DATE	218-225	10									SYSTEM DATE (YYYYMMDD)
31	RECEIVED DATE											
	YEAR	226-229	4	N	R	0	BLANK					
	MONTH	230-231	2	N	R	0	BLANK					
	DAY	232-233	2	N	R	0	BLANK					
32	FILLER	234-274	41									SPACES

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS --SERVICE 40*

RECORD LENGTH: *750*

BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS

DATE: 02 / 03 / 2005

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
33	AMOUNT	275-287	13	N	R	0	0					
34	DISCOUNT	288-300	13	N								ZEROS
35	FILLER	301-369	69									SPACES
36	PENALTY AMOUNT	370-382	13	N								ZEROS
37	VENDOR NAME	383-432	50	A	L	BLANK	BLANK					
38	FILLER	433-679	247									SPACES
39	MILEAGE	680-685	6	N	R	0	0					
40	FILLER	686-750	65									SPACES

BATCH HEADER SHEET
GOODS & SERVICES

DATE: 01/21/2009

BATCH AGENCY: M42

TOTAL: JAN 21 PM $13,621.54

STD. JOB: FMIS – SERV (PGM4)

BATCH NAME: FSER – M42 A A

Evaluation/Assessment Billing Form

Primary Care Coalition Child Assessment Center

EIN:

January 15, 2008

D.

Bill Total: $ 5,280.00

Please make check payable to:

[redacted] **10th Floor**
Silver Spring, MD 20910

Name of Contact Person:
Phone Number of Contact Person: 301-628-

Received
JAN 21 2009
Sexual Assault
Reimbursement Unit

BATCH HEADER SHEET

GOODS & SERVICES

PGM 4

DATE __/__/____

BATCH AGENCY - M42

TOTAL _____

STD. JOB : FMIS - SERV

BATCH NAME : FSER - M42 __ __

DOCUMENT NUMBER - VZ 30 FMIS-SERV FSER PGM 4

REF DOC NUMBER - 32A (8 CHARACTERS)

GOODS OR SERVICES RECEIVED

Quantity & Quality O.K. .....
NOT SUBJECT to approval of State Purchasing Bureau

FFY 10 8 42

INDEX 18

INVOICE DATE 28			DUE DATE 33			SER/MER RECEIVED 34		
MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR

VENDOR NUMBER/MC	INVOICE NO./NAME (14 characters)
24 25	27

INVOICE DESCRIPTION (30 characters)

38

REASON FOR DELAY

Price and extensions checked, payment not requested previously for items included in this invoice

Department of Health and Mental Hygiene

By _____

PCA	AOBJ	AMOUNT	R
20	22	36	14

7/18/95 DAR

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 42* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 08 / 18 / 2004 PAGE: 1 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
1	BATCH AGENCY	1 – 3	3	A/N								'M42'
2	FILLER	4 – 5	2									SPACES
3	BATCH DATE	6 – 11	6	N								CURRENT DATE (YMD)
4	BATCH TYPE	12	1	N								'4'
5	BATCH NUMBER	13 – 15	3									'005'
6	BATCH SEQUENCE	16 – 20	5	N								'00000'
7	OPERATOR ID	21 – 28	8	A/N								'INTERM00'
8	FILLER	29 – 32	4									SPACES
9	FILLER	33 – 40	8									SPACES
10	FFY	41 – 42	2	N	R	0	BLANK					
11	FILLER	43 – 44	2									SPACES
12	TRANSACTION CODE	45 – 47	3									'242'
13	FILLER	48	1									SPACES
14	REVERSE	49	1	A	L	BLANK	BLANK					
15	FINANCIAL AGENCY	50 – 52	3									'M00'
16	FILLER	53 – 58	6									SPACES
17	INDEX PREFIX	59 – 61	3									'200'
18	INDEX	62 – 63	2	N	R	0	BLANK					
19	FILLER	64 – 72	9									SPACES

