Approved 4/1/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by SENATOR RICHARD L. BOND
Chairperson
at

9:00 a.m./~~p.m.~~ on MONDAY, MARCH 25, 1991 in room 529-S of the Capitol.

All members were present ~~except~~:

Committee staff present:
Bill Wolff, Research Department
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:
Representative Larry Turnquist
Dick Brock, Kansas Insurance Department
Chip Wheelen, Kansas Medical Society
Tom Bell, Kansas Hospital Association
Bill Sneed, Health Insurance Association of America
Harold Riehm, Kansas Association of Osteopathic Medicine
John Alquest, SRS Services
David Hanson, Kansas Life Association

Chairman Bond called the meeting to order at 9:08 a.m.

HB 2216 - Universe health insurance claim form.

Representative Larry Turnquist appeared before the committee in support of this proposed legislation which would utilize a single, universal form for the filing of accident and health insurance claims in Kansas. Representative Turnquist pointed out that our system in the United States spends a greater amount on administrative costs than the Canadian health care system and part of the reason is the multiplicity of forms. He further stated that the actual development of the form would be left up to the Insurance Commissioner's office. (Attachment 1)

Dick Brock, Kansas Insurance Department, informed the committee that administrative uniformity usually resulted in a more efficient, cost-effective and better understood process. Since most providers submit claims on behalf of their patients, Mr. Brock advised the committee that he called his wife, a medical secretary, and she said that anything that could be done to require some uniformity in health insurance claim forms would be most helpful. (Attachment 2)

Chip Wheelen, Kansas Medical Society, advised the committee that his organization originally supported the bill but that the House had added amendments that they find objectionable. One of Mr. Wheelen's objections was new section 2 requiring all health care providers to assist their patients in completing accident and sickness insurance claim forms. He stressed that, although many providers assist voluntarily, requiring them to do so, by statute, imposes a new burden and possible legal liability. Mr. Wheelen also stated that, subsequent to the House hearings, his organization had decided that a similar law, preferred by the Health Insurance Association of America, would also be more acceptable to them. (Attachment 3)

Tom Bell, Kansas Hospital Association, addressed the committee in support of a universal form but desiring the removal of new section 2. Mr. Bell further stated that they also supported the more uniform law as presented by the Health Insurance Association of America (HIAA). (Attachment 4)

Bill Sneed, Health Insurance Association of America, advised the committee that while they were in support of uniformity they would like to have it also in other states they serve and not just Kansas. He said that his amended language was pattered after Indiana regulations. He further stated that Indiana found that each area of health care needs certain information that the other does not, therefore, they allow each

group to have their own form. Mr. Sneed's balloon also deletes new section 2. (Attachment 5)

During the discussion which followed, a committee member objected to deletion of new section 2 saying that the forms are very complicated and when people reach a certain age they need assistance with the forms. Mr. Sneed replied that making assistance mandatory usually resulted in increased costs and at a time when we are trying to reduce costs.

Harold Riehm, Kansas Association of Osteopathic Medicine, stood in support of the bill but urging deletion of new section 2.

John Alquest, SRS Services, informed the committee that he supported the universal form concept if specific forms, developed as national uniform claims, could be retained. He advised that the cost of new claim forms would be $65,000 with ongoing costs of $6,000 per month through 1995. (Attachment 6)

HB 2441 - Investments of insurance companies.

Dick Brock, Insurance Department, advised the committee that this bill will take advantage of the opportunity to avoid the federal preemption if it is enacted and becomes effective on or before October 3 of this year which is when the seven year period expires. Mr. Brock further stated that enactment of this bill would allow Kansas insurers and insured to retain control over their investment alternatives. Mr. Brock offered an amendment to the bill to temporarily allow certain specific purchases of securities under state law. (Attachment 7)

David Hanson, Kansas Life Association, informed the committee that he supports HB 2441 with Mr. Brock's amendment. Mr. Hanson also stated that they would feel more comfortable working with the state insurance department than with federal regulations.

Senator Kerr made a motion to amend HB 2441 as proposed by Mr. Brock. Senator Salisbury seconded the motion. The motion carried.

