JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

CATHY BETTS
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

TRISTA SPEER
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

April 12, 2024

MEMORANDUM

MEMO NO.
QI-2408 [Replaces QI-2334]
FFS 24-05 [Replaces FFS 23-20]

TO: QUEST Integration (QI) Health Plans
All Medicaid Dental Ground Transportation Providers

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: DENTAL GROUND TRANSPORTATION

This memo replaces QI-2334 and FFS 23-20 previously issued on August 30, 2023.

The purpose of this memorandum is to describe a new ground transportation process for Medicaid beneficiaries receiving dental services through the Medicaid fee for service program and include additional detail on suggested billing codes and expected fees. This memo has an effective date of April 15, 2024.

Ground transportation to or from non-dental services are excluded from this memo.

Beneficiary Details

Ground transportation to and from dental appointments for Medicaid covered benefit(s) will be provided via taxi service upon authorization. Dental ground transportation services are only authorized when a Medicaid beneficiary is unable to make their own transportation arrangements. If, for example, the beneficiary is able to use public transportation or arrange

their own ride, then transportation service will not be authorized. The dental trip can be one-way or round-trip, between the home of a Medicaid beneficiary and to the dental office of the scheduled appointment. Beneficiary side trips – for example, to a pharmacy or to go shopping – are not allowed.

Medicaid beneficiaries with scheduled appointments seeking transportation to dental appointments should call Community Case Management Corp (CCMC) at 808-792-1055. Requests for transportation must be made with CCMC at least two (2) weeks in advance of the scheduled appointment. In case of an urgent appointment, the request for transportation can be less than two (2) weeks. CCMC will confirm the dental appointment with the dental office and contact the transportation providers to reserve a dental trip.

Provider Details

CCMC will provide a Prior Authorization (PA) code to the transportation provider when reserving a dental trip. The transportation providers shall contact Medicaid beneficiaries no less than two (2) business days prior to the reserved dental trip date to confirm their transportation arrangements. If Medicaid beneficiaries inform the transportation provider that their dental appointments have changed, the transportation providers shall notify CCMC immediately. CCMC will also change the trip reservation if Medicaid beneficiaries inform them on the new dental appointment date. No payments shall be made when the beneficiary is a "no show." Providers should note that beneficiary side trips – for example, to a pharmacy or to go shopping – are not allowed and will not be reimbursed if a claim is submitted.

The dental ground transportation providers shall use the following information when submitting dental trip claims to Medicaid fiscal agent (Conduent is the current fiscal agent). The transportation providers may submit electronic or paper claims with a CMS 1500 form. The CMS 1500 paper form must include an original signature, be printed double sided and in color. Samples of the CMS 1500 form filled for different ground transportation services are included below as attachments. Note that these samples assume a 5-mile one-way/10-mile roundtrip, and that providers must use actual mileage when submitting the CMS 1500 form. Transportation providers may contact Conduent for additional details on the optional electronic claims submission process.

- A0100 is used as base code (pick-up fee) and S0215 is used as mileage (1 unit = 1 mile) billing.

Code	Description	Payment rate
A0100	NON-EMERGENCY TRANSPORTATION; TAXI	$5.25
S0215	NON-EMERGENCY TRANSPORTATION; MILEAGE, PER MILE	$4.48

A0120	STRETCHER VAN (For gurney)	$107 (one way)
A0130	WHEELCHAIR LIFT FEE	$50 (one way)

- ICD 10 CM (Diagnostic code) = Y92.81 definition TRANSPORT VEHICLE AS PLACE
- Place of Service = 99 – definition OTHER PLACE OF SERVICE
- PA code provided by CCMC
- Modifiers:

Modifier for A0100, A0120, A0130	Description – Residence on the Island to the Dental Office on the same Island
RP	RESIDENCE TO DENTAL OFFICE
PR	DENTAL OFFICE TO RESIDENCE

Modifier for A0100, A0120, A0130	Description – From Neighbor Islands Residence to the Neighbor Island Airport
RI	RESIDENCE TO AIRPORT
IR	AIRPORT TO RESIDENCE

Modifier for A0100, A0120, A0130	Description – From ʻOahu Airport to ʻOahu Dental Office
IP	AIRPORT TO DENTAL OFFICE
PI	DENTAL OFFICE TO AIRPORT

Modifier for S0215	Description
KZ	TOTAL MILEAGE

Dental ground transportation providers may call Conduent's Provider Relations Hotline at 808-952-5570 or 1-800-235-4378 on neighbor islands or email hi.providerrelations@conduent.com, for any questions related to claim submission. A copy of the blank CMS 1500 form, can be obtained here: https://www.cigna.com/static/www-cigna-com/docs/form-cms1500.pdf

Notwithstanding guidance contained in this memo, transportation providers should remember

that each claim submission for payment is a legal document and the sole responsibility of the provider.

Health Plan Details

Health plans should refer Medicaid beneficiaries to CCMC if they need ground transportation to their dental appointments. CCMC requires two (2) weeks advance notification for dental trip requests.

If you have any questions, please contact HCSBInquiries@dhs.hawaii.gov.