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 42* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 08 / 18 / 2004 PAGE: 2 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
20	PCA	73 – 77	5	A/N	L	BLANK	BLANK					
21	FILLER	78 – 81	4									SPACES
22	AOBT	82 – 85	4	N	R	0	BLANK					
23	FILLER	86-151	66									
24	VENDOR NUMBER	152-161	10	N	R	0	0					
25	MAIL CODE	162-164	3	N	R	0	0					
26	FILLER	165	1									SPACES
27	INVOICE NUMBER	166-179	14	A/N	L	BLANK	BLANK					
28	INVOICE DATE											
	YEAR	180-183	4	N	R	0	BLANK					
	MONTH	184-185	2	N	R	0	BLANK					
	DAY	186-187	2	N	R	0	BLANK					
29	FILLER	188-195	8									SPACES
30	DOCUMENT NUMBER	196-203	8	A/N	L	BLANK	BLANK					
31	DOCUMENT SUFFIX	204-206	3									'001'
32	REF DOC NUMBER	207-214	8	A/N	L	BLANK	BLANK					
33	FILLER	215-217	3									'001'
34	DUE DATE											
	YEAR	218-221	4	N	R	0	BLANK					
	MONTH	222-223	2	N	R	0	BLANK					
	DAY	224-225	2	N	R	0	BLANK					

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 42* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 08 / 18 / 2004 PAGE: 3 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
35	SER/MER RECEIVED DATE											
	YEAR	226-229	4	N	R	0	BLANK					
	MONTH	230-231	2	N	R	0	BLANK					
	DAY	232-233	2	N	R	0	BLANK					
36	FILLER	234-274	41									SPACES
37	AMOUNT	275-287	13	N	R	0	0					
38	DISCOUNT	288-300	13	N								ZEROS
39	INVO8ICE DESCRIPTION	301-330	30	A/N	L	BLANK	BLANK					
40	FILLER	331-369	39									SPACES
41	PENALTY AMOUNT	370-382	13	N								ZEROS
42	FILLER	383-748	366									
43	FFY	749-750	2	N	R	0	BLANK					

FMIS M43

OFFICE OF THE CHIEF MEDICAL EXAMINER
STATE OF MARYLAND
111 PENN STREET
BALTIMORE, MD 21201
(410) 333 – 3250

INTERFACE PAYMENT BLOCK

Document Number	VZ 002069
Ref Doc Number	
Appropriation Year	2003
Invoice Date	08/11/2003
Due Date	8/27/2003
Serv. Merc Received Date	08/19/2003
Vendor Number	
Mail Code	000
PCA	C 1 0 1 G
Agency Object	0 2 9 9
Total	25.00
Invoice Number	08/11/2003
Invoice Description	ME / FI

Signature Thomas Pobrisir

Date: August 19, 2003

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 43* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 08 / 18 / 2004 PAGE: 1 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
1	BATCH AGENCY	1 – 3	3	A/N								'M43'
2	FILLER	4 – 5	2									SPACES
3	BATCH DATE	6 – 11	6	N								CURRENT DATE (YMD)
4	BATCH TYPE	12	1	N								'4'
5	BATCH NUMBER	13 – 15	3									'003'
6	BATCH SEQUENCE	16 – 20	5	N								'00000'
7	OPERATOR ID	21 – 28	8	A/N								'INTERM00'
8	FILLER	29 – 32	4									SPACES
9	FILLER	33 – 40	8									SPACES
10	APPROP YEAR	41 – 42	2	N	R	0	BLANK					
11	FILLER	43 – 44	2									SPACES
12	TRANSACTION CODE	45 – 47	3									'242'
13	FILLER	48 – 49	2									SPACES
14	FINANCIAL AGENCY	50 – 52	3									'M00'
15	FILLER	53 – 72	20									SPACES
16	PCA	73 – 77	5	A/N	L	BLANK	BLANK					
17	FILLER	78 – 81	4									SPACES
18	AGENCY OBJECT	82 – 85	4	N	R	0	BLANK					
19	FILLER	86-151	66									SPACES

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 43* RECORD LENGTH: *750* BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS DATE: 08 / 18 / 2004 PAGE: 2 OF 3

