ATTACHMENT A – PART 3

DATA ENTRY DOCUMENT SAMPLES

1. **Burial (Transit Permit) – Sample**
2. **Death Certificate – Sample**
3. **FMIS M40 – Batch Header**
4. **FMIS M40 – Sample**
5. **FMIS M42 (Goods & Services) – Batch Header**
6. **FMIS M42 (Goods & Services) – Sample**
7. **FMIS M43 (Payment Block) – Sample**
8. **GES (Adult Evaluation and Review Services) – Sample**
9. **Cancer CMS 1500 – Batch Header**
10. **CMS 1500 – Blank Sample (Used for Cancer and Kidney Programs)**
11. **Cancer UB04 (CMS 1450) NDC – Batch Header**
12. **Cancer UB04 (CMS 1450) – Blank Sample**
13. **Kidney CMS 1500 – Batch Header**
14. **Kidney CMS 1500 – Sample**
15. **Kidney UB04 (CMS 1450) – Batch Header**
16. **Kidney UB04 (CMS 1450) – Sample**
17. **MAP 3808 – Batch Header**
18. **MAP 3808 – Sample**
19. **STEPS/PASRR – Batch Header**
20. **STEPS/PASRR – Sample**
21. **STEPS/PASRR – Sample (with "Override" Stamp)**
22. **Medical Assistance UB04 (Inpatient) – Sample**
23. **Medical Assistance UB04 (Outpatient) – Batch Header**
24. **Medical Assistance UB04 (Outpatient) - Sample**

State of Maryland / Department of Health and Mental Hygiene

2- For State Registrar

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

Reg. No. 00000

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	
5. Social Security Number 123-45-6789	6. Sex X 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 X 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 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X 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 X 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 X 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 [signature]		22. Name and Address of Facility 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 J64 Grave 301

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

Signature [signature] *Sexton or other person in charge* Date signed Dec. 6, 2008

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)*	X **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 [signature]		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			
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

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 [X] 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 [X] Yes 2 [ ] No
10e. Street and Number: 123 Main Street
10f. Zip Code: 12345
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] 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 [X] 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 [X] 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: Jenny Doe M01163
22. Name and Address of Facility: Doe Funeral Home 456 Main Street Baltimore, MD 12345

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 of 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 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

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

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)* Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death: 1 [X] 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)*
29a. Certifier *(Check only one)* 1 [X] **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

Baltimore, Maryland 21215-0036

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 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

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

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

SAMPLE
NOT FOR USE
NOT A LEGAL DOCUMENT

DHMH 17 Rev 1/2001

ORIGINAL

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 ☐

NOTE: SEE BACK FOR INSTRUCTIONS ON COMPLETION OF FORM

(1) NAME	
(2) SOCIAL SEC. NO.	
VENDOR NO.	
ADDRESS	
CITY STATE	ZIP

(3) 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

(4) PCA	(5) INDEX	(6) AG/OBJ	(7) AMOUNT	FED. GRANT	PACKING	MILEAGE (8)	AG

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
		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

(9) (10)

DHMH — 1 (Rev. 3/03)

COMPTROLLER'S COPY

M40

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

FMIS M42

DOCUMENT NUMBER - VZ (1)

REF DOC NUMBER - (8 CHARACTERS) (12)

GOODS OR SERVICES RECEIVED 843697 (1)

Quantity & Quality O.K.....

NOT SUBJECT to approval of State Purchasing Bureau

FFY	INDEX

INVOICE DATE (2)			DUE DATE (3)			SER/MER RECEIVED (4)		
Month	Day	Year	Month	Day	Year	Month	Day	Year
07	22	2008				10	22	2008

VENDOR NUMBER/MC (5) (6)	INVOICE NO./NAME (7) (14 Characters)
152 3557235/000	Sharon, Einstein

INVOICE DESCRIPTION (30 Characters) (8)

SORU

REASON FOR DELAY

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

Department of Health and Mental Hygiene

By LD 10/22/08

PCA (9)	AOBJ (10)	AMOUNT (11)	R
X660G	0817	$631.00	
	0870		

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 Shawn Robinson **Date:** August 19, 2003

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 3-CONSULTATION
2-EVALUATION

