

**Cumberland County  
Mental Health Center**

**REIMBURSEMENT  
POLICY  
AND  
PROCEDURES  
MANUAL**

SECTION D: Billing Procedures

1. General Information:

Insurance claims and client statements must be mailed out on a monthly basis. Qualified Mental Health Professional Status must be obtained for a therapist before claims can be filed. See Appendix H-6 for Qualified Mental Health Professional definition.

2. Non-Qualified Mental Health Providers:

Clients who have third party coverage and are seen by clinical staff who do not meet the requirement (QMHP) of filing for third party reimbursement will be interviewed and a fee established through normal procedures. The amount of money that the insurance would normally pay would be adjusted. The client would be responsible for the balance up to their ability to pay. We would not penalize a client because the therapist assigned is not a QMHP.

3. Submission of Claims:

A HCFA 1500 (see Appendix H-7) is required for all outpatient services claim filing. A UB 92 form is required for Therapeutic Leave billing only. The HCFA 1500 and UB 92 are generated by a computerized billing system on a monthly basis. The form must have all essential information completed. The full cost of eligible services will be billed to the insurance company.

All claims should be submitted to the insurance companies by the 15<sup>th</sup> of the following month.

If an insurance company has not responded within 60 days with a payment, denial, etc., an inquiry should be sent to the insurance company. Claims that have denied should be researched and resubmitted or appealed within 30 days of denial.

4. Statements to Client:

Statements to clients are processed by a computerized billing system on a monthly basis. Statements are mailed to clients by the 15<sup>th</sup> of each month. Clients must continue to receive statements during the collection process. Statements will include date and description of all services provided to client during a given month. Also included will be a list of payments received, services billed to third party payors, and the amount due from client. See Appendix H-8 for Client Statement.

PLEASE DO NOT  
STAPLE IN  
THIS AREA

CHAMPUS  
BCBS OF SC  
PO BOX 100502

FLORENCE, HEALTH INSURANCE CLAIM FORM  
SC 29501-0502

FORM APPROVED  
OMB NO. 0938-0028

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

MEDICARE (MEDICARE NO.)   
  MEDICAID (MEDICAID NO.)   
  CHAMPUS (SPONSOR'S SSN)   
  CHAMPVA (VA FILE NO.)   
  FECA BLACK LUNG (SSN)   
  OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)  
DOE, Janie L.

2. PATIENT'S DATE OF BIRTH  
10 | 01 | 76

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)  
Doe, John Q.

4. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)  
123-45-6789

5. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)  
4 June Smith  
123 Main Street  
Fayetteville, NC 28301

6. INSURED'S SEX  
MALE  FEMALE

7. PATIENT'S RELATIONSHIP TO INSURED  
SELF  SPOUSE  CHILD  OTHER

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)  
USA/AD/E6

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)  
BCBS OF NORTH CAROLINA  
June Smith  
098-76-5432

10. WAS CONDITION RELATED TO:  
A. PATIENT'S EMPLOYMENT  
YES  NO   
B. ACCIDENT  
AUTO  OTHER

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)  
EFFECTIVE DATE: 10-01-76  
EXPIRATION DATE: 09-31-91  
TELEPHONE NO.

11.A. CHAMPUS SPONSOR'S STATUS  
ACTIVE  DECEASED   
DUTY  RETIRED

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING). I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.  
SIGNED SIGNATURE ON FILE DATE 01-31-89

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.  
SIGNED (INSURED OR AUTHORIZED PERSON) SIGNATURE ON FILE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY  
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)  
CUMBERLAND COUNTY MENTAL HEALTH CENTER

21. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 1, ETC. OR OX CODE  
1. 313.81

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?  
YES  NO

23. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, CHECK HERE  
EMERGENCY

24. PRIOR AUTHORIZATION NO.

A. DATE OF SERVICE FROM	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE IDENTIFY (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DATE OR UNITS	G. P. / G. S.	H. LEAVE BLANK
01-03-89	3	90801 Debra Sharpe, Social Worker INTAKE INTERVIEW		39.00	060 MIN		
01-11-89	3	90815 Debra Sharpe, Social Worker INDIVID PSYCH W/FAMILY INCLUDED		39.00	060 MIN		
01-17-89	3	90862 Tom Grove, Psychologist PSYCHOLOGICAL EVALUATION #4		78.00	120 MIN		
01-23-89	3	90825 Steven Fleishman, MD PSYCHIATRIC EVALUATION		30.00	030 MIN		
01-23-89	3	90843 Debra Sharpe, Social Worker INDIVIDUAL PSYCHOTHERAPY		19.50	030 MIN		
01-31-89	3	90810 Tim Campbell, Social Worker GROUP PSYCHOTHERAPY		46.80	120 MIN		

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE) OR CREDENTIALS & CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE NOT A PART THEREOF.  
DATE Ralph Moress, MD 02-08-89

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)  
YES  NO

27. YOUR SOCIAL SECURITY NO.  
310000655

28. YOUR EMPLOYER'S ID NO.  
566000291

29. TOTAL CHARGE 252.30

30. AMOUNT PAID 0

31. BALANCE DUE 252.30

32. PHYSICIAN'S NUMBER AND/OR OTHER NAME ADDRESS ZIP CODE  
310000655  
CMBRLND CO M/H CTR  
PC 6CX 2065  
FAYETTEVILLE NC 29302

BERLAND CO MENTAL HEALTH  
O. BOX 1069  
BRADFORD AVENUE  
PETTEVILLE NC 28302-1069  
0) 323-0601

Statement Date: 07/12/2002

Page 1

Client :

Bill to:

Current Amount Due \$3,106.00  
Please Pay By 08/10/2002

Amount Paid: \_\_\_\_\_

Please detach here and return the top portion with your payment.