Attachments:

CMS 1500 form – Taxi Service
CMS 1500 form – Taxi Service with Wheelchair Lift
CMS 1500 form – Taxi Service with Stretcher Van
1500 Claims Crosswalk for Dental Taxi Transportation Services

Medicaid Billing Required Fields for the CMS 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA 1 — PICA

1. MEDICARE (Medicare#)	MEDICAID [X] (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): **1112223334**

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

3. PATIENT'S BIRTH DATE MM DD YY: **01/01/1975** SEX M [X] F [ ]

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: **Hawaii Medicaid– Dental**

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. **Y92.81** B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

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 **01/01/2023**	**01/01/2023**	**99**		**A0100**	**RP**	**1**	**5.25**	**1**		NPI	**1234567891**
2 **01/01/2023**	**01/01/2023**	**99**		**A0100**	**PR**	**1**	**5.25**	**1**		NPI	**1234567891**
3 **01/01/2023**	**01/01/2023**	**99**		**S0215**	**KZ**	**1**	**44.80**	**10**		NPI	**1234567891**
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: **99-1234567** [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ **55.30**

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

14 **Sign Here and Date**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

15 **Yellow Cab 1100 Bishop St.**
Honolulu, HI 96817
808-555-1234

a. **1234567891** b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Medicaid Billing Required Fields for the CMS 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA 1 — PICA

1. MEDICARE (Medicare#)	MEDICAID [X] (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1112223334

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

3. PATIENT'S BIRTH DATE MM DD YY: 01/01/1975 SEX M [X] F [ ]

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Hawaii Medicaid– Dental

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Y92.81 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

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 01/01/2023	01/01/2023	99		A0100	RP	1	5.25	1		NPI	1234567891
2 01/01/2023	01/01/2023	99		A0100	PR	1	5.25	1		NPI	1234567891
3 01/01/2023	01/01/2023	99		S0215	KZ	1	44.80	10		NPI	1234567891
4 01/01/2023	01/01/2023	99		A0130	RP		50.00	1		NPI	1234567891
5 01/01/2023	01/01/2023	99		A0130	PR		50.00	1		NPI	1234567891
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-1234567 [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 155.30

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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.)

Sign Here and Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Yellow Cab 1100 Bishop St.
Honolulu, HI 96817
808-555-1234

a. 1234567891 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Medicaid Billing Required Fields for the CMS 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA 1 — PICA

1. MEDICARE (Medicare#)	MEDICAID [X] (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1112223334

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

3. PATIENT'S BIRTH DATE MM DD YY: 01/01/1975 SEX M [X] F [ ]

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Hawaii Medicaid– Dental

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Y92.81 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

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 01/01/2023	01/01/2023	99		A0100	RP	1	5.25	1		NPI	1234567891
2 01/01/2023	01/01/2023	99		A0100	PR	1	5.25	1		NPI	1234567891
3 01/01/2023	01/01/2023	99		S0215	KZ	1	44.80	10		NPI	1234567891
4 01/01/2023	01/01/2023	99		A0120	RP		107.00	1		NPI	1234567891
5 01/01/2023	01/01/2023	99		A0120	PR		107.00	1		NPI	1234567891
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-1234567 [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 269.30

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

Sign Here and Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Yellow Cab 1100 Bishop St.
Honolulu, HI 96817
808-555-1234

a. 1234567891 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500 Claims Crosswalk for Dental Taxi Transportation Services

Point 1 - Box 1- Insurance Name	Insurance Name - Check “Medicaid”
Point 2 – Box 1a	Please indicate the Medicaid Recipient 10-digit Identification number.
Point 3 – Box 2	Please provide the name of the Medicaid Recipient
Point 4 – Box 3	Patient’s Date of Birth and Sex
Point 5 – Box 6	Always mark “SELF” for patient relationship to insured
Point 6 – Box 10 a, b, c	Mark “N” for all three
Point 7 – Box 9 d	Indicate “Hawaii Medicaid- Dental for the Insurance plan name
Point 8 – Box 21	Indicate ICD-10 diagnosis Y92.81, with an ICD-10 indicator of “0” in the field
Point 9 – Box 23	Must indicate the Prior Authorization #
Point 10 – Box 24 A, B, D, E, F, G, J	24A Indicate the date of transportation service. 24B indicate Place of Service 99. 24D indicate 5 digit HCPC “A0100” (base code for pick0up fee) with or w/o “SO215 KZ” for milage. 24E is the diagnosis pointer. Indicate “1” to indicate the ICD-10 code in box 21A field. 24F Charges for each line. Charges should equal the rate x the units. **A0100 RP is 5.25 x1 = $5.25, A0100 PR is 5.25 x 1=$5.25 24G indicates “1” for based code A0100 with mod (one way/ round trip) and indicate total mileage code S0215 KZ. For example: $4.48 per milage cost x 10 units of milage = Total Charges for S0215 KZ (mileage) is $44.80 24J indicates the provider NPI Additional codes and modifiers should be added for other transportation type if appropriate. Refer to sample forms.
Point 11 – Box 25	Indicate Tax ID #
Point 12 – Box 27	Accept Assignment is “Yes”
Point 13 – Box 28	Total Charges from column 24F
Point 14 – Box 31	Live inked signature and date
Point 15 – Box 33	Billing Information