(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	(12) SEX	(13) MARITAL STATUS	(14) MEDICAL COVERAGE *(Circle all that apply)*	(15) OTHER HEALTH COVERAGE
1-WHITE	1-MALE	1-NOW MARRIED	1-MA	1-NO
2-BLACK/AFRICAN AMERICAN	2-FEMALE	2-WIDOWED	2-QMB	2-YES
3-AMERICAN INDIAN	9-UNKNOWN	3- DIVORCED	3-SLMB	9-UNKNOWN
4-ASIAN		4-SEPARATED	4-MEDICARE	
5-HISPANIC/LATINO		5-NEVER MARRIED	9-UNKNOWN	
6-OTHER		9-UNKNOWN		
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) ____ ____ 78-SERVICE PROVIDED
(34) ____ ____ 79-REFERRED
(36) ____ ____ 92-AWAITING SERVICE
(38) ____ ____ 93-INELIGIBLE
(40) ____ ____ 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
WORK REQUEST

BREAST AND CERVICAL CANCER

Document Title/Name: CMS 1500 FORMS

Data Entry Standard Job: CANHIC09

Data Entry Batch Name: P057

Date Delivered to Data Entry: 09/ 25 /2009

Number of Documents: 02

Fiscal Year: 2010

Date Batched: 09/ 25 /2009

Prepared by: GPA

OUTPUT TO FILE:

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

DATE RECEIVED BY DATA ENTRY

CMS 1500

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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.

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 MM DD YY FROM TO MM DD YY

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

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Fold

DHMH DATA ENTRY
WORK REQUEST

BREAST AND CERVICAL CANCER

Document Title/Name: UB04 FORMS (with NDC)

Data Entry Standard Job: CANUBDES

Data Entry Batch Name: N043

Date Delivered to Data Entry: 09 / 25 / 2009

Number of Documents: 01

Fiscal Year: 2010

Date Batched: 09 / 25 / 2009

Prepared by: GPA

OUTPUT TO FILE:

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

DATE RECEIVED BY DATA ENTRY

– CANCER UB-04

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL

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 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 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

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 a b c | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID a b c

58 INSURED'S NAME a b c | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. a b c

63 TREATMENT AUTHORIZATION CODES a b c | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME a b c

66 DX | 67 | 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 | 81 CC a b c d

DHMH DATA ENTRY
WORK REQUEST

KIDNEY DISEASE PROGRAM

Document Title/Name: MISCELLANEOUS (LABS)
NON MEDICARE

Data Entry Standard Job: KDPHCFA

Data Entry Batch Name: K7 _____

Date Delivered to Data Entry: ____/____/____

Number of Documents : _____

Fiscal Year: _____

Date Batched: _____/_____/_____

Prepared by: _____

OUTPUT TO FILE:

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

MARYLAND KIDNEY PROGRAM
201 W PRESTON ST
RM 314A
BALTIMORE, MD 21201

COPY KDS

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 107693

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM [redacted] DD 26 YY 1967 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

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

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

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

CITY: BALTIMORE STATE: MD

8. PATIENT STATUS: Single [ ] Married [ ] Other [X] 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): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

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

c. OTHER ACCIDENT? [ ] YES [X] NO

10d. RESERVED FOR LOCAL USE: 107693

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S DATE OF BIRTH MM [redacted] DD 26 YY 1967 SEX M [X] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME: MARYLAND KIDNEY PROGRAM

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 09 03 2009

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 PROVIDER OR OTHER SOURCE: LOWDER, GERARD M., MD

17a. 1G B69608

17b. NPI 1447258876

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. 27549
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

RECEIVED SEP 7 2009 KIDNEY DISEASE PROGRAM

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 08 27 08	08 27 08	81		82310		1	43 20	1		NPI	1730149709
2 08 27 08	08 27 08	81		84100		1	39 78	1		NPI	1730149709
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 650127483 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 0103409-60

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

28. TOTAL CHARGE $ 82.98

29. AMOUNT PAID $

30. BALANCE DUE $ 82.98

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.)

GARY S PEARL MD, PHD
09 03 2009
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
DVA LABORATORY SERVICES
3951 SW 30TH AVENUE
FORT LAUDERDALE, FL 3331268
a. 1730149709 b.