Senator Kerr made a motion to recommend HB 2441, as amended, favorable for passage. Senator McClure seconded the motion. The motion carried.
The Chairman requested the committee's wishes concerning HB 2216.

Senator Salisbury made a motion to amend HB 2216 by keeping new section 1; adding "b" and "c" from Mr. Sneed's balloon and striking new section 2. Senator Reilly seconded the motion. The motion carried.

Senator Salisbury made a motion to recommend HB 2216, as amended, favorable for passage. Senator Yost seconded the motion. The motion carried.

Senator Strick made a motion to approve as written the minutes for Wednesday, March 20, and Thursday, March 21, 1991. Senator Yost seconded the motion. The motion carried.

The meeting adjourned at 9:56 a.m.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: Mon. Mar 25, 91

NAME	ADDRESS	ORGANIZATION
Sandra Hazlett	Medical Services	SRS
John Algeo		SRS
Bill Sneed	Topeka	KFAA
Tom Bell	Topeka	Ks-Hosp Assn.
Joe FURJANIC	Topeka	KCA
Michelle Lieston	Topeka	John Peterwood & Associates
Marla Simpkins	Topeka	KS Foundation for Medical Care
Dave Hanson	Topeka	Ks Life Assn
Nancy Zogleman	Topeka	BC/BS of Ks
Anita Larson	Topeka	SBG, Inc
JIM OLIVER	"	PIAK
M. Haaver	"	Capitol-Journal
J. RIEGER	"	KAOM
Dick Brock	"	Ins Dept
Lee Wright	Overland Park	Farmers Ins Group
Gary SHELLHORN	TOPEKA	KNS
LARRY MAGILL	"	IIAK

Testimony on HB 2216 - Universal Accident and Health Claim Form

By Representative Larry Turnquist

I have had a belief for sometime that we should be utilizing a single, universal form, or possibly forms, for the filing of claims in relationship to accident and health insurance claims in this state. Presently companies can have their own set of claim forms which ask for approximately the same kinds of information but are arranged and worded in a different fashion. This causes a great deal of inefficiency in the preparation of these claims by office personnel and duplication of effort if more than one insurance company is involved.

As was brought out during the joint hearings on the Canadian health care system, currently our system in the United States does expend a greater amount of premiums for administrative expenses than other health care systems. One reason is the use and processing of such a multitude of forms.

Besides alleviating administrative time in the completion of forms, one universal form would help eliminate the omission of required information which is oftentimes erroneously omitted in the preparation of such forms and causes delay in processing.

Attachment 1
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Along with improving efficiency, there should also be a cost reduction in form planning and printing. Such a universal claim form would allow the state or any other interested organization to set up a health and/or medical information data base. This data base would allow for the development of statistical data which would be of benefit to various health organizations, insurance companies, and the state in the planning of health care programs.

Possible benefits from having access to such current data are limitless. The only way to have such data made available to the public and organizations is the use of a universal claim form. It would be very difficult to garner this information from the various claim forms that are now in use.

The actual planning and development of this form would become the responsibility of the Kansas Insurance Commissioner's Office. They have the expertise and the knowledge to develop such a form. Quite possibly this form could be patterned after other forms such as Medicare's form, which is already accepted by some insurance companies. Insurance companies, health maintenance organizations, trade associations, and other interested parties would be involved in the development of such an instrument.

Thank you for the opportunity to speak before the committee. I appreciate your support and would urge you to vote for the favorable passage of this bill as I am convinced it would be of benefit to both the insurance industry and the consumers.

Testimony By
Dick Brock, Kansas Insurance Department
Before the Senate Financial Institutions and Insurance Committee
on House Bill No. 2216
March 25, 1991

House Bill No. 2216 requires the Commissioner to devise a uniform claim form for accident and sickness insurance claims. In addition, the bill requires all accident and sickness insurers, health maintenance organizations and Blue Cross and Blue Shield plans to begin using the form not later than six months following notification to those entities effected that such form has been developed and providing them a copy with appropriate instructions.

The Insurance Department has no problem with this assignment -- it would seem to be "doable" -- and there are few, if any, situations where administrative uniformity does not result in a more efficient, cost-effective and a better understood process.

