STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE
AND
HEALTH SERVICES

HEALTH SERVICES PROGRAM

SPECIAL HOSPITAL MANUAL

DO NOT CIRCULATE

FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material the provider will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapter will be issued as the need presents itself.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

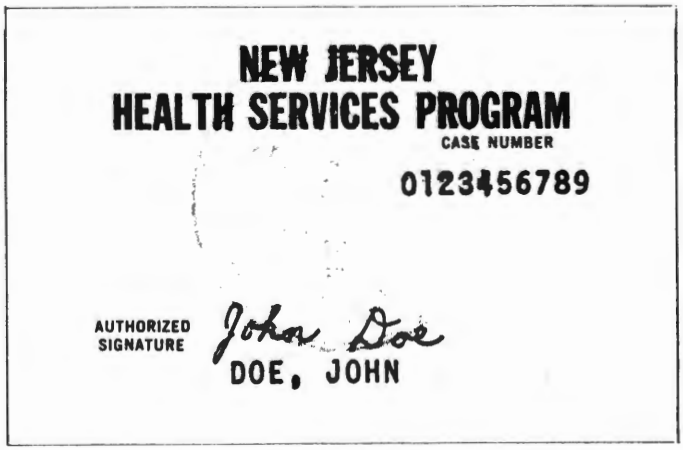
The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation Form on all Requests for Authorization and claim forms.

GENERAL INFORMATION

_____ COUNTY WELFARE BOARD

VALIDATION FOR HEALTH SERVICES PROGRAM

Valid Only for Month of Jan. 1970

BUCKINGHAM 11 30 051234

01 John
02 Mary
20 Emma Jones
21 Lila
22 James
23 Belinda Smith
24 Olive
25 Sarah
26 Adolph

101.3 Temporary Identification and Validation Form (Exhibit III)

In certain circumstances, a temporary identification and validation form will be issued. This form will identify the case as eligible for health services for 30 days from the date of issue.

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TEMPORARY IDENTIFICATION AND VALIDATION OF ELIGIBILITY

CURRENT CASE NO.			EFFECTIVE DATE		
CTY	PROG	NUMBER	MO	DAY	YR
01	2,3	4,5,6,7,8,9	0,1	0,1	70

Line No.	Person Code	LAST NAME	FIRST NAME	M.I.	BIRTH DATE MO	DAY	YR
1	01	D.O.E	J.O.H.N.	D.	02	05	19
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

NOTICE TO PROVIDER OF HEALTH SERVICES:

This form, when signed by or on behalf of the person whose name is first listed, identifies the person(s) listed as eligible for payment for authorized health services under the New Jersey Health Services Program.

This form also serves as a temporary validation of eligibility for a period not exceeding 30 days from the effective date entered above.

The information appearing on this form should be used in completing the claim form to be submitted to the appropriate Contractor for the State of New Jersey.

NOTICE TO CLIENT:

This form must be signed on the line below marked "Signature" by or on behalf of the person whose name is first listed. This form must be presented to the provider of health services to prove eligibility for payment. DO NOT USE this form after receiving your plastic identification card and your monthly "Validation for Health Services".

Signature _____

Prepared By Date

Approved By Date

MAP-16 (11/69)
TEMP

102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

(a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;

(b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;

(c) Outpatient hospital services;

(d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;

(e) Laboratory and X-ray services;

(f) Skilled nursing home services;

(g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;

(h) Other practitioners' services, limited by State law to podiatrists and optometrists;

(i) Dental services, including dentures;

(j) Home health care services;

(k) Pharmaceutical services [prescribed drugs (legend and non-legend)]

(l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;

(m) Rehabilitation services; and

(n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transporation.

103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;

Certified Independent Clinical laboratories;

Dentists;

Hearing Aid Dealers;

Home Health Agencies;

Hospitals;

Skilled Nursing Homes;

Opticians;

Optometrists;

Approved Clinics (Independent Outpatient Health Facilities);

Certified Orthotists;

Pharmacies;

Physicians;

Podiatrists;

Certified Prosthetists;

Providers of Medical Transporation.

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the local medical assistance unit may assist in obtaining an appropriate practitioner.

105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to The Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

2. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside the State of New Jersey.

3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is <u>not</u> made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;

2. Any services or items furnished in connection with elective cosmetic surgery;

   Note: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the physician to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;

4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;

5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;

6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy, any other private or governmental health benefit system, or through any similar third party liability;

7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage;

8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;

9. Any services or items furnished for which the Provider does not normally charge;

10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;

11. Services furnished by an immediate relative or member of the covered person's household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which ocvered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

   The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

2. Workmen's Compensation

   No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

   When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

CHAPTER II

COVERAGE OF SPECIAL HOSPITAL SERVICES

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COVERAGE OF SPECIAL HOSPITAL SERVICES

200. DEFINITIONS

200.1 Approved Special Hospital

Because of the wide variances of Special Hospitals it is necessary to identify these by three (3) classifications. Each hospital will be required to be listed under one of the classifications and must meet the standards as set forth to qualify as a provider.

All special hospitals would be divided into the following three classifications based on standards for participation and reimbursement:

Classification A. (Acute or Short Term): May be reimbursed on the basis of reasonable costs if all following criteria are met:

1. Licensed as a Special Hospital by the State of New Jersey.
2. Accredited by the Joint Commission ~~of Accredited~~ ON ACCREDITATION of Hospitals.
3. Adoption of Approval by Individual Diagnosis (AID) Program.
4. Have departmental cost findings and RCCAC cost allocation capabilities to provide facts for rate determination.
5. Signed agreement to participate in the Health Services Program.

Classification B. (Rehabilitation or Long Term): May be reimbursed on the basis of reasonable costs if all following criteria are met:

1. Licensed as a Special Hospital by the State of New Jersey.
2. Accredited by the Joint Commission ~~of Accredited~~ ON ACCREDITATION of Hospitals.
3. Adoption of Utilization Review as follows:
   21 day recertification by attending physician
   Active Utilization Review Committee
   Prior authorization through Local Medical Assistance Unit for each additional 30 day period after the first 21 days, with authorizations to list expiration dates. Treatment plan required to support authorization request.

   Note: See Section 203.4 for procedure on obtaining prior authorization.
4. Have departmental cost findings and RCCAC cost allocation capabilities to provide facts for rate determination.
5. Signed agreement to participate in the Health Services Program.

Classification C. (Special Hospital not qualifying to meet the standards of Classification A or B). Special Hospital in this classification will be reimbursed on negotiated rate as determined by certified cost information furnished by the hospital. However, said per diem rate is limited by the ceiling established for the skilled nursing home.

1. Licensed as a Special Hospital by the State of New Jersey.
2. Adoption of the AID Program (as in A) or Utilization Review (as in B) whichever is applicable to service provided.
3. Signed agreement to participate in the Health Services Program.

200.2 Special Hospitals Outside the State

Special Hospitals outside the State of New Jersey must be licensed by the appropriate agency under the laws of the respective state and must meet the requirements of Number 2 and 3 under Classification A or B or Number 2 under Classification C, whichever is applicable.

200.3 Inpatient Hospital Services

The term "Inpatient Hospital Services" means those items and services ordinarily furnished by an approved special hospital for the care and treatment of inpatients which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases.

200.4 Inpatient

"Inpatient" means a person registered as such for hospital bed occupancy in an Approved Hospital.

200.5 Semi-Private Accommodations

"Semi-Private Room" means a hospital room containing two, three or four beds and classified as semi-private by the hospital.

INPATIENT HOSPITAL SERVICES
(If normally available in Special Hospital)

201. COVERED INPATIENT HOSPITAL SERVICES

Subject to the general limitations and exclusions and those hereinafter specified, hospital care and services shall include:

201.1 Bed and Board in Semi-Private Accommodations

Including special medical dietary services.

Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations (See Chapter III, "Explanation of Accommodations").

201.2 General Nursing Services

201.3 Other Medical Services

Services by voluntary or paid hospital employees, by an intern or other physician in training in the hospital, or by a practitioner or other person(s) with whom the hospital contracts to provide eligible services.

