KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

Psychology
# PART II
PSYCHOLOGY PROVIDER MANUAL

## Introduction

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### BENEFITS AND LIMITATIONS

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Procedure Codes and Nomenclature

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Appendix I
This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to psychology providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations and Appendices.

The **Billing Instructions** subsection gives an example of the billing form applicable to psychology services. The form is followed by directions for completing and submitting it.

The **Benefits and Limitations** subsection defines specific aspects of the scope of psychology services allowed within the Kansas Medical Assistance Program.

The **Appendix** subsection contains information concerning procedure codes. The appendix was developed to make finding and using procedure codes easier for the biller.

**HIPAA Compliance**

As a participant in the Kansas Medical Assistance program, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General’s Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
Introduction to the HCFA-1500 CMS-1500 Claim Form

Psychology providers must use the HCFA-1500 CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program. An example of the HCFA-1500 CMS-1500 claim form is shown in the Forms section at the end of this manual. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the HCFA-1500 CMS-1500 claim form to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line by line instructions for completion of the HCFA-1500 CMS-1500 are available in the General Billing Provider Manual, pages 5-14 through 5-19.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 11/03

Psychology services (including psychotherapy) require a copayment of $3.00 per office visit.

Do not reduce charges or balance due by the copayment amount. This reduction will be made automatically during claim processing.
Psychological Testing:
Psychological Testing/Assessment: Psychological testing/assessment documentation must:

- Clearly identify the questions and issues to be addressed
- Describe the individual at the time of the assessment
- Illustrate the need for initiating/continuing intervention
- Include the interpretation of findings with impressions and observations
- Give suggestions and recommendations

The beneficiary’s record must include the following components. Documentation is not required to be in a standard format.

A. Referral
- Source of referral
- Reason for referral

B. Pertinent Past and Present History

C. Treatment Plan
- Psychological tests, procedures and techniques to be used
- Reviewed and updated appropriately

D. Evaluation
- Interpretation of all completed/attemptsed psychological tests, procedures and techniques utilized with conclusions reached
- Recommendations that are related to meaningful aspects of the individual’s everyday existence

It is recommended that if an underlying cause of the maladaptive behavior is suspected of being physical in origin, a medical evaluation should precede a psychological evaluation. Results of the medical evaluation must also be documented in the record.

All limitations for psychological testing identified in Section 8400 of the provider manual remain in effect.
Kansas Medical Assistance beneficiaries will be assigned to one or more Medical Assistance benefit plans. The assigned plan or plans will be listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. From the provider’s perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990.

For example for the MediKan benefit plan:

Psychological testing and assessment is limited to four (4) hours every three calendar years, per consumer, regardless of provider. **Prior authorization will not override this limitation.**

Psychotherapy is limited to 24 hours of individual, group therapy or any combination of the two, per calendar year.
Psychological services are covered when provided by a Kansas licensed psychologist (Ph.D.). The psychologist must bill Medicaid directly for services. Medicaid does not reimburse psychologists to supervise someone else who is doing therapy. Uncertified assistants may be utilized in administering tests.

**Adult Care Home Services:**
Individual and group psychotherapy services provided in an adult care home are covered. Scheduled face-to-face meetings involving consultation concerning behavior management or problems associated with a group of NF/MH (Nursing Facility/Mental Health) patients is covered if ordered by the psychiatrist (M.D.). The meetings may include treatment staff, collaterals, or other agency representatives of the patient, including ICF/MH staff. A separate claim form must be submitted for each patient. Psychological testing/assessment is allowed in an ICF/MR (Intermediate Care Facility/Mental Retardation) facility.

**Mental Health Services for NF/MH Consumers:** Mental health services to consumers residing in a Nursing Facility for Mental Health are non-covered. Exception will be made for up to eight hours of therapy (90806) for individuals in acute trauma and for Targeted Case Management and Community Psychiatric Supportive Treatment during the 120 days just prior to discharge. These exceptions must be approved by the local quality enhancement coordinator. Other exceptions are psychiatric diagnostic interview (90801), and psychiatric pre-admission assessments (Y9514) which require no special approval.

**Children and Family Services (CFS) Contractors:**
Medicaid reimbursable services will not be paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to the Kansas Medical Assistance Program and will be reimbursed at the approved Medicaid rate. Prior authorization and other restrictions apply.

Refer to Section 2900 of your General Provider Manual for an all-inclusive list of the categories of service covered under the CFS contract.