Service Date	Service Description	Service Charge	Client Charge	Payment /Adjust	Client Balance
5/17/02	Balance Forward	3046.00			3046.00
7/08/02	IND THER-IP/RES/SA	60.00	60.00		3106.00

Service Balance: 3,106.00

Please pay this amount: 3,106.00

Current	Over 30 Days	Over 60 Days	Over 90 Days	Total Client Bal.
60.00	0.00	0.00	3,046.00	3,106.00

Client :  
Statement Date: 07/12/2002

PURSUANT TO NCGS 25-3-512, \$25.00 PROCESSING  
FEE WILL BE CHARGED ON ALL RETURN CHECKS.

VIII. 4a. **Ongoing Capital Improvement Projects**

Spainhour Center

Building is owned by Cumberland County  
Renovations and replacement of roof  
Cost: \$128,145.00

Roxie Avenue Center

Building is owned by Cumberland County  
Renovations and replacement of roof  
Cost: \$125,000.00

Executive Place

Installation of new and upgrading of telephone system  
Building is owned by Cumberland County  
Cost: \$173,153.00

There have not been any purchases or sales of Mental Health Property in the last 36 months.

The Executive Place building is on the books as being purchased 6/16/97.

VIII. 4b. **Long Term Bonded Debt**

Executive Place			Roxie Avenue Center		
Fiscal Year	Principle	Interest	Fiscal Year	Principle	Interest
2003	315,000	102,991	2003	115,617	80,194
2004	315,000	89,210	2004	121,829	74,298
2005	315,000	75,350	2005	128,042	67,963
2006	315,000	60,860	2006	134,944	61,177
2007	315,000	46,055	2007	142,537	53,890
2008	315,000	30,935	2008	150,130	46,050
2009	310,000	15,500	2009	150,130	46,050
2010	0		2010	150,130	46,050
2011	0		2011	158,068	37,793
2012	0		2012	167,041	29,099
2013	0		2013	176,359	19,912
2014	0		2014	185,668	10,212
<b>TOTAL</b>	<b>\$2,200,000</b>	<b>\$420,901</b>		<b>\$1,780,495</b>	<b>\$572,688</b>

**Total Principle**      **\$3,980,495**  
**Total Interest**        **993,589**  
**GRAND TOTAL**        **\$4,974,084**



VIII 46 cont

FA001 RUN-DATE: 08/06/2002 COUNTY OF CURREBLAND PROPERTY NUMBER LISTING PAGE 4

CD	BLDG	ROOM	DEPT	PROP	NUMB	DATE	ADDR	CHECK	FED	MC	D	N	COST	DESCRIPTION	ADDER	COST
K	BLDG	ROOM	DEPT	PROP	NUMB	DATE	ADDR	CHECK	FED	MC	D	N	COST	DESCRIPTION	ADDER	COST
D	65		4341	80331	08/28/1996	105622							16789	TELEPHONE SYSTEM FOR SPAIRNOOR SCHOOL-DIGITAL KEY		
F	36		4341	804517	01/10/2000	289875							3676	TELEPHONE SYSTEM MERIDIAN VOICE MAIL-Add to 801399		
F	65		4341	910170	09/18/1999	235506	4/285						13567	A/C CARRIER MOL 5073008-561 5074004C		
I	36		4341	910292	09/31/2000	289510	??						4155	CIT SW METAFRAME 1.8 777 - 3871400AC		
I	36		4341	910316	06/11/1997								361306	LAND- (PIN 0427-32-4891 DEED 4618/586) WINDING CREE		
B	32		4335	910317	06/11/1997								871193	BLDG- (PIN 0427-32-4891 DEED 4618/586) WINDING CREE		
B	32		4335	910317	06/11/1997								477585	LAND- WINDING CREEK EXEC BLDG (ADD TO 775179 AFTER		
D	32		4335	910317	06/11/1997								4321	IMPR- WINDING CREEK EXEC BLDG (ADD TO 775179 AFTER		
D	32		4335	910317	06/11/1997								2688	CPU COMPAD PROLIANT M1356 P3-608 SERVER SM- /YX2701		
I	35		4351	910399	12/19/2000	280183	4/252						2688	PC DELL LATITUDE C600 7000HZ NOTEBOOK SM- IXX 2701		
I	35		4351	910400	12/19/2000	280183	4/252						2688	PC DELL LATITUDE C600 7000HZ NOTEBOOK SM- IXX 2701		
D	36		435D	910500	05/18/2001	306187	4/635	??					33971	LAMER VOICEMAIL 2400 DIGITAL DICTATION SYSTEM (		

TOTAL

14013173