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
20	VENDOR	152-161	10	N	R	0	0					
21	MAIL CODE	162-164	3	N	R	0	0					
22	FILLER	165	1									
23	INVOICE NUMBER	166-179	14	A/N	L	BLANK	BLANK					
24	INVOICE DATE											
	YEAR	180-183	4	N	R	0		YES				
	MONTH	184-185	2	N	R	0		YES				
	DAY	186-187	2	N	R	0		YES				
25	FILLER	188-195	8									SPACES
26	DOCUMENT NUMBER	196-203	8	A/N	L	BLANK	BLANK					
27	DOCUMENT SUFFIX	204-206	3									'001'
28	REF DOC NUMBER	207-214	8	A/N	L	BLANK	BLANK					
29	FILLER	215-217	3									'001'
30	DUE DATE											
	YEAR	218-221	4	N	R	0	BLANK					
	MONTH	222-223	2	N	R	0	BLANK					
	DAY	224-225	2	N	R	0	BLANK					

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: *FABFMIS – SERVICE 43*

RECORD LENGTH: *750*

BLOCK SIZE: *23250*

COMPLETED BY: ADRIANE LEWIS

DATE: 08 / 18 / 2004

Tape #	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Const.	Range Low	Check High	SPECIAL Instruction
31	SER/MER RECEIVED DATE											
	YEAR	226-229	4	N	R	0		YES				
	MONTH	230-231	2	N	R	0		YES				
	DAY	232-233	2	N	R	0		YES				
32	FILLER	234-274	41									SPACES
33	AMOUNT	275-287	13	N	R	0	0					
34	DISCOUNT	288-300	13	N								ZEROS
35	INVO8ICE DESCRIPTION	301-330	30	A/N	L	BLANK	BLANK					
36	FILLER	331-750	420									SPACES

GES

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH SERVICES
DIVISION OF LONG TERM CARE
ADULT EVALUATION AND REVIEW SERVICES

(See Reverse for Code Sheet)

(1) DATE OF REFERRAL __ __ / __ __ / __ __ __ __ (MONTH DATE YEAR) **(2) TYPE OF SERVICE** ____ (1-I & R 2-EVALUATION 3-CONSULTATION) **(3) COUNTY** ____ / ____

(4) REASON FOR REFERRAL (SELECT AT MOST (2) ___ ___ (*See Code Sheet*) #1 ___ ___ #2 **(5) REFERRAL SOURCE** ____/____ (*See Code Sheet*)

(6) MA 1-CERTIFIED 2-APPLICATION IN PROCESS 4-INELIGIBLE 9-UNKNOWN

(7) NAME _____ (LAST FIRST M.I.) **(8) DATE OF BIRTH** __ __/__ __/__ __ __ __

(9) HOME ZIP CODE _____ **(10) LOCATION DURING EVALUATION** ____ / ____ (*See Code Sheet*)

(CIRCLE ONE)

(11) RACE
1-WHITE
2-BLACK/AFRICAN AMERICAN
3-AMERICAN INDIAN
4-ASIAN
5-HISPANIC/LATINO
6-OTHER
9-UNKNOWN

(12) SEX
1-MALE
2-FEMALE
9-UNKNOWN

(13) MARITAL STATUS
1-NOW MARRIED
2-WIDOWED
3- DIVORCED
4-SEPARATED
5-NEVER MARRIED
9-UNKNOWN

(Circle all that apply)

(14) MEDICAL COVERAGE
1-MA
2-QMB
3-SLMB
4-MEDICARE
9-UNKNOWN

(15) OTHER HEALTH COVERAGE
1-NO
2-YES
9-UNKNOWN

AERS STAFF/CONSULTANTS	#CONFERENCES	#ON SITE VISITS	#TELEPHONE CALLS (OPTIONAL)
NURSE	(16) _____	(17) _____	(18) _____
SOCIAL WORKER	(19) _____	(20) _____	(21) _____
PHYSICIAN	(22) _____	(23) _____	(24) _____
PSYCHIATRIST	(25) _____	(26) _____	(27) _____
PSYCHOLOGIST	(28) _____	(29) _____	(30) _____

RECOMMENDED ACTION (*USE CODES A ,B AND C*)
(31) _____ ___ ___
(33) _____ ___ ___
(35) _____ ___ ___
(37) _____ ___ ___
(39) _____ ___ ___

CURRENT STATUS (*USE THE FOLLOWING CODES*)
(32) ____ ____
(34) ____ ____
(36) ____ ____
(38) ____ ____
(40) ____ ____

78-SERVICE PROVIDED
79-REFERRED
92-AWAITING SERVICE
93-INELIGIBLE
94-FAMILY DECLINED
95-PATIENT DECLINED
98-NOT AVAILABLE