**Family Therapy:**
Therapy that involves treatment of the family as a "system" with family being the focus of attention and change, specifically including children (may refer to adult children). The individual who is the Medicaid cardholder must be present during the delivery of service.

Family therapy is covered when there is a treatment plan containing a psychiatric diagnosis and goals of treatment. This limitation is monitored post-pay and requires the provider to document, in legible writing, the amount of time spent in therapy, major issues covered and changes in medication, diagnosis, condition, treatment plan or course of treatment. The provider must document that a review of the treatment plan has been conducted every three months.
Hospitalization:
Inpatient psychiatric admissions are covered only after a psychiatric preadmission assessment has been completed and a determination made that the most appropriate treatment setting is the hospital. No payment will be made for the hospital admission or related physician services without the completion of the preadmission assessment and determination that the hospital admission meets criteria. When seeking to admit a Kansas Medical Assistance Program consumer for inpatient treatment call 1-800-466-2222 to arrange for the assessment to be completed. This toll free number is staffed 24 hours a day by the Mental Health Consortium (MHC).

After receiving a request for a psychiatric preadmission assessment the MHC will contact the appropriate Community Mental Health Center (CMHC), or other approved provider if the admission is out of state, to complete the assessment face-to-face with the consumer. The hospital and admitting physician will be notified of the results verbally and via a letter from the MHC. If the admission was approved a prior authorization (PA) number will be included in the letter for the hospital and physician to utilize when billing for the approved admission and related services.

The primary care case manager’s referral is not required when the hospital admission has been approved by the MHC. The PA number assigned by the consortium must be noted on the claim.

Emergency Psychiatric: Screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric care. The individual is in crisis and not currently in a place of safety. A screening is completed immediately (no later than 3 hours) to determine appropriate placement.

Urgent Psychiatric: Screening is initiated if the individual meets one of the four independent criteria and is currently in a place of safety. An observation bed may be used to provide security and “observation” for individuals in imminent danger and to assist in the determination of the need for psychiatric hospitalization. In this instance, the screening must be completed as soon as possible and within two (2) days of the Consortium’s receipt of the request.

Planned Psychiatric: Non-crisis in nature, the screening must be completed within two (2) days of the Consortium’s receipt of the request. The admission must occur within two (2) days of the completion of the screening.

Retroactive Psychiatric: Individuals whose Medicare or other primary insurance denied payment for treatment, and who were Medicaid eligible at the time of admission. Other retroactive screens may be authorized for denied requests when eligibility is in question. If the individual receives a valid Medicaid card after a hospital admission has been completed, the Consortium requests the admission information, and completes a pre-admission screening within five (5) working days of the receipt of that information.
Cases Involving Retroactive Eligibility
The assessment must be requested and completed prior to the admission and related services being billed to Medicaid. The assessment will not be face-to-face and will be completed by the MHC. The MHC must complete the assessment within five (5) working days of receiving the request.

Cases Involving Other Insurance Or Medicare
If the admission and related services are billed to other insurance or Medicare first, the psychiatric preadmission assessment is not necessary. If the other insurance or Medicare does not allow payment on the claim, an assessment must be completed prior to billing the claim to Medicaid. The MHC will complete the assessment within five (5) working days of receiving the request. The assessment will not be face-to-face.

A face-to-face psychiatric preadmission assessment consists of a psychiatric diagnostic interview examination including history, mental status examination, and communication with family members and other collateral contacts in order to develop an appropriate treatment plan.

Individual and Group Psychotherapy:
Daily individual or group psychotherapy is required for inpatient hospital stays for psychiatric illness; however, group psychotherapy is not covered when provided by psychologists, physicians or CMHC’s in a hospital setting. Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital.

Individual and group psychotherapy are covered when there is a treatment plan containing a psychiatric diagnosis and goals of treatment. This limitation is monitored post-pay and requires the provider to document, in legible writing, the amount of time spent in therapy, major issues covered and changes in medication, diagnosis, condition, treatment plan or course of treatment. The provider must document that a review of the treatment plan has been conducted every three months.

Outpatient psychotherapy (individual, group, family) is not covered for consumers when provided by the same provider within the same quarter as partial hospitalization activity and targeted case management services, except for brief therapy for crisis or continuing evaluation purposes. If more than six hours of individual, group, or family therapy are billed in the same quarter, a Medical Necessity (MN) form must be completed and attached to the claim. Medical necessity is defined as the individual exhibiting behavior that is dangerous to himself/herself or others, and without additional therapy inpatient hospitalization would be required.
8400. Updated 11/03
KAN Be Healthy participants continue to be eligible for outpatient psychotherapy (individual, group, family), targeted case management, and partial hospitalization services concurrently.