201.4 Facilities and Equipment

Use of operating room,recovery room, delivery room, emergency room, intensive care unit, or other special room, including their respective facilities and equipment.

201.5 Supplies

Therapeutic solutions, all types of anesthetic agents, oxygen, serums, dressings, surgical supplies, bandages, plaster casts and splints.

201.6 Drugs and Biologicals

All drugs, medicines and medications customarily supplied by the hospital or which, at the time prescribed, are in commercial production and commercially available to the hospital and have been listed or accepted for listing by any one of the following publications: "United States Pharmacopoeia," "Homeopathic Pharmacopoeia of the United States," "National Formulary," "New and Non-Official Drugs" and "Accepted Dental Therapeutics."

201.7 Blood

Whole blood, and/or derivatives, and necessary processing and administration thereof, when not otherwise available (See Section 208).

201.8 Rehabilitation Services

Rehabilitation medicine services including therapy by physical medicine, occupational therapy and other restorative services.

201.9 Diagnostic X-ray

Diagnostic use of X-ray or radioactive isotopes.

201.10 Radiation Therapy

Including teleradiotherapy, radioactive isotope therapy (non-sealed sources) administered internally, radium and radioisotopes (sealed sources).

201.11 Laboratory Examinations and Diagnostic Studies

Shall include diagnostic laboratory examinations and clinical tests, such as electrocardiograms, electroencephalograms, echoencephalograms, and other similar clinical tests.

201.12 Prosthetic Devices

Required to complete a surgical procedure including pacemakers. (Excluding artificial limbs, custom made braces, dentures and artificial eyes).

201.13 Maternity

Maternity services are those relating to any admission for: childbirth, care related to pregnancy or childbirth; or any disease, injury or condition incident to pregnancy or childbirth. Such maternity services shall also include any concurrent services in the hospital to the newborn during the initial eligible joint hospital stay of the mother and newborn.

201.14 Ambulance

Hospital-based emergency ambulance service which results in inpatient admission.

201.15 Services in Connection with Dental Conditions

Inpatient hospital services for dental conditions provided that:

a. The services are necessary because of accidental injury, or
b. The patient is admitted for an eligible non-dental condition and dental services are rendered (a) as part of the prescribed treatment for such condition, or (b) to alleviate the patient's discomfort during the period of hospitalization for such condition.

201.16 Renal Dialysis and Renal Transplant

a. Reimbursement for renal dialysis and renal transplant shall be made only to Centers approved by the New Jersey Department of Health. For additional information on the Division of Medical Assistance and Health Services policy on Renal Dialysis contact:

Medical Director
Division of Medical Assistance and Health Services
Post Office Box 2486
Trenton, New Jersey 08625

b. In renal transplant, reimbursement for services rendered to or item dispensed or furnished a donor will be considered a charge on behalf of the eligible recipient.

201.17 Other Hospital Facilities

All other hospital facilities and equipment ordinarily provided for care and treatment of inpatients and not specifically excluded.

202. NON-COVERED INPATIENT SPECIAL HOSPITAL SERVICES

Benefits are not payable for any services rendered or items dispensed or furnished in connection with:

202.1 Elective Cosmetic Surgery

202.2 Mental Disorders

Any illnesses which according to generally accepted professional standards are not amenable to favorable modification, except that benefits for mental health services shall be available to determine that such disorders or illness are not amenable to favorable modification (e.g., senility).

Note: (A Specialty Hospital for the treatment of mental illness and tuberculosis is not eligible to receive payment for care of patients under 65 years of age).

202.3 Private Duty Nursing Services

202.4 Items Not Related to Patient Care

Services and supplies not directly related to the care of the patient, such as guest meals and accommodations, television, telephone, and similar items and services. Personal items may be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items.

202.5 Patient Transportation

(Except as stated under Covered Services Section 201.14.)

202.6 Research or Teaching Studies

Admission or extension of hospital stay solely for research or teaching studies.

202.7 Services Rendered Prior to and After Period of Eligibility

a. Inpatient hospital services rendered prior to date of application.

b. Where a Health Services Program recipient in a Special Hospital loses his eligibility during his hospital stay, the Program will cover the costs of the entire stay. Eligibility on the date of admission or from the date of application (whichever is applicable) carries for the entire length of that hospital stay.

202.8 Services Rendered Prior to Day Medically Necessary

Inpatient hospital services rendered prior to the day it is medically necessary for the diagnostic services and/or surgical or medical treatment for which the patient is admitted.

202.9 Services Rendered After Day Medically Necessary

Inpatient hospital services rendered after the day it is medically necessary, except when special circumstances prevent the discharge or transfer of the patient. Authorization must be obtained from the Local Medical Assistance Unit for reimbursement of additional hospital stay.

202.10 Admissions Primarily for Rest Cure, Custodial or Convalescent Care, etc.

Rest cure, custodial, convalescent or sanatorium care, diet therapy for exogenous obesity;

Diagnostic procedures which can be done on an outpatient or out-of-hospital basis, including but not limited to laboratory tests, electrocardiograms, and diagnostic X-ray;

Any condition for which hospitalization is not medically necessary.

202.11 Services Which Are Billed By and Payable to Another Provider

202.12 Items Not Normally Charged to Patient

Any services or items furnished for which the hospital does not normally charge.

202.13 Prior Authorization Not Obtained or Denied

Any service or item requiring prior authorization where authorization has not been obtained, or has been denied.

202.14 Any service, item which is not medically required for the diagnosis or treatment of a disease, injury or condition

203. SPECIAL PROVISIONS

Entitlement to payment for each continuous period of hospitalization is subject to the following:

203.1 Notification of Admission

The hospital is responsible to give notice of admission to the Local Medical Assistance Unit within two (2) working days following admission. (See Section 304. for instructions).

203.2 Medical Certification

The admitting (attending) physician is required to certify concerning the reasons for admission. This requirement shall be considered to be satisfied when the admitting form, including diagnosis(es) is completed by the hospital and signed by the physician.

203.3 Approval by Individual Diagnosis - AID Program

The AID Program (Approval by Individual Diagnosis) is a system whereby the initial number of days of hospitalization approved depends on the diagnosed condition for which the patient is treated. Instructions for determining number of days allowed are contained in the AID Manual.

203.4 Medical Recertification

Whenever the span of inpatient days allowed under AID is exceeded, the attending physician is required to certify the necessity of continued hospitalization on or before the expiration of the AID days. Use Inpatient Recertification Form MC-2 (1-70). (See Section 309. of this Manual for instructions).

The physician's recertification is considered approval of additional days, however, the maximum days allowed may not exceed those initially allowed under AID. Subsequent recertification(s) are required if hospitalization is medically necessary beyond this additional period.

For those hospitals which do not have the AID program, the MC-2 (1-70) will serve as a request for prior authorization. Prior authorization from the local Medical Assistance Unit is required after the first 21 days of hospitalization. Initial or subsequent authorization shall not exceed 30 calendar days. Section 2 of the MC-2 (1-70) must include a treatment plan in sufficient detail to support the authorization request. See Section 309.1 for the proper disposition of the MC-2 (1-70).

203.5 Utilization Review

The hospital is required to meet the requirements of Title XVIII concerning utilization review for all medical assistance patients.

203.6 Discharge Planning

A. When an inpatient is to be discharged from the special hospital and continuing medical care is required, either in another medical facility (i.e., Extended Care Facility, Skilled Nursing Home, General Hospital) or by a community health agency (e.g., Home Health Agency), the hospital is responsible for providing the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care. This information shall be provided at the time of hospital discharge and must be signed by the attending physician. Copies of the transfer form shall also be sent to the Local Medical Assistance Unit. (See Section 304. for instructions). The Patient Information Transfer Form, Hospital and Nursing Home, adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association (Form #766), or equivalent transfer form, may be used.

B. **"When an inpatient is to be discharged from an Acute Care or Short Term Hospital (Class A) to an Extended Care Facility or Skilled Nursing Home, the Health Services Program will reimburse the receiving facility for up to 30 days without prior authorization by the Program."**

C. When the inpatient is 65 years of age or older, transfer must be to an Extended Care Facility if Medicare (Title XVIII) benefits are available.