(41) DISPOSITION (CIRCLE ONE)
1-REMAIN IN COMMUNITY
2-REMAIN IN INSTITUTION
3-ADMIT TO INSTITUTION
4-DISCHARGE TO COMMUNITY
5-MOVED OUT OF AREA
6-EXPIRED

(42) CLOSING RESIDENCE _____ ___ ___ (*SELECT FROM CODES A OR B*)

(43) CLOSING DATE __ __/__ __/__ __ __ __ (Month Day Year)

(44) TYPE OF INTERVENTION 1-STEPS____ 2- PASRR ____ 3- OTHER ____

(45) LOCAL USE _____

DHMH 3846 7/00revised

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

GES

RECORD TITLE: Adult Evaluation & Review Services (Service Type 3) RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/03 PAGE 1 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	Range Check High	Special Instructions
1.	Type of Service Source Doc. #2	1	1	N	R	N/A	N/A	Yes	N/A	1	3	
2.	Name Source Doc. #7	2-29	28	A/N	L	Spaces	N/A	Yes	N/A	N/A	N/A	If keying name, key last name, first name, mid int
2A.	Last Name	2-16	15	A	L	Space	N/A	Yes	N/A			
2B.	First Name	17-28	12	A	L	Space	N/A	Yes	N/A			
2C.	Middle Int	29	1	A	L	Space	Space	No	N/A			
3.	Date of Birth Source Doc#8	30-37	8	N	R	Zero	Zero	No	N/A			Service Type 3 only
3A.	Birth-Month	30-31	2	N	R	Zero	Zero	No	N/A	01	12	
3B.	Birth-Day	32-33	2	N	R	Zero	Zero	No	N/A	01	31	
3C.	Birth-Year	34-37	4	N	R	Zero	Zero	No	N/A	0000	9999	
4.	County Source Doc#3	38-39	2	N	R	Zero	N/A	Yes	N/A	01	24,30	

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: Adult Evaluation & Review Services RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/2003 PAGE 2 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	Range Check High	Special Instructions
5.	Race Source Doc#11	40	1	N	R	N/A	Space	No	N/A	1	5,9	9=Unknown
6.	Sex Source Doc#12	41	1	N	R	N/A	Space	No	N/A	1	2,9	9=Unknown
7.	Marital Status Source Doc#13	42	1	N	R	N/A	Space	No	N/A	1	5,9	9=Unknown
8.	Date Of Referral Source Doc#1	43-50	8	N	R	Zero	N/A	Yes	N/A			
8A.	Referral –Month	43-44	2	N	R	Zero	N/A	Yes	N/A	01	12	
8B.	Referral-Day	45-46	2	N	R	Zero	N/A	Yes	N/A	01	31	
8C.	Referral-Year	47-50	4	N	R	Zero	N/A	Yes	N/A	0000	9999	
9.	Reason for Referral Source Doc#4	51-54	4	N	R	N/A	N/A	Yes	N/A	00	99	99=Unknown
9A.	Reason for Referral	51-52	2	N	R	N/A	N/A	Yes	N/A	00	99	99=Unknown
9B.	Reason for Referral	53-54	2	N	R	N/A	N/A	No	N/A	00	99	99=Unknown
10.	Referral Source Source Doc#5	55-56	2	N	R	Zero	N/A	Yes	N/A	01	99	
11.	Recommended Action A Source Doc#31	57-58	2	N	R	Zero	Space	No	N/A	01	99	Special Instructions 00-49