In checking with our Consumer Assistance Division, I was informed that two forms already exist which are widely accepted by insurers. I have attached a copy of these forms to my testimony and, as you will note, one of them is designed for physician services and one is for hospital services. Because these are widely accepted and because there are two different forms, the House Committee on Insurance amended the bill so that plural forms could be developed. However, it appears the "a" appearing at the end of line 17, page 1 should have been stricken from it to read properly.

Our Consumer Assistance Division also reported that they don't encounter many complaints from consumers regarding the submission of claims for "general" medical and/or hospital services but there are some misunderstandings and problems regarding the submission of claims for

Attachment 2
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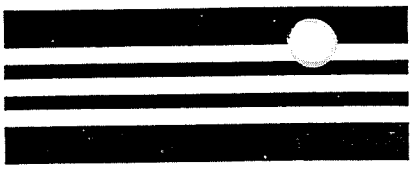
various "specialty" type services or policies. Vision care, cancer policies, drugs, disability income are some of the conditions and products in this category.

Having advised you of the experience of our Consumer Assistance Division, I also must tell you that I doubt that our Department is in a position to accurately evaluate the situation. This is because most provider offices and most, probably all, hospitals submit claims for or on behalf of their patients. Therefore, the acceptance, non-acceptance and other administrative problems caused by claim forms are handled at that level.

To confirm this, I called my wife who is a medical secretary but whose duties include the processing of insurance claims in an ophthalmologist's office. She asked me to tell you that anything that could be done to acquire some uniformity in health insurance claim forms would be very helpful from their perspective. She indicated that most companies will accept the HCFA 1500 form but many do not. She also said that in the past, there was a universal claim form that virtually all insurers she dealt with would accept but about 10 years or so ago many companies started requiring their own form. She did not know and I have been unable to discover the reason.

Finally, I would note that House Bill No. 2216 was also amended by the House Committee to apply its operative requirement to nonprofit dental, optometric and pharmacy service corporations as well as nonprofit medical and hospital service corporations and New Section 2, which seems to be self-explanatory, was added.

PLEASE DO NOT STAPLE THIS AREA



FOR OMB ED 008

HEALTH INSURANCE CLAIM FORM

(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)

2. PATIENT'S DATE OF BIRTH

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

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

5. PATIENT'S SEX — MALE ☐ FEMALE ☐

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)

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

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐

B. ACCIDENT — AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11.a. CHAMPUS SPONSOR'S:

STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE

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 DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON)

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

16.a. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY — FROM THROUGH

DATES OF PARTIAL DISABILITY — FROM THROUGH

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

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

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

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐

PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	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. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE:

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

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

I.D. NO.

2-3

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

1500044

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form **HCFA-1500 (1-84)**
Form **CHAMPUS-501**
Form **OWCP-1500**
Form **RRB-1500**

1	2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL

5 BC/BS PROV. NO.	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV.D.	24 N-C.D.	25 C-I.D.	26 L-R.D.	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34

CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REPL	42 NOT RP.	43 DED	44 SP PROG.	45

	46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a								
b								

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A							
B							
C							
			DUE FROM PATIENT ▶				

65 INSURED'S NAME	66 SEX	67 P.REL.	68 CERT.-SSN-HIC.-ID. NO	69 GROUP NAME	70 INSURANCE GROUP NO.
A					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN. CODE	OTHER DIAGNOSES CODES 78	79	80	81

82 P.C.	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	85 OTHER PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE

PSRO UR DATA 87 CD	88 APP. FROM	89 APP. THROUGH	90 GRC.	91 TREATMENT AUTH.	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID.

94 REMARKS

VERIFIED N-C STAY DATES FROM	THROUGH	FOR INTERMEDIARY USE ONLY PR. PSC. D.	