203.7 Hospital Benefits in a Non-Approved Hospital

Hospitals which do not meet the definition of an approved hospital are not eligible for payment unless such services are made necessary by reason of accidental injury or sudden and serious illness requiring treatment on an emergency basis. Reimbursement for emergency care shall be limited to a maximum of 20 days.

Claims filed by a non-approved hospital must be accompanied by a statement made by the attending physician, including a description of the nature of the emergency, pertinent clinical information concerning the condition of the patient, and a certification that the services rendered were necessary to prevent the death of the individual or the serious impairment of his health.

OUTPATIENT HOSPITAL SERVICES
(For A & B Classified Special Hospitals)

204. OUTPATIENT HOSPITAL SERVICES (If Approved Facility)

Outpatient services in Special Hospitals are those preventive, diagnositc, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physican or dentist in an approved special hospital Outpatient Department.

204.1 Outpatient

"Outpatient" means a person registered in the outpatient department in an approved special hospital in order to obtain services other than those requiring bed occupancy as an Inpatient.

205. COVERED OUTPATIENT HOSPITAL SERVICES

Approved special hospital outpatient departments may provide the following services to outpatients when medically necessary.

205.1 Examination and Treatment

By a physician, dentist, or other practitioner eligible to participate in the New Jersey Health Services Program.

205.2 Emergency Room Services, Including Ambulance

Hospital based ambulance services when outpatient is not subsequently admitted.

205.3 Diagnostic or Therapeutic Radiology

205.4 Laboratory Examinations and Diagnostic Studies

Shall include diagnostic laboratory examinations and clinical tests such as electrocardiograms, electroencephalograms, echoencephlograms, and other similar clinical tests.

205.5 Drugs

Dispensed by the hospital pharmacy. For regulations on take home drugs, see Special Provisions.

205.6 Rehabilitation Services

Physical, occupational, speech therapy and hearing services (See Section 209).

205.7 Psychiatric Services

Including psychological testing.

205.8 Supplies

Necessary for the diagnosis and treatment of the condition for which the hospital outpatient services are required, and ordinarily furnished to an outpatient.

205.9 Blood

Whole blood and/or derivatives, and necessary processing and administration thereof, when not otherwise available (See Section 208).

205.10 Dental Services

(1) Reimbursement for hospital outpatient dental services will be made on a per visit basis.

(2) Routine dental services rendered in hospital outpatient departments do not require prior authorization. All other dental services require prior approval.

(3) Post operative X-rays will be kept with the patient's records in the outpatient department for post audit review.

The following is the definition of routine dental services:

Routine Dentistry

(Includes the following procedures, as defined in the Dental Services Manual)

1. Emergency treatment

2. Examination with necessary radiography

3. Preventive Dentistry
   a. Prophylaxis
   b. Fluoride treatment

4. Restoration of carious permanent or deciduous teeth with:

   a. Silver Amalgam
   b. Silicate, plastic, or composite filling material
   c. Stainless steel crowns

5. Pulp Capping or pulpotomy for permanent and deciduous teeth, endodontic treatment (single rooted teeth) Limitation: If more than one tooth requires endodontic treatment, prior approval is required.

6. Extraction of non-restroable teeth

NOTE: See Dental Manual for other allowable Dental services.

205.11 Outpatient Surgical Procedures

205.12 Other Items or Services

That are medically indicated and provided in the medical management of disease or injury and are ordinarily furnished to an outpatient.

205.13 Family Planning Services

206. NON-COVERED OUTPATIENT HOSPITAL SERVICES

Benefits are not payable for any service rendered or items dispensed or furnished in connection with:

206.1 Elective Cosmetic Surgery

206.2 Private Duty Nursing Services

206.3 Services and Supplies Not Related to Patient Care

206.4 Research or Teaching Studies

206.5 Prior Authorization Not Requested or Denied

Outpatient hospital services rendered prior to the date of application for medical assistance.

Any service or item requiring prior authorization where such authorization has not been obtained or has been denied.

206.6 Any service, admission or item which is not medically required for the diagnosis or treatment of a disease, injury or condition

206.7 Transportation

Transportation including non-emergency ambulance (see Section 205.2 on transportation).

207. SPECIAL PROVISIONS RELATED TO PAYMENT

207.1 Prior Authorization

a. There is no limitation on the duration or number of visits available to an eligible patient in the outpatient department. However, services which involve an extended course of treatment, such as rehabilitation services, require that certification for continued need be submitted to the Local Medical Assistance Unit every 21 days. (See Section 304 for mailing instructions). Certification and/or subsequent recertification shall consist of a typewritten report from the prescribing physician stating the medical necessity for continued therapy, the objective of therapy, and the estimated number of treatments to achieve the objective. Therapy prescriptions must be definitive as to type and scope of procedures to be rendered. Prescriptions such as, "Physical therapy 3 X a week," will not be accepted.

b. Special items and services which are not usually part of the outpatient service (e.g., surgical supplies, glasses, custom made limbs and braces, etc.) will require prior authorization. See Section 204. Medical Supplies Manual and Section 203.2, Vision Care Manual.

c. Procedure for Obtaining Prior Authorization When Dental Services are Other Than Routine

If in the course of the initial examination and development of a treatment plan, services requiring prior authorization are included, then all subsequent services including those defined as routine dentistry require prior approval. The hospital will submit the treatment plan on the Dental Form (MC-10) with X-rays to the appropriate Local Medical Assistance Unit for review.

If a treatment plan is developed which requires only routine dentistry, but a treatment change becomes necessary and services requiring prior authorization are indicated, then the routine services to that date may be submitted for payment and the request for additional services must be submitted for approval at the Local Medical Assistance Unit. A record of care already completed with appropriate X-rays must be included.

207.2 Concurrent Care

Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by two different outpatient facilities, are not covered. Payment will be made only for one service, except in an emergency.

207.3 Free Choice of Transfer

Transfer from one outpatient facility to another or a change from outpatient facility to private practitioner care is allowable, however, every effort should be made to avoid duplication of diagnostic tests and services.

SPECIAL PROVISIONS

208. SPECIAL PROVISIONS RELATED TO BLOOD--INPATIENT AND OUTPATIENT

Blood may be provided to an inpatient of an approved hospital, an outpatient of an approved hospital, or any approved medical facility when prescribed and supervised by a licensed physician.

208.1 Scope of Service

Whole blood, and/or derivatives, and necessary processing and administration thereof, is allowed with the following limitations.

(a) Efforts should be made to arrange for the replacement of blood. This can be done by contribution of a blood donor, or by using a blood replacement plan that includes the eligible person as a beneficiary (if available).

(b) The cost of donated blood or blood received through a replacement plan is not reimbursable. However, the charge for cross-matching, indexing, storage and transfusing is reimbursable.

(c) Certification by the supplier or the facility where the transfusion is given, that voluntary blood donations cannot be obtained is required.

209. REHABILITATION SERVICES - SPECIAL HOSPITAL OUTPATIENT ONLY

209.1 Definitions

(a) "Rehabilitation services" such as physical therapy, occupational therapy, speech therapy, and hearing services and the use of such supplies and equipment as are necessary in the provision of such services.

(b) A "qualified physical therapist" is a graduate of a program of physical therapy approved by the Council on Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent, and where applicable, is licensed or registered by the State.

(c) A "speech therapist" is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

(d) A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupation therapy approved by the Council on Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

209.2 Scope of Services

This section is concerned with rehabilitation service which includes physical therapy, occupational therapy, speech therapy, and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill or a qualified physical therapist.

Rehabilitation services shall be made available to covered persons as an integral part of a comprehensive medical care program. Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

209.3 General Policies

a. Providers of Services

Rehabilitation services shall be provided by qualified therapists employed by or under contract to the hospital.