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: Adult Evaluation & Review Services RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/2003 PAGE 3 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	High	Special Instructions
12.	Recommended Action B Source Doc#33	59-60	2	N	R	Zero	Space	No	N/A	01	99	Special Instructions 00-49
13.	Recommended Action C Source Doc#35	61-62	2	N	R	Zero	Space	No	N/A	01	99	Special Instructions 00-49
14.	Recommended Action D Source Doc#37	63-64	2	N	R	Zero	Space	No	N/A	01	99	Special Instructions 00-49
15.	Recommended Action E Source Doc#39	65-66	2	N	R	Zero	Space	No	N/A	01	99	Special Instructions 00-49
16.	Current Status A Source Doc#32	67-68	2	N	R	Zero	Space	No	N/A			Valid #'s 78,79,92,93,94,95,98
17.	Current Status B Source Doc#34	69-70	2	N	R	Zero	Space	No	N/A			Valid #'s 78,79,92,93,94,95,98
18.	Current Status C Source Doc#36	71-72	2	N	R	Zero	Space	No	N/A			Valid #'s 78,79,92,93,94,95,98
19.	Current Status D Source Doc#38	73-74	2	N	R	Zero	Space	No	N/A			Valid #'s 78,79,92,93,94,95,98
20.	Current Status E Source Doc#40	75-76	2	N	R	Zero	Space	No	N/A			Valid #'s 78,79,92,93,94,95,98

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: Adult Evaluation & Review Services RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/2003 PAGE 4 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	High	Special Instructions
21.	Filler	77-84	8	A	R	Space	N/A	Yes	Space			
22.	Closing-Date Source Doc#43	85-92	8	N	R	N/A	Zero	Zero	No	N/A		
22A.	Closing-Month	85-86	2	N	R	Zero	Space	No	N/A	01	12	
22B.	Closing-Day	87-88	2	N	R	Zero	Space	No	N/A	01	31	
22C.	Closing-Year	89-92	4	N	R	Zero	Space	No	N/A	0000	9999	
23.	Disposition Source Doc#41	93	1	N	R	N/A	Space	No	N/A	1	6	
24.	MA Source Doc#6	94	1	N	R	N/A	N/A	Yes	N/A	1	4,9	9=Unknown
25.	Med Coverage Source Doc#14	95	1	N	R	N/A	N/A	Yes	N/A	1	4,9	9=Unknown
26.	Other Health Source Doc#15	96	1	N	R	N/A	Space	No	N/A	1	2,9	9=Unknown
27.	Filler	97-110	14	A	R	Space	Space	No	N/A			

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: Adult Evaluation & Review Services RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/2003 PAGE 5 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	Range Check High	Special Instructions
28.	Type of Intervention Source Doc#44	111	1	N	R	N/A	Space	No	N/A	1	3	
29.	Zip Code Source Doc#9	112-116	5	N	R	Space	Space	No	N/A	All Zero	All Nines	
30.	Evaluation Location Source Doc#10	117-118	2	N	R	Zero	Space	No	N/A	01	10,99	99=Unknown
31.	Closing Residence Source Doc#42	119-120	2	N	R	Zero	Space	No	N/A	01	17	
32.	Nurse	121-128	8	N								
32A.	Conference Source Doc#16	121-122	2	N	R	Zero	Space	No	N/A	01	99	
32B.	On-Site Source Doc#17	123-124	2	N	R	Zero	Space	No	N/A	01	99	
32C.	Telephone Source Doc#18	125-126	2	N	R	Zero	Space	No	N/A	01	99	
32D.	Filler	127-128	2	A	R	Space	Space		Space			
33.	Social Worker	129-136	8	N								

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: Adult Evaluation & Review Services RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/2003 PAGE 6 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	Range Check High	Special Instructions
33A.	Conference Source Doc#19	129-130	2	N	R	Zero	Space	No	N/A	01	99	
33B.	On-Site Source Doc#20	131-132	2	N	R	Zero	Space	No	N/A	01	99	
33C.	Telephone Source Doc#21	133-134	2	N	R	Zero	Space	No	N/A	01	99	
33D.	Filler	135-136	2	A	R	Space	Space		Space			
34.	Physician	137-144	8	N								
34A.	Conference Source Doc#22	137-138	2	N	R	Zero	Space	No	N/A	01	99	
34B.	On –Site Source Doc#23	139-140	2	N	R	Zero	Space	No	N/A	01	99	
34C.	Telephone Source Doc#24	141-142	2	N	R	Space	Space	No	N/A	01	99	
34D.	Filler	143-144	2	A	R	Space	Space		Space			

DHMH DATA ENTRY JOB SPECIFICATIONS
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: Adult Evaluation & Review Services RECORD LENGTH: 175 BLOCK SIZE: 175