AMT. REIMBURSED	N-PYM. CD			APPROV. BY	DATE APPROV

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X

96 DATE 2-4

UB-82 HCFA-1450

PAYER COPY

KMS

KANSAS MEDICAL SOCIETY

1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 25, 1991

TO: Senate Financial Institutions and Insurance Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: House Bill 2216; Standard Health Insurance Claim Forms

Thank you for this opportunity to testify on HB 2216. The KMS was one of the proponents of this bill when it was considered by the House Committee. Subsequent to that hearing, the bill was amended in a fashion that we find objectionable.

New section 2 of HB 2216 would require all health care providers to assist their patients in completing accident and sickness insurance claim forms. While this may seem to be good public policy, we respectfully suggest that it imposes a new burden with possible attached legal liability. Assisting a policyholder regarding his or her contractual relationship with a third party insurer has nothing to do with the ability of a physician to practice competent medicine and surgery, nor should it be a requirement imposed on the physician. In fact, Attorney General's Opinion 90-130 indicates that the contractual relationship between the patient and the insurer is entirely outside the scope of the Healing Arts Act. We believe that this opinion corroborates our position on this subject.

Also subsequent to the House Committee hearings on HB 2216, we have discussed a similar law that is supported by the Health Insurance Association of America. Upon review, it would appear that the "model" law preferred by the HIAA would be more acceptable to the Kansas Medical Society and it does not contain features unrelated to the subject of standardized claim forms.

The original purpose of HB 2216 was to reduce the amount of time and thus cost involved in the process of administration of reimbursement for health care services. Obviously, we support that goal. It is for this reason that we urge you to consider legislation that accomplishes exactly that; a streamlined process for administration rather than other policy objectives.

Thank you for considering our concerns. We respectfully request that you amend HB 2216 appropriately before taking any action on the bill.

CW/cb

Attachment 3
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3/25/91

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 25, 1991

TO: Senate Financial Institutions and Insurance Committee

FROM: Kansas Hospital Association

RE: House Bill 2216

The Kansas Hospital Association appreciates the opportunity to comment on the provisions of House Bill 2216. This bill would require the Commissioner of Insurance to devise a universal form to be utilized by every insurance company offering any type of accident and sickness policy for individuals in this state.

We support the idea of the preparation of a universal form or forms. We think that this could be helpful in reducing confusion on the part of both consumers and providers. We do, however, have some concerns about new Section 2 of House Bill 2216. This section would require health care providers to assist any of their patients in completing accident and sickness insurance claim forms upon request of such patients.

As a practical matter, such advice and assistance already occurs in many instances. To adopt a state law requiring such assistance, however, creates problems for health care providers while providing no additional benefit to patients. First, there is no reason to assume that health care providers have any special expertise in filling out such forms. To require such providers to do something for which they have no special expertise not only places the provider in a bind, but also gives the patients false assurance that they can rely on the assistance provided.

In addition, we think that new Section 2 essentially creates a new cause of action against health care providers in Kansas. This section places a duty upon providers to assist patients in completing these forms. As such, when that assistance is not provided, or when that assistance is provided in a potentially improper manner, the health care provider will potentially be liable for any resulting damages. There could potentially be a new class of lawsuits based on a health care provider's inability to correctly fill out an insurance claim form. We do not think this is the legislative intent behind House Bill 2216.

We understand that the Health Insurance Association of America has a proposal to change the bill to comply with a more uniform law. We have no problems with that approach. Our main concern is new Section 2 and the problems it creates for both providers and patients.

Thank you for your consideration of our comments.

Attachment 4
FIVI
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1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

As Amended by House Committee

Session of 1991

HOUSE BILL No. 2216

By Representative Turnquist

2-12

AN ACT relating to insurance; requiring the commissioner of insurance to devise ~~a~~ universal accident and sickness claim ~~form~~ forms and providing for ~~its~~ usage thereof; mandating assistance of health care providers in completing forms; amending K.S.A. 40-19a10 and 40-19b10 and K.S.A. 1990 Supp. 40-19c09 and 40-19d10 and repealing the existing ~~section~~ sections.