EXCLUSION: Rehabilitation services provided by a physical therapist on a private basis are not reimbursable.

b. Where Care May Be Provided

Rehabilitation services may be provided in the patient's home or other place of residence, in a hospital outpatient department, in an approved clinic (independent outpatient health facility not part of a hospital).

c. Prior Authorization (See Section 207.1)

d. Supervision of Therapy

All therapy must be provided under direct personal supervision and in the presence of a qualified therapist or fully licensed physician.

210. TAKE HOME DRUGS--OUTPATIENT ONLY

209.2 Scope of Services

This section is concerned with rehabilitation service which includes physical therapy, occupational therapy, speech therapy, and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill or a qualified physical therapist.

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d. Supervision of Therapy

All therapy must be provided under direct personal supervision and in the presence of a qualified therapist or fully licensed physician.

210. TAKE HOME DRUGS--OUTPATIENT ONLY

210.1 Prescription Policies

The program provides payment for take home drugs dispensed by the hospital pharmacy.

The choice of prescription drugs remains at the discretion of the prescribing physician. However, preference should be given to:

1. Drugs listed in the latest edition of the U.S. Pharmacopoeia (U.S.P.), National Formulary (N.F.), New Drugs, and Accepted Dental Therapeutic Remedies.

2. Oral medication when as effective as injectable preparations.

3. Non-proprietary or generic named drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand-named drugs.

210.2 Non-Reimbursable Prescriptions

Prescriptions will not be eligible for payment under the program in the following instances:

1. Drugs for which adequate literature, i.e., package inserts, etc., and price catalogues are not readily available.

2. Experimental drugs.

3. Drugs and biologicals provided without charge through programs of other public or voluntary agencies (i.e., New Jersey State Department of Health, New Jersey Heart Association, etc., Drug and Biological Listing available from pharmacies).

210.3 Quantity Limitations

The Quantity of Medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60 day supply.

EXCEPT: 1. Oral antibiotics or anti-infective agents may not be prescribed for more than a ten (10) day supply.

2. Oral contraceptives may be prescribed for up to a three-month supply.

At the decision of the prescribing physician, commonly used sustaining drugs should be prescribed in sufficient quantity to treat the patient for up to sixty (60) days.

210.4 Prescription Requirements

1. All prescriptions should signify in writing the prescribing physician's intentions for refills up to two times. Two refills within a six-month period are eligible for payment (see Exceptions 1 and 2, Section 210.3).

   Payment will not be made under the program unless the prescribing physician includes specific directions on all prescriptions ("prn", "as directed", and "ad lib" are examples of non-acceptable directions). This ruling does not apply for prescriptions such as topical preparations, aerosol inhalers or Nitroglycerin tablets since specific directions are seldom possible in these instances.

2. Two refills within a six-month period are eligible for payment. Oral contraceptives for which the prescriber may indicate a three-month supply may be refilled twice within a nine-month period.

CHAPTER III

ADMISSION AND BILLING PROCEDURES

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ADMISSION AND BILLING PROCEDURES

300. SUMMARY OF ADMISSION PROCEDURES FOR INPATIENTS

The purpose of this section is to give a brief outline of routine handling of admissions.

300.1 Identification Card and Validation Form

The first step in preparing the Notice of Admission in inpatient cases is to ask the patient for his identification card and validation form.

It is very important that the case number and person number be accurately recorded on the claim form. The case cannot be processed if either of the numbers is missing or incorrect.

(For more detailed information, see Section 101.)

301. INPATIENT HOSPITAL CLAIM (FORM MC-1) (Exhibits I & V)

This 3-part form serves two purposes: (1) To report to the Local Medical Assistance Unit the admission of a covered person who is eligible for medical assistance; (2) To bill the program for the inpatient services rendered.

Contractor's Copy (MC-1-A) - To be used by Provider when billing the Contractor.

Provider Copy (MC-1-B) - To be retained by the Provider.

County Copy (MC-1-C) - This copy must be submitted to the Local County Medical Assistance Unit within two working days of admission. It is not to be sent to the Contractor.

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301.1 Completing Inpatient Hospital Claim (Form MC-1)

Use a typewriter or legible printing for all entries on the form.

The following items are to be completed at the time of admission:

Item 1: Patient's Name--Enter the patient's last name, and first name, as shown on the validation form.

Item 2: Sex--Enter "X" in the appropriate block.

Item 3: Birth Date--Enter the patient's birth date by month, day and year. If the date of birth is unknown, transmit the claim form without the date of birth. If only the year of birth is known, show the year. While the date of birth is useful as identification and should be shown when available, a claim will be processed without it.

Item 4: Leave blank.

Item 5: Enter Admission Date.

Item 6-9: Leave blank.

Item 10: Enter Attending Physician's Name.

Item 11: Enter Medical Record Number.

Item 12: Health Services Program Case Number--Enter the covered person's program case number as shown on the identification card or validation form (See Section 101.)

Item 13: Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)

NOTE: In maternity cases, when the child remains in the hospital after the mother is discharged, the hospital must contact the County Welfare Board in order to obtain the child's person number.

Item 14: Enter Provider Name and Address--Abbreviations may be used. This information may be preprinted.

Item 15: Enter Provider Number--This information may be preprinted.

Item 16: Case Name--Enter name as it appears on the permanent identification card.

Item 17: Patient's Certification, Authorization to Release Information and Payment Request-- Have the patient or his authorized representative read and sign the statement on the form. If the hospital obtains the signature on its own admission record form, check the block marked "Contained in Provider's Record." The signature on Form MC-1 need be legible only on the original. If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf. The statement should be read to a patient who signs by mark, and witnessed by a person who knows the patient. Enter the name and address of the witness. In certain situations, a hospital representative may sign on behalf of the patient. If the patient is a minor, a parent or guardian should sign and indicate relationship.

Items 18-21: Leave blank.

Item 22: Admitting Diagnosis--Enter the admitting diagnoses as furnished by the physician. List the primary condition first.

NOTE: This Item must be completed in all instances.

301.2 Disposition of Form MC-1-C

The bottom copy of the Claim Form, County Copy (MC-1-C) must be submitted to the Local County Medical Assistance Unit within 48 hours after admission. It is not to be sent to the contractor. The two top copies are retained by the hospital for billing purposes. (See Exhibits.)

302. BILLING PROCEDURES FOR INPATIENT SERVICES--GENERAL

Form MC-1 (1-70)--Inpatient Hospital Claim is used to bill for inpatient services in a participating hospital and for emergency inpatient services in a nonparticipating hospital.

NOTE: The hospital should not include charges for services of physicians, other practitioners, therapists or technicians who customarily bill patients directly and who are not directly or indirectly employed or contracted for by the hospital.

302.1 Inpatient Admission After Outpatient Services

Sometimes a patient is admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient before midnight of the day outpatient services were rendered, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day on inpatient hospital services.

302.2 Leave of Absence

It is not necessary to submit a new admission and billing each time the patient has a leave of absence. Instead, the hospital may bill for days, excluding leave of absence. (See Section 303.)

302.3 Medicare/Medicaid Coverage

When the patient is covered under both programs, only a Medicare form (SSA 1453) should be completed, with Item 14 showing the Health Services Program case and person number on that Medicare form.

Where benefits have been exhausted under Medicare, the charges to be billed to the program must be itemized for the non-covered period and the case and person number must be shown on the Medicare form.

303. COMPLETION OF BILLING ITEMS ON THE FORM MC-1 (Exhibit I)

Items 6-7: From and Thru Dates--Enter 6 digit "From" and "Thru" dates for period covered by the bill.

In interim billing situations, the "Thru" date will be the last day billed. On the final bill submitted, the "Thru" entry will show the date of discharge or death.

Item 8: Enter number of Days involved in "From-Thru" dates.

NOTE: Days should not include:

a. Day of discharge or death.
b. Days for which no payment can be made because patient was on a leave of absence.

If interim bill situation, include last day being billed. If final bill, do not include day of discharge or death.