COMPLETED BY: Felice Morgan DATE: 03/04/2003 PAGE 7 OF 7

Seq. No.	Field Name	Output Position	Size	A/N	Justify R/L	Fill Chart	No Data	Mandt	Const	Range Check Low	Range Check High	Special Instructions
35.	Psychiatrist	145-152	8	N								
35A.	Conference Source Doc#25	145-146	2	N	R	Zero	Space	No	N/A	01	99	
35B.	On-Site Source Doc#26	147-148	2	N	R	Zero	Space	No	N/A	01	99	
35C.	Telephone Source Doc#27	149-150	2	A	R	Space	N/A	Yes	N/A	01	99	
35D.	Filler	151-152	2	A	R	Space	Space		Space			
36.	Psychologist	153-158	8	N								
36A.	Conference Source Doc#28	153-154	2	N	R	Zero	Space	No	N/A	01	99	
36B.	On-Site Source Doc#29	155-156	2	N	R	Zero	Space	No	N/A	01	99	
36C.	Telephone Source Doc#30	157-158	2	A	R	Space	N/A	Yes	N/A	01	99	
37.	Filler	159-175	17	N		Space	Space		Space			

KIDNEY CMS 1500

9/1/05

DHMH DATA ENTRY
WORK REQUEST

KIDNEY DISEASE PROGRAM

Document Title/Name: PHYSICIANS MEDICARE

Data Entry Standard Job: KDPHCFA

Data Entry Batch Name: M1 _____

Date Delivered to Data Entry: ___/___/___

Number of Documents: _____

Fiscal Year: _____

Date Batched: ___/___/___

Prepared by: _____

OUTPUT TO FILE:

ENTER	VERIFY
1. _____ ___/___/___	1. _____ ___/___/___
2. _____ ___/___/___	2. _____ ___/___/___

PLEASE DO NOT STAPLE IN THIS AREA

KIDNEY DISEASE AFTER MEDICARE

KIDNEY DISEASE PROGRAM
201 W PRESTON STREET
ROOM SS3
BALTIMORE,MD 21201

CHG-127642(TES)/PYMT-112809/mc

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 216363360A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 19[redacted] 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: BALTIMORE STATE: MD

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 21286 TELEPHONE (Include Area Code): [redacted]

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? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

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.

RECEIVED AUG 18 2006 KIDNEY DISEASE PROGRAM

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE 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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING 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? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
599.0
1. ___ 2. ___ 3. ___ 4. ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
06 14 2005		81	01	88108		1	116.00	1				
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 14-I15502777

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 116.00

29. AMOUNT PAID $ 101.69

30. BALANCE DUE 14.31

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 07/15/2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
U OF MD PROFESSIONAL BLDG

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
UNIV OF MD PATHOLOGY ASSOC PA
P.O. BOX 64592 410-328-3408
BALTIMORE,MD 21264-4592
PIN# GRP#

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500 APPROVED OMB-0720-0001 (CHAMPUS)

DHMH DATA ENTRY
WORK REQUEST

SAMPLE

KIDNEY DISEASE PROGRAM

Document Title/Name: MISCELLANEOUS VISION

Data Entry Standard Job: **KDPHCFA**

Data Entry Batch Name: **K 8** _____

Date Delivered to Data Entry: ____/____/____

Number of Documents : _____

Fiscal Year: _____

Date Batched: ____/____/____

Prepared by: _____

OUTPUT TO FILE:

ENTER	VERIFY
1. _____ ___/___/___	1. _____ ___/___/___
2. _____ ___/___/___	2. _____ ___/___/___

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

KIDNEY DISEASE PROGRAM
201 WEST PRESTON STREET
SS3
BALTIMORE MD 21201

97
KDP

CARRIER

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM 09 DD 26 YY 19 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) DRIVE

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street) DRIVE

CITY BALTIMORE STATE MD

8. PATIENT STATUS Single [X] Married Other Employed Full-Time Student Part-Time Student

CITY BALTIMORE STATE MD

ZIP CODE 21225-1306 TELEPHONE (Include Area Code) (410)

ZIP CODE 21225-1306 TELEPHONE (Include Area Code) (410) [redacted]

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 [X] NO

a. INSURED'S DATE OF BIRTH MM 09 DD 26 YY SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME RETIRED

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME KIDNEY DISEASE PROGRAM

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE 107693

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06 19 2008

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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM 02 DD 01 YY 2007 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [redacted] MD

17a. 1GF23848

17b. NPI [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 585.6 3.