33. BILLING PROVIDER INFO & PH. # (800) 688-4522
DVA LABORATORY SERVICES
PO BOX 281226
ATLANTA, GA 303841226
a. 1730149709 b. 7482310400

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

DHMH DATA ENTRY
WORK REQUEST

KIDNEY DISEASE PROGRAM

Document Title/Name: OUTPATIENT HOSPITAL MEDICARE

Data Entry Standard Job: KDPUB

Data Entry Batch Name: M5 _____

Date Delivered to Data Entry: ____/____/____

Number of Documents : _____

Fiscal Year: _____

Date Batched: _____/_____/_____

Prepared by: _____

OUTPUT TO FILE:

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

MERCY MEDICAL CENTER
301 ST PAUL PLACE
BALTIMORE MD 21202
4109511700

MERCY MEDICAL CENTER
P.O. BOX 64733
BALTIMORE MD21264

3a PAT. CNTL # JAB06007
b. MED. REC. # M836801
4. TYPE OF BILL 0131
5 FED. TAX NO. [redacted]
6 STATEMENT COVERS PERIOD FROM 061109 THROUGH 061109
7

8 PATIENT NAME a
b [redacted]
9 PATIENT ADDRESS a [redacted]
b MIDDLE RIVER c MD d [redacted] 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
[redacted]1952	M	061109	11	3	1		01													

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

38 KIDNEY DISEASE PROGRAM
201 W. PRESTON ST. RM SS3

BALTIMORE, MD 21201

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	0	81	0		
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
0270	MED/SURG SUPPLIES		061109	2	34772		
0300	LABORATORY	88305	061109	1	12613		
0300	LABORATORY	88312	061109	1	3153		
0360	OR SERVICE	43239	061109	1	60000		
0370	ANESTHESIA	99144	061109	1	5100		
0710	REC RM/SAME DAY SURGERY		061109	1	55100		
0001	PAGE 1 OF 1		CREATION DATE 073009		TOTALS	170738	0

RECEIVED
AUG 6 2009
KIDNEY DISEASE PROGRAM

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE OUTPATIENT SUR		Y	Y	125500		1144282583
KIDNEY DISEASE PROGRAM		Y	Y		30994	57 OTHER PRV ID 210008

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
[redacted]	01	[redacted]		
[redacted]	01	[redacted]		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
NO PRECERT REQ NO PRECERT REQ		MARYLAND GNEERAL HOSPITAL

66 DX: 53540 | 2113 | 4556 | 25001 | 4019 | 4439 | V4581 | V4364 | V4965 | 68
9V427

69 ADMIT DX 5368 | 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
4516	061109	4524	061109			

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

76 ATTENDING NPI 1932139078 QUAL 1GD57073
LAST HUBER FIRST SCOTT
77 OPERATING NPI 1932139078 QUAL 1GD57073
LAST HUBER FIRST SCOTT
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS J3880367

M514
ID

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997—Created by latric FOL 02/23/07

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

MARYLAND MEDICAL ASSISTANCE PROGRAM
BATCH CONTROL SHEET
DATA ENTRY CLAIMS

SAMPLE
MAP HEADER

BATCH TYPE (CIRCLE ONE)

A B C D E F

(G) H K L M

3808's

Force / Override Codes:
Authorized by:

INPUT MEDIA [1] 1 = DATA ENTRY 5 = O.C.R.

JAN 2? P.M.

JAN 23 P.M.

BATCH DATE 0 9 0 2 2

BATCH NUMBER 2 5 1

NUMBER OF CLAIMS 0 0 2

BEGINNING CLAIM # 0 0 1

ENDING CLAIM # 0 0 2

ATTACHMENTS:

OPERATIVE REPORTS [ ]

OTHER [ ]

RETURN TO: _____ SECTION [ ]

==========

CLAIM SEQUENCE NUMBERS DELETED FROM BATCH # _____, #_____, #_____, #_____

==========

BATCH ROUTE REVIEW:

BATCH PREPARED BY:	W.S.	1-22-09 DATE
MICROFILMED BY:	73	1/22/09 DATE
MICROFILM AND DOCUMENT COUNT REVIEW BY:		DATE
BATCH CONTROL FILE ENTERED BY:	MS	DATE
BATCH CONTROL FILE ENTRY REVIEWED BY:	MS	DATE

==========

KEY ENTRY / O.C.R. OPERATOR _____, _____ _____ DATE

KEY VERIFIER / O.C.R. VERIFIER _____, _____ _____ DATE COMPLETED

109022.251.001

MAP

DOCUMENT NUMBER
3001968

Maryland Medical Assistance Program
ADMISSION AND LENGTH OF STAY CERTIFICATION

1) Houston Northwest Medical Center [redacted]
HOSPITAL (Print or Type) — Medical Records Number

2) [redacted]
HOSPITAL PROVIDER NO.