Example:

Period Billed	No. of Days
1-1-70 thru 1-15-70 (Bill #1)	15
1-16-70 thru 1-19-70 (Bill #2)	4
1-20-70 thru 1-22-70 (Discharged)	2

Item 9: Leave Days--Show number of leave days. (See Section 302.2)

Item 18: Statement of Charges

Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form, utilize Items 26, 27 and 28.

Accommodations--See Section 201.1 for an explanation of the rules on other than semiprivate accommodations.

Accommodation days should not include the day of discharge, even where the discharge was late. However, where the hospital normally makes an extra charge for a late discharge, it should enter the extra charge under "Covered Charges." Where this charge was made because the patient remained in the hospital after checkout time for his own convenience, the charge should be entered under "Noncovered Charges." However, where the patient's stay beyond the checkout hour is occasioned by his medical condition, e.g., a bedridden patient awaiting transfer to his home or to an extended care facility, the services furnished by the hospital are entered under "Covered Charges."

Where the patient is discharged on his first day of entitlement, it is permissible to submit a billing form with no accommodation charge, but with ancillary charges shown on Lines 06 through 28. Ancillary charges for day of discharge, death, or the day on which a leave of absence begins, should be shown in the proper department.

Where more than one rate has been used for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

NOTE: In a maternity case, during the joint eligible stay, bill the accommodations for the mother on the appropriate accommodation line, and bill the nursery charge on Line 06. If the child continues to be hospitalized after the mother has been discharged, the nursery charges should be billed on a separate claim form.

All-Inclusive Rate Hospitals--For hospitals using all-inclusive rates, the line for the accommodation actually furnished is to be completed. The number of days, all inclusive rate, covered charges, and non-covered charges must be entered on the bill.

One Bed--Where a patient needed a private room for medical reasons, complete and attach one copy of form MC-5 to explain the medical necessity. (See Section 305.) Enter the number of days, the customary charge for a one-bed room and enter the total charge in the "Covered Charges" column. There is to be no entry in the "Non-covered Charges" column.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the cost of semi-private accommodations. (The completion of Form MC-5, Explanation of Accommodation Furnished, is not necessary in this case). In the non-covered charges column, show the difference between the private room charges and the most prevalent semi-private room charges at the time of admission.

2-3-4 Bed--If the patient occupies semi-private accommodations (2,3, or 4 bed room) show the number of days and the actual daily rate for the accommodations and enter total under "Covered Charges".

Ward (5 or More Beds)--Under the Health Services Program, payment is ordinarily made for semi-private accommodations (2,3, 4 bed room). If the patient is assigned to a room with 5 or more beds, the hospital should complete Form MC-5, Explanation of Accommodations Furnished, explaining the reasons for this accommodation. A copy of the form should be attached to the billing form, and submitted to the contractor. (See Section 306.)

Coronary/Intensive Care and Self Care (If available and/or necessary)

Show the number of days the patient was in the coronary/intensive care and/or self care unit, number of days, applicable rate and enter total under "Covered Charges."

Line 05: Enter total "Covered" and "Non-Covered" charges for accommodations in "Subtotal" line.

Lines 06-28: General

Show all charges for the period covered by the current billing for each of the departments. NOTE: Line 07 includes recovery room and Line 22 includes intravenous solution.

Line 98: Enter total of covered and noncovered charges.

Item 19: Other Coverage--Remaining Charges

If patient has Medicare and Medicaid coverage, see Section 302.3. If patient does not have Medicare coverage, enter charges not covered by other insurance on Line 32 of Item 19. Appropriate information should be entered in Item 25.

NOTE: Item 19 is reserved solely for other insurance coverage. Items 18 and 19 cannot be completed on the same claim form.

Item 20: Patient Status--Check Appropriate Block.

If discharged also enter date in Item 21.

If transferred to another medical facility, i.e., skilled nursing home, hospital, extended care facility, etc., the hospital should submit a discharge bill at this point and show the date the transfer occurred in Item 21. The hospital should also show under "Remarks" the name and address of the institution to which the patient was transferred.

If deceased enter date of death in Item 21.

If still patient when bill is submitted, check still patient block.

Item 21: Discharge Date--Enter date as noted in Item 20.

Item 22: Admitting Diagnosis--(See Section 301.2)

Item 23: Discharge or Current Diagnoses--Enter all the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis shown is the illness or condition which was the primary reason for the patient's hospitalization. Other diagnoses should be shown under secondary. The diagnoses should be shown in accordance with recognized nomenclature, e.g., "International Classification of Diseases Adapted," "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

Item 24: Surgical Procedure--Surgical procedure should be specified in detail using recognized nomenclature such as that in "Current Medical Terminology," "Current Procedural Terminology," "Standard Nomenclature of Diseases and Operations," etc. For the purpose of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 25: Employment Related--If the condition is considered to be employment related, the admitting diagnosis should always be shown along with the name and address of the employer. No program payments shall be made for a patient covered by Workmen's Compensation. (Any amounts not covered by Workmen's Compensation should be entered in Item 19, line 32 with an appropriate explanation in the Remarks section.)

Item 26: Other Insurance or Liability Coverage--Applies to coverage other than Medicare or Workmen's Compensation. (See Section 110.)

Item 27: Provider Certification and Signature--When a certification or recertification is required, a hospital representative should make sure that the physician's certification and recertifications are in the hospital records. In all cases the claim form should be dated before it is submitted to the contractor. The date forwarded should be the date the bill is actually mailed to the contractor and should not be before the "Thru" date in Item 7. A stamped signature is acceptable.

REMARKS--This block will be used by the hospital and/or contractor.

Item 28-37. For Contractor's use only.

304. Disposition of Forms MC-1, Reports and Request to Local Medical Assistance Units

304.1 Form MC-1

a. The original copy (MC-1-A, Contractor's copy) must be forwarded to the hospital's contractor for processing.

b. The second copy (MC-1-B, Provider's copy) is to be retained by the hospital.

c. The third copy (MC-1-C, Notice of Admission) must be mailed to the Local Medical Assistance Unit within two (2) working days after admission.

304.2 Other Reports and Requests Required by Local Medical Assistance Units

a. The first two digits of the recipient's Health Services Program Identification number indicate the Local Medical Assistance Unit having jurisdiction. Notices of Admission and any other reports required by the Local Medical Assistance Unit are to be sent to the Unit indicated.

NB Inquiries concerning eligibility and applications for eligibility are to be sent to the County Welfare Board of patient's residence.

304.3 Directory of Local Medical Assistance Units

County	Street Address	Municipality	Zip Code	P.O. Box	Telephone
Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
Cape May	" "				
Bergen	90 Main Street	Hackensack	07601		201-488-5667
Burlington	Chesley & Alloway Bldg. Rt. 38 & Eayrestown Rd.	Mt. Holly	08060		609-261-0448
Camden	709 Market Street	Camden	08101	19	609-365-3926
Cumberland	7 E. Broad Street	Bridgeton	08302	440	609-451-6550
Essex	505 S. 15th Street	Newark	07103	1576	201-548-3700
Gloucester	10 Harrison Street	Woodbury	08096	1900	609-845-7185
Salem	" "				
Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
Hunterdon	6 Court Street	Flemington	08822		201-782-1130
Somerset	" "				
Warren	" "				
Mercer	205 E. State Street	Trenton	08625	2465	609-292-7315
Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-245-0653
Monmouth	320 Broad Street	Red Bank	07701		201-842-6440
Morris	4 Court Street	Morristown	07960		201-267-1700
Sussex	" "				
Ocean	1851 Hooper Avenue	Toms River	08753		201-255-6226
Passaic	152 Market St.	Paterson	07590	2863	201-523-2800
Union	7 Bridge Street	Elizabeth	07201		201-355-8860

305. EXPLANATION OF ACCOMMODATION FURNISHED (FORM MC-5) (Exhibit II)

Form MC-5, Explanation of Accommodation Furnished is used by the hospital to explain an accommodation other than a two, three, or four bedroom.

The cost of a one-bed accommodation is covered by the Health Services Program if it is medically necessary. The medical necessity for a private accommodation should be described on the MC-5 from the physician's order and the reason as given by him in the hospital's medical record. It is not necessary to attach a special statement from the doctor for this purpose.