Only 32 hours of individual or group psychotherapy (or any combination of these) are covered within a calendar year for non-KAN Be Healthy consumers.

KAN Be Healthy participants are allowed 40 hours of individual therapy or group psychotherapy (or any combination of these) per calendar year.

Psychotherapy is not covered for consumers whose only diagnosis is "mental retardation."

Psychological Services Not Covered by Medicaid:
- Conference calls
- Consultation in an ICF/MR facility
- Crisis intervention - site visit
- Hypnosis, biofeedback or relaxation therapy
- Occupational therapy
- Perceptual therapy
- Phone calls
- Psychometric testing when there is not continuous psychologist/beneficiary contact
- Psychotherapy for patients whose only diagnosis is mental retardation
- Services of social workers, psychiatric nurses, team or therapy coordinator
- Therapy provided by an uncertified assistant

Psychological Testing/Assessment:
Psychological Testing/Assessment is defined as the use, in any manner, of established psychological tests, procedures and techniques with the intent of diagnosing adjustment, functional, mental, vocational or emotional problems, or establishing treatment methods for persons having such problems.

Psychological testing and assessment is limited to four (4) hours every two calendar years, per beneficiary, regardless of provider. KAN Be Healthy participants are limited to six (6) hours of psychological testing and assessment every two calendar years. Prior authorization (PA) will not override these limitations.

Testing performed by an uncertified assistant, supervised by a Ph.D. psychologist, is covered when the psychological assessment conforms to the rules and regulations of the Behavioral Sciences Regulatory Board, 102-1-11.

Reimbursement for psychological testing includes the administration of standardized psychological tests, interpretation and the preparation of a written test report.
Special Psychological Program for Children:
This program was developed for children in the KAN Be Healthy Program who require intensive therapy above normal Medicaid limitations. Such therapy programs require prior authorization and are limited to six months duration.

The process of handling applications and approval for this special program will follow the guidelines listed below:

- Request prior authorization (through EDS) to initiate a plan of intensive care.
- Attach to the PA form a complete summary of psychological and medical history, prognosis, and treatment goals.
- Progress summaries shall be submitted to the Director of Medical Programs, Adult and Medical Services, upon request.
- If inpatient psychiatric treatment becomes necessary, the special outpatient treatment program will be suspended.
- The possible return of the child to the outpatient program after discharge from inpatient services will be re-evaluated by the Adult and Medical Services.

Substance Abuse Treatment:
Day treatment and alcohol and drug addiction treatment provided in an intermediate setting (e.g., Alcohol and Drug Addiction Treatment Facility) are covered. Inpatient alcohol and drug addiction treatment services are not covered.
APPENDIX I  Updated 11/03

PROCEDURE CODES AND NOMENCLATURE

The following codes represent an all inclusive list of psychology services billable to the Kansas Medical Assistance Program. Procedures not listed here are considered non-covered.

NC  -  Non-covered Kansas Medical Assistance Program service.

<table>
<thead>
<tr>
<th>COV. CODE</th>
<th>PROCEDURE CODE</th>
<th>NOMENCLATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>90801</td>
<td>Psychiatric diagnostic interview examination</td>
</tr>
<tr>
<td>90802</td>
<td>90802</td>
<td>Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication</td>
</tr>
<tr>
<td>90804</td>
<td>90804</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient</td>
</tr>
<tr>
<td>90805</td>
<td>90805</td>
<td>with medical evaluation and management services</td>
</tr>
<tr>
<td>90806</td>
<td>90806</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient</td>
</tr>
<tr>
<td>90807</td>
<td>90807</td>
<td>with medical evaluation and management services</td>
</tr>
<tr>
<td>90808</td>
<td>90808</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient</td>
</tr>
<tr>
<td>90809</td>
<td>90809</td>
<td>with medical evaluation and management services</td>
</tr>
<tr>
<td>90810</td>
<td>90810</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient</td>
</tr>
<tr>
<td>90811</td>
<td>90811</td>
<td>with medical evaluation and management services</td>
</tr>
<tr>
<td>90812</td>
<td>90812</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient</td>
</tr>
<tr>
<td>90813</td>
<td>90813</td>
<td>with medical evaluation and management services</td>
</tr>
<tr>
<td>90814</td>
<td>90814</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient</td>
</tr>
<tr>
<td>90815</td>
<td>90815</td>
<td>with medical evaluation and management services</td>
</tr>
<tr>
<td>PROCEDURE UPDATE 11/03</td>
<td>CODE</td>
<td>NOMENCLATURE</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>90816</td>
<td></td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90817</td>
<td></td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90818</td>
<td></td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90821</td>
<td></td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90822</td>
<td></td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90823</td>
<td></td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90824</td>
<td></td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90826</td>
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<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90827</td>
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<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90828</td>
<td></td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90829</td>
<td></td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90847</td>
<td></td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
</tr>
<tr>
<td>90853</td>
<td></td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>96100</td>
<td></td>
<td>Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour</td>
</tr>
<tr>
<td>W1083</td>
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<td>Program consultation NF/MH per individual (per hour)</td>
</tr>
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</table>