3) Patient: [redacted] [redacted] [redacted]
LAST — NAME (Print or Type) — FIRST

4) 04-[redacted]-640
PATIENT MEDICAID NO.

5) Date of Birth: 11-27-19[redacted] 6) Category: ☐ F ☑ S 7) Sex: ☐ M ☑ F

8) Type of Admission (Select Appropriate No. 1-3): 1

9) Actual admission date: 7-13-07 Actual discharge date: 8-10-07

10) Admission: 07-13-07 (Month Day Year)

11) REQUEST APPROVAL/CERTIFICATION FOR (Check one):
☐ 1. elective admission ☐ 2. emergency admission ☑ 3. retroactive admission

12) Discharge: 08-10-07 (Month Day Year)

13) PRINCIPAL DIAGNOSIS: 551.8

14) PRINCIPAL (One ICD-9CM Code): 551-8

15) SECONDARY DIAGNOSIS: 276.2
(COMORBIDITY) 345.10, 282.62
Admitting DX 787.03

16) SECONDARY (One ICD-9CM Code): 276-2

17) SECONDARY (One ICD-9CM Code): 345-10

18) SECONDARY (One ICD-9CM Code): 282-62

19) PROCEDURES AND DATES:
1. 4591, 7-18-07 4. 5296, 7-18-07
2. 5459, 7-15-07 5. 9672, 7-14-07
3. 539, 7-15-07 6. 9604, 7-14-07

20) 1st ICD-9CM Procedure Code: 45-91

21) 2nd ICD-9CM Procedure Code: 54-59

22) 3rd ICD-9CM Procedure Code: 05-39

23) HOSPITAL COURSE: NA, please see attached medical records

24) DISCHARGE STATUS (Same as Codes on Invoice UB-92): 14

ATTACH ADDITIONAL SHEET(S) IF NECESSARY

25) DRG: 569

REQUESTOR'S NAME AND TITLE [redacted] Medicaid AIR Rep. DATE 12-15-08 TELEPHONE 214-387-[redacted]

FOR AGENT USE ONLY

Returned without UCA Action for:

Preadmission Review (check one):
☐ not obtained ☐ approved

Approved for (circle): 1. 2. 3.

Denied for (circle): 1. 2. 3.

MAC? ☐ yes ☐ no

DCP? ☐ yes ☐ no

SSO: emergency ☐ obtained ☐ waived ☐

Acute days approved: 028

Acute days denied: 000

Days not covered: 000

Adm. days approved: 000

Adm. days denied: 000

Reason for denial:

Authorized Signature [redacted] R.N. Date 12/31/08

DHMH 2908 (REV. 7/96)

MARYLAND MEDICAL ASSISTANCE PROGRAM
BATCH CONTROL SHEET
DATA ENTRY CLAIMS

SAMPLE
STEPS Header

BATCH TYPE (CIRCLE ONE)

A B C D E F

G H K L M

STEPS

Force / Override Codes:
Authorized by:

INPUT MEDIA [1] 1 = DATA ENTRY 5 = O.C.R.