Where the patient was furnished a one-bed accommodation for reasons other than medical necessity, it is not necessary to complete a form MC-5.

Where the patient requested a five-bed accommodation, the hospital should complete a single copy of the MC-5 for attachment to the bill and have the patient sign the form in the Patient's Signature block under Item 19.

Where the patient was assigned a five-bed accommodation not at his request, the hospital should complete the MC-5 for attachment to the bill showing the reason for such assignment.

306. COMPLETING ITEMS ON THE FORM MC-5

Items 1-16: Should be entered exactly as they appear on inpatient hospital claim form MC-1.

Item 17: Type of Accommodation Furnished

Enter the accommodation furnished and the applicable daily rate. Item A, the most prevalent semiprivate rate, should be completed in all cases. This is the semiprivate rate most frequently used in the hospital. (A hospital with private rooms only will use the equivalent semiprivate rate determined by the contractor.)

To determine the most prevalent charge for semiprivate accommodations, consider the following features:

1. Type of Accommodation.
2. Total rooms of each type for each different room rate.
3. Total beds found in each type for each room rate.
4. Rate you charge daily for the type of room.

Your most prevalent charge for semiprivate accommodations is that single rate you charge for the largest entry appearing under your "Total Beds" column.

Example:

(1) Type of Accommodation	(2) Total Rooms of this Type	(3) Total Beds Col. (1) X Col. (2)	(4) Rate per Day
2 beds	10	20	$30
2 beds	8	16	35
3 beds	2	6	20
4 beds	1	4	15

NOTE: $30 is the most prevalent semiprivate charge.

Item 18: Reason for Assignment to Accommodation Mentioned

A. Patient's Request--Where a five or more bed accommodation was furnished at a patient's request, the patient should sign the MC-5 in Item 19. Enter the date of signing in Item 20.

Item 19: Patient's Signature--As noted above.

Item 20: Date of Signature.

Item 21: Medical Necessity--Describe the reason for assignment to a one-bed room from the physician's order shown in the hospital records.

Item 22: Other Reasons--Where the hospital believes that an assignment to a five or more bed accommodation is justifiable for some other reason, it should describe the reason in this block.

Item 23: Signature of Hospital Representative--The responsible hospital representative should sign and date the form in Item 24. A stamped signature is acceptable.

Item 24: Date of Signature.

Item 25-28: For Contractor's use only.

307. INPATIENT RECERTIFICATION

307.1 Recertification

Whenever the span of inpatient days allowed under AID (Approval by Individual Diagnosis--See Section 203.3) will be exceeded, the attending physician is required to certify concerning the necessity of continued hospitalization beyond the AID days.

307.2 Promptness of Recertification

The regulations of the New Jersey Health Services Program require the recertification of the need for continued hospital stay of the patient. The attending physician is required to complete the recertification on or before the expiration of the AID days. Program payment will not be made unless this requirement is met.

307.3 Inpatient Recertification (Form MC-2) (Exhibit III)

Form MC-2 Inpatient Recertification is to be used by the attending physician whenever AID days are exceeded as noted above. The form is to be completed in quadruplicate, and signed by the attending physician (See Section 309.).

308. COMPLETING ITEMS ON FORM MC-2 (For Recertification)

Inpatient Recertification--Items 1-16--Information can be obtained from the claim Form MC-1 and listed exactly as it appears on that form.

Attending physician is required to answer the Items listed below:

Item 1: Current Diagnosis--The Current Diagnosis must be specified in all instances.

Item 2: Reason for Continued Hospitalization--State why confinement will exceed number of days allowed under AID.

Item 3: Approximate Additional Necessary Length of stay if still hospitalized. The additional stay required should be specified in days.

Date: The month, day and year on which the recertification was completed and signed should be indicated.

The attending physician's signature must appear on all copies of the form.

309. DISPOSITION OF COPIES OF COMPLETED FORMS MC-2 (A.I.D. Hospital)

A. The original (MC-2-A Contractor's Copy) must be forwarded to the hospital's contractor with Form MC-1 for processing.

B. The second copy (MC-2-B County Copy) must be mailed to the Local County Medical Assistance Unit.

C. The third copy (MC-2-C Provider Copy) will be retained by the hospital.

D. The fourth copy (MC-2-D Utilization Committee Copy) will be forwarded to the provider's Utilization Review Committee for review.

309.1 Disposition of Copies of Completed Forms MC-2 When Used for Prior Authorization Request

Hospitals which do not have the AID Program must utilize the MC2 (1-70) as a request for Prior Authorization for inpatient services beyond the 21st day.

The completed original, second, and third copies are forwarded to the Local Medical Assistance Unit for review. The fourth copy will be forwarded to the provider's Utilization Review Committee. If the Local Medical Assistance Unit has authorized the additional days, it will be indicated by signature on the original and third copy, specifying the additional days allowed and the expiration date. The hospital will forward the original copy (MC-2A) to the appropriate Contractor together with the claim for payment.

310. BILLING PROCEDURES FOR OUTPATIENT SERVICES--GENERAL
(Not Available for Special Hospital in Classification C)

Form MC-4 Outpatient Hospital Billing--will be used by a hospital to report outpatient services.

Under the New Jersey Health Services Program, the Hospital should submit this form on a monthly billing cycle. However, separate claim forms will be required for services rendered in different calendar quarters.

A. PROCEDURE FOR BILLING FOR DENTAL SERVICES

After completion of treatment, either authorized or routine, the Dental Form (MC-10), with descriptions and dates of services rendered, utilizing proper procedure code numbers, is attached to the Hospital Outpatient Form (MC-4) which is used to make the charge for the dental clinic visit. These forms are then submitted to the appropriate fiscal agent for the hospital.

B. PROCEDURE FOR BILLING FOR MEDICARE/MEDICAID PATIENT

When the patient is covered under both programs only a Medicare Form (SSA 1483) should be completed, with Item 11 showing the Health Services Program Case and Person Number on that Medicare form.

Where prior authorization is required for program purposes it must be obtained and submitted with the Medicare billing form.

311. COMPLETION OF ITEMS FORM MC-4 (Exhibit IV)

Use a typewriter or legible printing for all entries on the form.

Item 1: Patient's Name--Enter the patient's last name, and first name, as shown on the validation form.

Item 2: Sex--Enter "X" in the appropriate block.

Item 3: Birth Date--Enter the patient's birth date by month, day and year. If the date of birth is unknown, transmit the claim form without the date of birth. If only the year of birth is know, show the year. While the date of birth is useful as identification and should be shown when available, a claim will be processed without it.

Items 4-5: Leave blank.

Items 6-7: Claim From and Thru Dates--Enter the dates of the first and last service for period covered by the claim form.

Item 8: Visits--Enter number of visits for the period covered by the claim form.

Item 9: Leave blank.

Item 10: Attending Physician--Enter attending physician's name.

Item 11: Enter Medical Record Number.

Item 12: Health Service Program Case Number--Enter the patient's program case number as shown on the identification card or validation form. (See Section 101.)

Item 13: Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)

Item 14: Provider Name and Address--Enter provider name and address. Abbreviations may be used. This information may be preprinted on all copies of the hospital's supply of these forms.

Item 15: Provider Number--Enter the provider number. This information may be preprinted.

Item 16: Case Name--Enter name as it appears on the permanent identification card.

Item 17: Patient's Certification, Authorization to Release Information and Payment Request--Have the patient or his authorized representative read and sign the statement on the form. If the hospital obtains the signature on its own admission record form, check the block marked "Contained in Provider's Record." The signature on form MC-4 need be legible only on the original.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf.

The statement should be read to a patient who signs by mark, and witnessed by a person who knows the patient. Enter the name and address of the witness. In certain situations, a hospital representative may sign on behalf of the patient. If the patient is a minor, a parent or guardian should sign and indicate relationship.

Item 18: Type of Clinic/Dates Visited--Enter type of clinic and the date of each visit.

Item 19: Statement of Charges--Enter the charges for the period covered by the claim. Lines 26, 27 and 28 should be used to list additional services. Show total charges on Line 98.