*Refer to Section 8400 for prior authorization requirements regarding psychological testing/evaluation.
FORMS SECTION

HCFA 1500
CMS-1500
**HEALTH INSURANCE CLAIM FORM**

1. **MEDICARE**
   - (Medicare#)
   - (Medicare’s SSA#)
   - (Medicare’s ID#)

2. **PATIENT’S NAME** (Last name, First Name, Middle Initial)
   - (Last name)
   - (First name)
   - (Middle initial)

3. **PATIENT'S BIRTH DATE** (MM YY)
   - (Month)
   - (Year)

4. **PATIENT'S SEX**
   - Male
   - Female

5. **PATIENT'S ADDRESS** (No., Street)
   - (Number)
   - (Street)

6. **PATIENT RELATIONSHIP TO INSURED**
   - Self
   - Spouse
   - Child
   - Other

7. **INSURER'S NAME** (Last Name, First Name, Middle Initial)
   - (Last name)
   - (First name)
   - (Middle initial)

8. **INSURER’S IDENTIFICATION NUMBER**
   - (SSN)
   - (ID#)

9. **INSURER’S POLICY GROUP OR PPO NUMBER**
   - (Policy group)
   - (PPO number)

10. **INSURER’S PLAN NAME OR PROGRAM NAME**
    - (Plan name)
    - (Program name)

11. **INSURER'S PAYMENT LIMIT**
    - (Payment limit)

12. **INSURER'S PLAN EXCLUSION**
    - (Plan exclusion)

13. **INSURER'S PLAN COVERAGE**
    - (Coverage)

14. **DATE OF PRESCRIPTION**
    - (Date)

15. **DOES PATIENT HAVE SAME INSURER ILLINOIS?**
    - Yes
    - No

16. **DATE PATIENT WAS INFIRMED TO WORK INCIDENT OCCUPIED FROM**
    - (Date)
    - (Month)
    - (Year)

17. **NAME OF PROVIDER: PHYSICIAN OR OTHER SOURCE**
    - (Name)

18. **RESERVED FOR LOCAL USE**
    - (Reserved)

19. **INSURER'S PLAN CODE**
    - (Plan code)

20. **INSURER'S PLAN REFERENCE NUMBER**
    - (Reference number)

21. **DATE OF SERVICE**
    - (Date)
    - (Month)
    - (Year)

22. **PHYSICIAN'S ADDRESS**
    - (Address)
    - (City)
    - (State)
    - (Zip Code)

23. **PROVIDER'S BILLING ADDRESS**
    - (Billing address)
    - (City)
    - (State)
    - (Zip Code)

24. **PHYSICIAN'S SIGNATURE**
    - (Signature)

25. **PHYSICIAN'S STATE REGISTRATION NUMBER**
    - (Registration number)

26. **PHYSICIAN'S IDENTIFICATION NUMBER**
    - (Identification number)

27. **INSURER’S PLAN NUMBER**
    - (Plan number)

28. **TOTAL AMOUNT BILLED**
    - (Amount)

29. **INSURER’S TOTAL AMOUNT**
    - (Amount)

30. **INSURER’S REMAINING AMOUNT**
    - (Amount)

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - (Signature)

32. **DATE**
    - (Date)

**PLEASE PRINT OR TYPE**

**APPROVED BY AMERICAN MEDICAL RECORDS ASSOCIATION**

**APPROVED C-125-2005/FORM 002-1000**

**APPROVED 05-05-2006**

**APPROVED 05-05-2006**

**APPROVED 05-05-2006**

**APPROVED 05-05-2006**

**APPROVED 05-05-2006**