2. 4.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 16 08 05 16 08	65		90935		1	168 03	1	N N	NPI	[redacted]
2	05 23 08 05 23 08	65		90935		1	168 03	1	N N	NPI	[redacted]
3	05 28 08 05 28 08	65		90935		1	168 03	1	N N	NPI	[redacted]
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER [redacted] SSN EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE $ 504 09

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 504 09

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.)

[redacted] MD

SIGNED 06/19/2008 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DAVITA HARBOR PARK
111 CHERRY HILL ROAD
BALTIMORE MD 21225

a. [redacted] b.

33. BILLING PROVIDER INFO & PH. # (410) 5365400

MID-ATLANTIC NEPHROLOGY ASSOC
PO BOX 64694
BALTIMORE MD 21264-4694

a. [redacted] b.

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

REVISED 5/31/2007

RECORD TITLE: CMS –KIDNEY UNEDITED FORM

RECORD LENGTH: 669

BLOCK SIZE:

COMPLETED BY: SANDRA JONES

DATE: 9/10/2004

PAGE: 1 OF 6

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
	BATCH NUM	1 – 4	4	A/N	R			Y			
	FISCAL YEAR	5-8	4	N	R			Y			
	REC SEQ NUM	9-11	3	N	R			Y			
10D, 1A	SOC SEC NUM	12-20	9								
* 33A	NPI	21-30	10								NEW PROVIDER ID
25	FED TAX ID NUM	31-45	15	N	L						Only 9 numbers for the FTI
	FLLLER	46-50	5								
25	**PROV/STORE /SUFFIX NUM**	**51-56**	**6**		L						All numbers that exceed 9 in box 25 –FTI
	SERV-TYPE	57	1								
	EOB FLAG	58	1								
	MED REC FLAG	59	1								
	FILLER	60-63	4								
21-1	DIAGNOIS CD - 1	64-68	5		R						
21-2	DIAGNOIS CD - 2	69-73	5		R						
21-3	DIAGNOIS CD - 3	74-78	5		R						
21-4	DIAGNOIS CD - 4	79-83	5		R						
24-1-A	DATE SER FROM #1	84-91	8								
24-1-A	DATE SER TO # 1	92-99	8								
24-1-B	PLACE SER #1	100-101	2								

NEW NPI FIELD BOX 33A JUST ADD FIELD at End OF DATA ENTRY SCREEN.

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UNIV UNEDITED FORM RECORD LENGTH: 669 BLOCK SIZE:

COMPLETED BY: SANDRA JONES DATE: 9/10/2004 PAGE: 2 OF 6

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24- 1-D	CPT/HCP # 1	102-106	5								
24-1-D	SER 1 MOD1	107-108	2								
24-1-D	SER-1 MOD2	109-110	2								
24-1-D	SER-1 MOD3	111-112	2								
24-1-D	SER-1 MOD4	113-114	2								
24-1-F	SER-1 CHARGES	115-121	7								
	UNIT -1	122-126	5								
24-2-A	DATE SER FRM # 2	127-134	8								
24-2-A	DATE SER TO # 2	135-142	8								
24-2-B	PLACE SER # 2	143-144	2								
24-2-D	CPT/HCP # 2	145-149	5								
24-2-D	SER 2 MOD1	150-151	2								
24-2-D	SER-2 MOD2	152-153	2								
24-2-D	SER-2 MOD3	154-155	2								
24-2-D	SER-2 MOD4	156-157	2								
24-2-F	SER-2 CHARGES	158-164	7								
	UNIT-2	165-169	5								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UNIV UNEDITED FORM RECORD LENGTH: 669 BLOCK SIZE:

COMPLETED BY: SANDRA JONES DATE: 9/10/2004 PAGE: 3 OF 6

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24-3-A	DATE SER FRM # 3	170-177	8								
24-3-A	DATE SER TO # 3	178-185	8								
24-3-B	PLACE SER # 3	186-187	2								
24-3-D	CPT/HCP # 3	188-192	5								
24-3-D	SER 3 MOD1	193-194	2								
24-3-D	SER-3 MOD2	195-196	2								
24-3-D	SER-3 MOD3	197-198	2								
24-3-D	SER-3 MOD4	199-200	2								
24-3-F	SER-3 TOTAL	201-207	7								
	UNIT -3	208-212	5								
24-4-A	DATE SER FRM # 4	213-220	8								
24-4-A	DATE SER TO # 4	221-228	8								
24-4-B	PLACE SER # 4	229-230	2								
24-4-D	CPT/HCP # 4	231-235	5								
24-4-D	**SER 4 MOD1**	**236-237**	**2**								
24-4D	SER-4 MOD2	238-239	2								
24-4D	SER-4 MOD3	240-241	2								
24-4D	SER-4 MOD4	242-243	2								
24-4F	SER-4 TOTAL	244-250	7								
	UNIT -4	251-255	5								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UNIV UNEDITED FORM RECORD LENGTH: 669 BLOCK SIZE:

COMPLETED BY: SANDRA JONES DATE: 9/10/2004 PAGE: 4 OF 6

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24-5-A	DATE SER FRM # 5	256-263	8								
24-5-A	DATE SER TO # 5	264-271	8								
24-5-B	PLACE SER # 5	272-273	2								
24-5-D	CPT/HCP # 5	274-278	5								
24-5-D	SER 5 MOD1	279-280	2								
24-5-D	SER-5 MOD2	281-282	2								
24-5-D	SER-5 MOD3	283-284	2								
24-5-D	SER-5 MOD4	285-286	2								
24-5-F	SER-5 TOTAL	287-293	7								
	UNIT-5	294-298	5								
24-6-A	DATE SER FRM # 6	299-306	8								
24-6-A	DATE SER TO # 6	307-314	8								
24-6-B	PLACE SER # 6	315-316	2								
24-6-D	CPT/HCP # 6	317-321	5								
24-6-D	SER 6 MOD1	322-323	2								
24-6-D	SER-6 MOD2	324-325	2								
24-6-D	SER-6 MOD3	326-327	2								
24-6--D	SER-6 MOD4	328-329	2								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UNIV UNEDITED FORM RECORD LENGTH: 669 BLOCK SIZE:

COMPLETED BY: SANDRA JONES DATE: 9/10/2004 PAGE: 5 OF 6

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
24-6-F	SER-6 TOTAL	330-336	7								
	UNIT-6	337-341	5								
28	TOTAL CHARGE	342-349	8								
29	AMUNT PAID	350-357	8								
30	BALANCE DUE	358-365	8								
2	LAST NAME	366-385	20								
2	FIRST NAME	386-400	15								
2	MIDDLE INIT	401	1								
	PAT ADDRR	402-426	25								
	PAT CITY	427-441	15								
	PAT STATE	442-443	2								
	PAT ZIP-1	444-448	5								
	PAT ZIP-2	449-452	4								
	PAT BIRTDATE	453-460	8								
	PAT SEX	461	1								
	PROVDR NAME	462-491	30								

DHMH DATA ENTRY JOB SPECIFICATION
OUTPUT RECORD FORMAT AND EDITING PROCEDURE

RECORD TITLE: UNIV UNEDITED FORM RECORD LENGTH: 669 BLOCK SIZE:

COMPLETED BY: SANDRA JONES DATE: 9/10/2004 PAGE: 6 OF 6

Source Doc Num	Field Name	Output Position	Size	A/N	Justify R/L	Fill Char	No Data	Mandt.	Range Low	Check High	Special Instructions
	PRVDR ADDR	492-511	20								
	PRVDR CITY	512-526	15								
	PRVDR STATE	527-528	2								
	PRVDR ZIP-1	529-533	5								
	PRVDR ZIP-2	534-537	4								
	DATE RECEIVED	538-545	8								MMDDCCYY DATE STAMP
	PHYSICAN NAME	546-565	20								
	GROUP NUMBER	566-580	15								
	INSUR NAME	581-605	25								
	BEN PLAN	601	1								
	OTHER GROUP NUM	607-621	15								
	OTHER DOB	622-629	8								
	OTHER PLAN NAME	630-654	25								
	REFER PHYSICAN	655-669	15								