BATCH DATE 0 8 3 1 2

BATCH NUMBER 9 9 6 1

NUMBER OF CLAIMS 0 0 1

BEGINNING CLAIM # 0 0 1

ENDING CLAIM # 0 0 1

ATTACHMENTS:

OPERATIVE REPORTS [ ]

OTHER [ ]

RETURN TO: _____ SECTION [ ]

==========

CLAIM SEQUENCE NUMBERS DELETED FROM BATCH # _____ , #_____ , #_____ , #_____

==========

BATCH ROUTE REVIEW:

BATCH PREPARED BY: W.L.S. 11-7-08 DATE

MICROFILMED BY: SS 11-7-08 DATE

MICROFILM AND DOCUMENT COUNT REVIEW BY: _____ DATE

BATCH CONTROL FILE ENTERED BY: _____ DATE

BATCH CONTROL FILE ENTRY REVIEWED BY: _____ DATE

==========

KEY ENTRY / O.C.R. OPERATOR _____, _____ DATE

KEY VERIFIER / O.C.R. VERIFIER _____, _____ DATE COMPLETED

1R0719 0C1 000

Maryland Department of Health and Mental Hygiene
Adult Evaluation and Review Services (AERS)
Comprehensive Evaluation and Recommended Plan of Care
STEPS/PASRR Claim and Statistical Form
Directions: Please enter the correct information and complete all items.

Reimbursement Code 0 1

Provider Identification:

1. Provider Agency Name KentCounty Health Department

Provider Agency ID#

Client Identification and Information:

3. Client's ID# 1 4
4. Client's Name- Last First E t h e l MI
5. Client's Address- Street R o a d
City W o r t o n State M D Zip Code 2 1 6 7 8
6. Referral Source- 1 0
7. Reason for Referral- (select at most 2) 0 3
8. Location during Evaluation- 0 7
9. Date of Birth- Mo-Day-Yr 0 6 - 0 1 - 1 9
10. Sex- Male (1) Female (2) 2
11. Race- 2
12. Martial Status- 1
13. Permanent Living Arrangement- 0 2
14. If nursing home resident, date admitted- Mo-Day-Yr
15. Client's Health Ins. Coverage- (select at most 3) 2
16. Client's Primary Source of Health Care- 1

Program Information:

Date of Referral- Mo-Day-Yr 0 3 - 0 4 - 0 3
18. Evaluation delayed because client not medically stable, or because of approved or client-related extenuating circumstances? Yes (1) No (2) 2
19. If yes, date client stabilized or the evaluation was allowed to proceed- Mo-Day-Yr
(Give explanation on back of this form.)
20. Date of Comprehensive Evaluation- Mo-Day-Yr 0 3 - 0 5 - 0 3
21. Client hospitalized? Yes (1) No (2) 2
22. Date Multidisciplinary Assessment completed Mo-Day-Yr 0 3 - 1 9 - 0 3
23. Date of MHA/DDA determination? (PASARR only) Mo-Day-Yr
24. Prior evaluation(s)? 2
25. If prior evaluation(s), date of most recent evaluation Mo-Day-Yr 1 0 - 0 9 - 0 3

Multi-Disciplinary Assessment:

26. PRO certified for nursing facility care? Yes (1) No (2) 2
27. If yes, date- Mo-Day-Yr
28. Client meets COMAR 10.09.30.01 B(1 0) requirements? (See coding sheet for paragraph) Yes (1) No (2) Potential (3) 3
29. Is client currently active Medicaid? Yes (1) No (2) 2
30. If yes, MA#
31. If no, is client STEPS financially eligible? Yes (1) No (2) N/A (3) 1

Client's Summary Information:

32. Total ADL Score- 1 1

Eating (item 1): 2 Transferring (item 2): 2 Dressing (item 3): 1 Bathing (item 4): 0 Toileting (item 6): 2

33. Medical Conditions Present (select at most 5) 1 0 0 1 1 1 0 3
34 Orientation? Yes (1) No (2) Partial (3) 3

Recommendations:

Plan of Care (select at most 8) 4 0 2 9 3 2 3 6
36. STEPS Case Management? Yes (1) No (2) 2

- PLEASE TURN AND SIGN THE BACK OF THIS FORM -

DOCUMENT CONTROL NO. - DO NOT WRITE HERE

DO NOT WRITE ->

DHMH 4288 7/00

Adult Evaluation and Review Services (AERS)
Comprehensive Evaluation and Recommended Plan of Care
STEPS/PASRR Claim and Statistical Form
Directions: Please enter the correct information and complete all items.