Item 20: Other Coverage--Remaining Charges

If patient is also covered under Medicare, see Section 310. If patient does not have Medicare coverage, enter charges not covered by other insurance in Item 20, Line 32. Appropriate information should be entered in Item 25.

NOTE: Item 20 is reserved solely for other insurance coverage. Items 19 and 20 cannot be completed on the same claim form.

Item 21: Patient Status--Check Appropriate Block.

Item 22: Nature of Services Rendered--List here, from the patient's hospital record, the nature of the illness or injury for which services were given. Acceptable medical terminology should be used, such as"International Classification of Diseases Adapted","Current Medical Terminology,"etc. If the nature of the illness or injury is not known, enter "not known".

Item 23: Surgical Procedures--Surgical procedures should be specified in detail using recognized nomenclature such as that used in "Current Medical Terminology," "Current Procedural Terminology", "Standard Nomenclature of Diseases and Operation," etc. For the purpose of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulations.

Enter the name of the procedures, if any, which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order.

Item 24: Employment Related--If the condition is considered to be employment related, the diagnosis should always be shown along with the name and address of the employer. No program payments shall be made for a patient covered by Workmen's Compensation. (Any amounts not covered by Workmen's Compensation should be entered in Item 20, Line 32, with an appropriate explanation in the Remarks section.)

Item 25: Other Insurance or Liability Coverage--Applies to coverage other than Medicare or Workmen's Compensation. (See Section 110.)

Item 26: Provider Certification and Signature--The date forwarded should be the date the bill is actually mailed to the contractor. The date used should not be before the "Thru" date in the "Statement Covers Period" Item 7. A stamped signature is acceptable.

Remarks--This block will be used by the hospital and/or contractor.

Items 28-37: For Contractor's use only.

312. DISPOSITION OF COPIES OF COMPLETED FORM MC-4

A. The original copy (MC-4-A Contractor's Copy) will be forwarded to the hospital's contractor for processing.

B. The second copy (MC-4-B Provider Copy) will be retained by the hospital.

313. COMPLETING ITEMS ON FORM MC-7

Form MC-7 Hospital Pharmacy Report must be completed when take home drugs are dispensed by Outpatient Hospital facilities.

Patient's Name--Enter the patient's last name and first name, as shown on the validation form.

Health Services Program Case Number--Enter the patient's program case number as shown on the identification card or validation form. (See Section 101.)

Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)

Drug Supplied--Enter generic name of drug.

Provider Number--Enter the provider number.

Manufacturer--Enter name of drug manufacturer.

Cost--Enter actual invoice cost.

Quantity Dispensed--Enter quantity dispensed in metric system only.

Day's Supply--Enter number of days.

Dosage Form--Enter drug directions.

Strength--Enter strength of drug.

Rx Number--Enter Rx number.

Original Rx or Refill--Check one.

Date Dispensed--Enter current date.

314. DISPOSITION OF COMPLETED FORM MC-7

a. Attach to Outpatient Claim form MC-4A.

b. Forward with MC-4A to the hospital's contractor for processing.

315. PROCEDURES FOR SUBMITTING CORRECTED INPATIENT AND OUTPATIENT BILLS

The hospital may find that a bill already submitted is incorrect. It is not necessary to submit a corrected Form MC-1 or Form MC-4 unless total charges change by more than $10.00.

To correct a previously submitted bill, the hospital should reproduce a legible copy of the submitted bill. The necessary corrections should be made in red in the appropriate item. The corrected bill should be marked "Debit--Adjust" in the upper right hand corner, and mailed to the Contractor.

To cancel all the charges on a previously submittted bill, reproduce a legible copy and mark it "Cancel Only" in the upper right margin. An explanation for the correction should be given on the reverse side of the bill, and mailed to the Contractor.

316. EXHIBITS

I.	MC-1-A	Inpatient Hospital Claim Form
II.	MC-5	Explanation of Accommodation Furnished Form
III.	MC-2-A	Inpatient Recertification Form
IV.	MC-4-A	Outpatient Hospital Claim Form
V.	MC-1-C	Hospital Admission - Notification Form
VI.	MC-7	Hospital Pharmacy Rx Report

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

EXHIBIT I

INPATIENT HOSPITAL CLAIM

Patient's Last Name	First Name	Sex 2.	Birthdate 3.
Doe	John	[X] Male [ ] Female	02 / 05 / 48 (Mo. / Day / Yr.)

Admission Date 5.	Claim From-Date 6.	Claim Thru-Date 7.	Days 8.	Leave Days 9.
01 / 06 / 70 (Mo. Day Yr.)	01 / 06 / 70 (Mo. Day Yr.)	01 / 11 / 70 (Mo. Day Yr.)	5	0

Attending Physician's Name 10. (Last First M.I.): Zotti Frank

Medical Record No. 11.: 2620

Health Services Program Case No. 12.: 0 1 2 3 4 5 6 7 8 9

Patient Person No. 13.: 01

Provider Name and Address 14.:
Alexander Linn
20 Walnut Street
Sussex, New Jersey

Provider Number 15.: 310004

Case Last Name 16.: Doe
First Name: John

17. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

[X] Contained in provider's record

Signature *(Patient or authorized representative)*

Date: 01-06-70

18. STATEMENT OF CHARGES

ACCOMMODATION	DAYS	RATE	COVERED CHARGES	NON-COVERED CHARGES
1 Bed				
2, 3, 4 Bed	5	55.00	275.00	
Ward				
Coronary/IntensiveCare				
Self Care				

		COVERED CHARGES		NON-COVERED CHARGES
SUBTOTAL ACCOM. CHARGES	05	275	00	
NURSERY	06			
OPERATING ROOM	07	100	00	
DELIVERY ROOM	08			
PHYSICAL THERAPY	10			
SPEECH THERAPY	11			
OCCUPATIONAL THERAPY	12			
RADIATION THERAPY	13			
INHALATION/OXYGEN THERAPY	14			
LABORATORY	15	80	00	
X-RAYS	16	25	00	
EKG'S	17			
EEG'S	18			
ADMIN. OF ANESTHESIA	19	50	00	
ADMIN. OF BLOOD	20			
BLOOD	21			
PHARMACY	22	15	00	
SUPPLIES-Medical/Surgical	23	15	00	
AMBULANCE *(Hospital Owned)*	24	25	00	
OTHER *(Describe)*	26			
	27			
	28			
TOTAL	98	585	00	

19. OTHER COVERAGE – REMAINING CHARGES

MEDICARE - DEDUCTIBLE	29			
MEDICARE - Co-Insurance	30			
MEDICARE - OTHER	31			
OTHER *(Describe)*	32			
TOTAL	99			

Patient Status 20.: [ ] Still Patient [ ] Deceased [X] Discharged [ ] Transfer to other inpatient facility

Discharge Date 21.: 01 / 11 / 70 (Mo. Day Year)

Admitting Diagnosis 22.:
Possible Appendicitis
Abdominal Pains

Discharge or current diagnoses 23.:
Primary: Acute Appendicitis
Secondary:

Surgical Procedures *(Show date of each)* 24.:
Primary: Appendectomy - 1/6/70
Secondary:

Claim related to employment? No . *If yes, give name of employer.* 25.:

Other insurance or liability coverage 26.:
Name: NONE Policy Number:

27. Provider Certification: I certify that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the provisions of Title VI of the Federal Civil Rights Act.