Reimbursement Code 11

Provider Identification:

Provider Agency Name: Cecil County Health Department

Provider Agency ID#: 7340737000

Cl .dentification and Information:

3. Client's ID#: 07-437-06-0099
4. Client's Name- Last: Robertson First: Emma M:
5. Client's Address- Street: 1106 Bainbridge Rd City: Port Deposit State: MD Zip Code: 21904
6. Referral Source- 14
7. Reason for Referral- (select at most 2) 11
8. Location during Evaluation- 01
9. Date of Birth- Mo-Day-Yr 01-29-1929
10. Sex- Male (1) Female (2) 2
11. Race- 2
12. Martial Status- 9
13. Permanent Living Arrangement- 01
14. If nursing home resident, date admitted- Mo-Day-Yr
15. Client's Health Ins. Coverage- (select at most 3) 124
16. Client's Primary Source of Health Care- 1

STEP/PASARR
Adjustment Overide-3
Date 5/19/09
Authorization [illegible]

Program Information:

17. Date of Referral- Mo-Day-Yr 10-21-08
18. Evaluation delayed because client not medically stable, or because of approved or client-related extenuating circumstances? Yes (1) No (2) 2
19. If yes, date client stabilized or the evaluation was allowed to proceed- Mo-Day-Yr
(Give explanation on back of this form.)
20. Date of Comprehensive Evaluation- Mo-Day-Yr 10-21-08
21. Client hospitalized? Yes (1) No (2) 2
22. Date Multidisciplinary Assessment completed, Mo-Day-Yr 10-21-08
23. Date of MHA/DDA determination? (PASARR only) Mo-Day-Yr
24. Prior evaluation(s)? 2
25. If prior evaluation(s), date of most recent evaluation, Mo-Day-Yr 11-29-07

Multi-Disciplinary Assessment:

26. PRO certified for nursing facility care? Yes (1) No (2) 2
27. If yes, date- Mo-Day-Yr
28. Client meets COMAR 10.09.30.01 B(10) requirements? (See coding sheet for paragraph) Yes (1) No (2) Potential (3) 3
29. Is client currently active Medicaid? Yes (1) No (2) 1
30. If yes, MA# 41 40028 6 00
31. If no, is client STEPS financially eligible? Yes (1) No (2) N/A (3)

Client's Summary Information:

32. Total ADL Score- 13
Eating (item 1): 2 Transferring (item 2): 1 Dressing (item 3): 1 Bathing (item 4): 1 Toileting (item 6): 1
33. Medical Conditions Present (select at most 5) 01 11 03 09 14
34. Orientation? Yes (1) No (2) Partial (3) 1

Recommendations:

35. Plan of Care- (select at most 8) 27 32 47 48 49
36. S S Case Management? Yes (1) No (2) 2

DO NOT WRITE HERE

DOCUMENT CONTROL NO. - DO NOT WRITE HERE

-PLEASE TURN AND SIGN THE BACK OF THIS FORM-

109128.968.001

Medical Assistance In-Patient

1 WVU HOSPITALS
DICAL CENTER DRIVE
RGANTOWN WV 26507
3045984032 3042935734

2

3a PAT. CNTL # [redacted]
MED. REC. # [redacted] 111
6 FED. TAX NO.
[redacted] 11/06/2003 11/14/2003

M CUMBERLAND MD 21502

10 BIRTHDATE	11 SEX	14 DATE	15 HR	16 DHR	17 STAT																
12/02/19[redacted]	F	11/06/2003	12	2	4	07	01	38	C5												

11	11/06/2003	A1	12/02/1975	A2	11/06/2003			71	11/06/2003	11/06/2003					

28
MARYLAND MEDICAL ASSISTAN
P O BOX 1935
BALTIMORE MD 21203

a	01	600.00	80	8.00	
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 CHRG	49
0120	ROOM-BOARD/SEMI	600.00		6	3600.00		
0122	OB/2BED	600.00		2	1200.00		
0250	PHARMACY			74	1098.77		
0272	MED SURG SUPPLY STERILE			2	120.00		
0300	LABORATORY			19	591.00		
0301	LAB CHEMISTRY			14	662.00		
0302	LAB IMMUNOLOGY			1	49.00		
0305	LAB HEMATOLOGY			8	476.00		
0307	LAB UROLOGY			1	40.00		
0310	PATHOLOGY LAB			1	171.00		
0720	LABOR ROOM			28	1400.00		
722	DELIVERY ROOM			1	183.00		
920	OTHER DX SVC			2	84.00		
001	PAGE 1 OF 1		CREATION DATE	12/11/2007	[redacted] 9674.77		