Carol Jones — *Provider Representative Signature*

1-12-70 — *Date Sent*

REMARKS:

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

EXHIBIT II

EXPLANATION OF ACCOMMODATION FURNISHED

1. Patient's Last Name	First Name	2. Sex	3. Birthdate	4
Doe	John	☒ Male ☐ Female	02/05/48 (Mo./Day/Yr.)	

5. Admission Date	6. Claim From-Date	7. Claim Thru-Date	8.	9.	10.	11. Medical Record No.
01/06/70 (Mo./Day/Yr.)	01/06/70 (Mo./Day/Yr.)	01/11/70 (Mo./Day/Yr.)				2620

12. Health Services Program Case No.	13. Patient Person No.	14. Provider Name and Address	15. Provider Number
0 1 2 3 4 5 6 7 8 9	01	Alexander Linn 20 Walnut Street Sussex, New Jersey	310004

16. Case Last Name	First Name
Doe	John

17. TYPE OF ACCOMMODATION FURNISHED

17A. MOST PREVALENT SEMI-PRIVATE RATE $ 48.00

17B. 1–BED			17C. 5–OR–MORE–BED		
FROM (Date)	TO (Date)	RATE	FROM (Date)	TO (Date)	RATE
01-06-70	01-11-70	$60.00			

18. REASON FOR ASSIGNMENT TO ACCOMMODATION MENTIONED

PATIENT'S REQUEST – The 5–or–more–bed accommodation shown above was furnished because I requested it.

19. PATIENT'S SIGNATURE	20. DATE
	01/06/70

21. MEDICAL NECESSITY (Describe)

Patient has communicable disease.

22. OTHER REASON (Specify)

23. SIGNATURE OF HOSPITAL REPRESENTATIVE	24. DATE
Carol Jones	1-12-70

25. FOR CONTRACTOR'S USE

26. Where Contractor determines that assignment to 5–or–more–bed room was not at patient's request, or was not consistent with the purposes of the Act, give difference between total of charges for accommodation at the most prevalent 2–3–4 bed room rate and charges for a 5–or–more–bed room for all covered days included on bill for services attached.	$

27. CONTRACTOR'S APPROVAL	28. DATE

MC-5 (1-70)

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

EXHIBIT III

INPATIENT RECERTIFICATION

1. Patient's Last Name	First Name	2. Sex	3. Birthdate	4.
Edwards	Joan	☐ Male ☒ Female	01 / 06 / 19 (Mo. Day Yr.)	

5. Admission Date	6. Claim From-Date	7. Claim Thru-Date	8. Days	9. Leave Days	10. Attending Physician's Name (Please Print) Last First M.I.	11. Medical Record No.
01/ 10/ 70 (Mo. Day Yr.)	01/10/70 (Mo. Day Yr.)	01/31/70 (Mo. Day Yr.)	21	0	Black Harold	2175

12. Health Services Program Case No.	13. Patient Person No.	14. Provider Name and Address	15. Provider Number
1 2 3 4 5 6 7 8 9 9	02	Alexander Linn 20 Walnut Street Sussex, New Jersey	310004

16. Case Last Name	First Name
Edwards	Joan

ATTENDING PHYSICIAN'S STATEMENT REGARDING CONTINUED HOSPITALIZATION

Attending Physician is Required to Answer Items Listed Below On All Cases in Hospital More Than The Number of Days Allowed on Individual Diagnosis (AID) Basis:

1. Current Diagnosis:

   Asthma

2. What is the Reason for Continued Hospitalization?

   Patient has difficulty in breathing. Continued use of oxygen therapy.

3. Approximate additional necessary length of stay if still hospitalized:
   Days

   11 days.

Date:

1 - 19 - 70
Month Day Year

Attending Physician

Harold Black
Signature

NOTE TO DOCTOR

The regulations of the New Jersey Health Services Program require the recertification of continued hospital need of your patient. Your prompt cooperation is required so that reimbursement for the additional days may be considered.

DISTRIBUTION: ORIGINAL – CONTRACTOR
COPY 1 – COUNTY
COPY 2 – PROVIDER
COPY 3 – UTILIZATION COMMITTEE

MC-2 (1-70)

EXHIBIT IV

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

OUTPATIENT HOSPITAL CLAIM

1. Patient's Last Name	First Name	2. Sex	3. Birthdate	4.
Doe	James	[X] Male [ ] Female	02 / 04 / 63 (Mo. / Day / Yr.)	

5.	6. Claim From-Date	7. Claim Thru-Date	8. Visits	9.
	02 / 01 / 70 (Mo. Day Yr.)	02 / 30 / 70 (Mo. Day Yr.)	4	

10. Attending Physician's Name (Please Print) — Last: Leone; First: Jason; M.I.:

11. Medical Record No.: 1821

12. Health Services Program Case No.: 0 1 2 3 4 5 6 7 8 9

13. Patient Person No.: 22

14. Provider Name and Address:
Alexander Linn
20 Walnut Street
Sussex, New Jersey

15. Provider Number: 310004

16. Case Last Name: Doe — First Name: James

17. PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

Patient's Signature (Authorized Representative): James Doe — Date: 3-1-70

18. TYPE OF CLINIC (Indicate Dates Visited)
(17) 2/1 2/15 2/20 2/28

19. STATEMENT OF CHARGES			
CLINIC VISIT	01	40	00
EMERGENCY/OPERATING ROOM	09		
PHYSICAL THERAPY	10		
SPEECH THERAPY	11		
OCCUPATIONAL THERAPY	12		
RADIATION THERAPY	13		
INHALATION/OXYGEN THERAPY	14		
LABORATORY	15	25	00
X-RAYS	16	15	00
ADMIN. OF ANESTHESIA	19		
ADMIN. OF BLOOD	20		
BLOOD	21		
PHARMACY	22		
SUPPLIES – MEDICAL/SURGICAL	23		
OTHER (Describe) EKG	26	20	00
	27		
	28		
TOTAL	98	100	00

20. OTHER COVERAGE – REMAINING CHARGES			
MEDICARE – DEDUCTIBLE	29		
MEDICARE – CO-INSURANCE	30		
MEDICARE – OTHER	31		
OTHER (Describe)	32		
TOTAL	99		

21. Patient Status: [ ] Still Patient [X] Discharged [ ] Deceased

22. Nature of Services Rendered: Rheumatic Heart Disease

23. Surgical Procedures (Show date of each)
Primary: None
Secondary:

24. Claim related to employment? No. If yes, give name of employer.

25. Other Insurance or Liability Coverage
Name: None — Policy Number:

26. PROVIDER CERTIFICATION: I certify that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the provisions of Title VI of the Federal Civil Rights Act.

Susan Patrick — Provider Representative Signature
3/1/70 — Date Sent

REMARKS:

REMARKS:

CARBON PADS HERE

MC-4B (1-70)

PROVIDER COPY

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

NOTICE OF ADMISSION

1. Patient's Last Name	First Name	2. Sex ☐ Male ☐ Female	3. Birthdate Mo. / Day / Yr.	4.

5. Admission Date Mo. / Day / Yr.	6. Claim From-Date Mo. / Day / Yr.	7. Claim Thru-Date Mo. / Day / Yr.	8. Days	9. Leave Days	10. Attending Physician's Name (Please Print) Last First M.I.	11. Medical Record No.

12. Health Services Program Case No.	13. Patient Person No.	14. Provider Name and Address	15. Provider Number

16. Case Last Name	First Name

NOTE: First two digits of Health Services Program Case Number indicate county designation.

01 – Atlantic	04 – Camden	07 – Essex	10 – Hunterdon	13 – Monmouth	16 – Passaic	19 – Sussex
02 – Bergen	05 – Cape May	08 – Gloucester	11 – Mercer	14 – Morris	17 – Salem	20 – Union
03 – Burlington	06 – Cumberland	09 – Hudson	12 – Middlesex	15 – Ocean	18 – Somerset	21 – Warren

22. Admitting Diagnosis

This form should be mailed within 48 hours to the local County Medical Assistance Unit.

COUNTY COPY

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

HOSPITAL PHARMACY RX REPORT

PATIENTS NAME			HEALTH SERVICES PROGRAM NO.		PERSON NO.
DRUG SUPPLIED					PROVIDER NO.
MANUFACTURER		COST			

QUANTITY DISPENSED	DAYS SUPPLY	DOSAGE FORM	STRENGTH	RX NUMBER	CHECK ONE		DATE DISPENSED
					ORIG RX	REFILL	

COMPLETE AND ATTACH TO OUTPATIENT CLAIM
MC-4A WHEN TAKE HOME MEDICATIONS ARE DISPENSED.

MC-7(1-70)