MARYLAND MEDICAID | Y | Y | 9674.77 | 57 OTHER PAYER | 005075000

M 18 MMA

UNEMPLOYED

64421 Y | 65451 Y | 64891 Y | 49390 Y | 56400 Y | 27800 Y | V1582 Y | V270 Y | 59

9 | 10

64403 | 0373 | 1G C74196

7359 | 11/13/2003 | 6996 | 11/13/2003 | 7534 | 11/06/2003

NPI [redacted] 1G C74196
LAST [redacted] FIRST J
NPI [redacted] 1G C74196
LAST [redacted] FIRST J
NPI
LAST FIRST
NPI
LAST FIRST

79 REMARKS

MARYLAND MEDICAL ASSISTANCE PROGRAM
BATCH CONTROL SHEET
DATA ENTRY CLAIMS

OUTPATIENT BATCH HEADER

BATCH TYPE (CIRCLE ONE)

A B C D E F

G H K L M

DMP SEP 16 2009

Force / Override Codes:
Authorized by:

INPUT MEDIA: 1 = DATA ENTRY, 5 = O.C.R. — 1

BATCH DATE: 09 13 8

BATCH NUMBER: 9 2 6

NUMBER OF CLAIMS: 0 2 0

BEGINNING CLAIM #: 0 0 1

ENDING CLAIM #: 0 2 0

ATTACHMENTS:

OPERATIVE REPORTS ☐

OTHER ☒

RETURN TO: _____ SECTION ☐

==========

CLAIM SEQUENCE NUMBERS DELETED FROM BATCH # _____, #_____, #_____, #_____

==========

BATCH ROUTE REVIEW:

BATCH PREPARED BY:	MAS	8/31/09 DATE
MICROFILMED BY:	DS	9-13-09 DATE
MICROFILM AND DOCUMENT COUNT REVIEW BY:	TL	9-16-09 DATE
BATCH CONTROL FILE ENTERED BY:	MS	DATE
BATCH CONTROL FILE ENTRY REVIEWED BY:		9/16 DATE

==========

KEY ENTRY / O.C.R. OPERATOR _____, _____ _____ DATE

KEY VERIFIER / O.C.R. VERIFIER _____, _____ _____ DATE COMPLETED

WASH COUNTY HOSP ASSN
251 EAST ANTIETAM STREET
HAGERSTOWN MD 21740-5724
2403139500 2403139530

109238.926

3a PAT. CNTL # H30560404171
b. MED REC # 1555500
TYPE OF BILL 0131
5 FED. TAX NO. 0000 [redacted]
6 STATEMENT COVERS PERIOD FROM 060309 THROUGH 060309
7

8 PATIENT NAME a 47703028900
b [redacted]
9 PATIENT ADDRESS a [redacted]
b HAGERSTOWN c MD d 21740 e

10 BIRTHDATE [redacted]2004
11 SEX M
12 ADMISSION DATE 060309
13 HR 13
14 TYPE 3
15 SRC 1
16 DHR
17 STAT 01
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE MD
30

31 OCCURRENCE CODE 11 DATE 032705
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 [redacted]
HAGERSTOWN MD 21740

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0440	SPEECH PATHOL	92507GN	060309	1	8100		
	Medical Assistance UB04 - Outpatient						
0001	PAGE 1 OF 1		CREATION DATE 082409		TOTALS	8100	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A ONE NET PPO, LLC	52148NOCD	Y	Y	6480		1942281266	
B MARYLAND MEDICAID FED	999990174	Y	Y		1620		000395600

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
[redacted]	19	[redacted]	HAGERSTOWN TEA	AM0083
	18	[redacted]	NOT EMPLOYED	

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME [redacted]

66 DX V573 31539 9
67
68
69 ADMIT DX V573
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 1487836086 QUAL
LAST SAJANKILA FIRST VANDANA
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
MARYLAND MEDICAID FED
PO BOX 1935
BALTIMORE MD 21203

81CC a B3282N00000X
b
c
d

B-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04L NUBC TFP24384485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SST ELECTRONIC