Be it enacted by the Legislature of the State of Kansas:

~~New Section 1. The commissioner of insurance shall devise a universal form forms to be utilized by every insurance company, including health maintenance organizations where applicable, offering any type of accident and sickness policy covering individuals residing in this state for the purpose of receiving every claim under such policy by persons covered thereunder. In the preparation of such form forms, the commissioner may confer with representatives of insurance companies, health maintenance organizations, trade associations and other interested parties. Upon completion and final adoption of such form forms by the commissioner, the commissioner shall notify those companies affected by sending them a copy of such form forms and an explanation of the requirements of this section. Every such company shall implement utilization of such form forms not later than six months following the date of the commissioner's notification.~~

DELETE

~~New Sec. 2. Health care providers, including institutional providers, shall assist any of their patients in completing accident and sickness insurance claim forms upon request of such patients.~~

DELETE

Sec. 2. ~~Sec. 2 3.~~ K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of ~~K.S.A. 1990 Supp. 40-2250 and 40-2251 and~~ *section 1 of this act,* to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-

NEW LANGUAGE

New Section 1. Uniform Claim forms. (a) The Commissioner shall prescribe by rule, after consultation with providers of health care or treatment, accident and sickness insurers, hospital, medical, and dental service corporations and other prepayment organizations, such accident and sickness insurance claim forms as the commissioner determines will provide for uniformity and simplicity in insurance reporting. The forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to the providing of care, treatment or services, sufficient for the purpose of meeting the proof requirements of an accident or sickness insurance policy or a hospital, medical, or dental service contract.

(b) An accident and sickness insurer may not refuse to accept a claim submitted on duly promulgated uniform claim forms. However, an insurer may accept claims submitted on any other form.

(c) An accident and sickness insurer does not violate subsection (a) by using a document that the accident and sickness insurer has been required to use by the federal government or the state.

Attachment 5
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237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2216 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. ~~1989~~ *1990* Supp. 40-2221a, 40-2221b, 40-2229 ~~and~~, 40-2230, *40-2250 and 40-2251*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

~~Sec. 4.~~ K.S.A. 40-19a10 is hereby amended to read as follows: 40-19a10. Such corporations shall be subject to the provisions of *section 1 of this act and to the provisions of* K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,102, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, 40-3301 to 40-3313, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

~~Sec. 5.~~ K.S.A. 40-19b10 is hereby amended to read as follows: 40-19b10. Such corporations shall be subject to *the provisions of section 1 of this act and to the provisions of* K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,102, 40-2a01 to 40-2a19, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3312, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

~~Sec. 6.~~ K.S.A. 1990 Supp. 40-19d10 is hereby amended to read as follows: 40-19d10. Such corporations shall be subject to the provisions of *section 1 of this act and to the provisions of* K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,102, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, 40-3301 to 40-3313, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

~~Sec. 7.~~ K.S.A. 40-19a10 and 40-19b10 and K.S.A. 1990 Supp. 40-19c09 ~~is~~ and 40-19d10 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

Rule 23

ACCIDENT AND SICKNESS INSURANCE — CLAIM FORMS

1-23-1 Authority to promulgate rule; effective date

Sec. 1. By authority vested in the Insurance Commissioner under the terms of I.C. 27-8-5.5-2 which became law in this state effective June 1, 1977, the following regulation *[760 IAC 1-23]* is to become effective on September 1, 1977. This action is predicated upon the need to establish uniformity of reporting data by providers of health care or treatment for the processing of health care and health insurance benefits. (Department of Insurance; Reg 24, Sec 1; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 528)

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

1-23-2 Approved forms

Sec. 2. All accident and sickness insurers, hospitals, medical and dental service corporations, and other prepayment organizations must accept forms approved by this Department for the administration of benefit payments.

It is the opinion of the Commissioner that the interests of the insuring public would be best served by adoption of forms developed for nationwide use by national health care provider organizations, health insurers and other prepayment organizations. Accordingly, the following forms are hereby adopted and approved for use in this state:

ATTENDING DENTIST'S STATEMENT — ADS (75), (Exhibit I), developed under the auspices of the American Dental Association by its Task Force representing dental insurance underwriters.

HEALTH INSURANCE CLAIM FORM — 6-74, (Exhibit II), developed under the auspices of and approved by the American Medical Association by its WORK GROUP on attending physician's billing and insurance reporting forms representing health insurers.

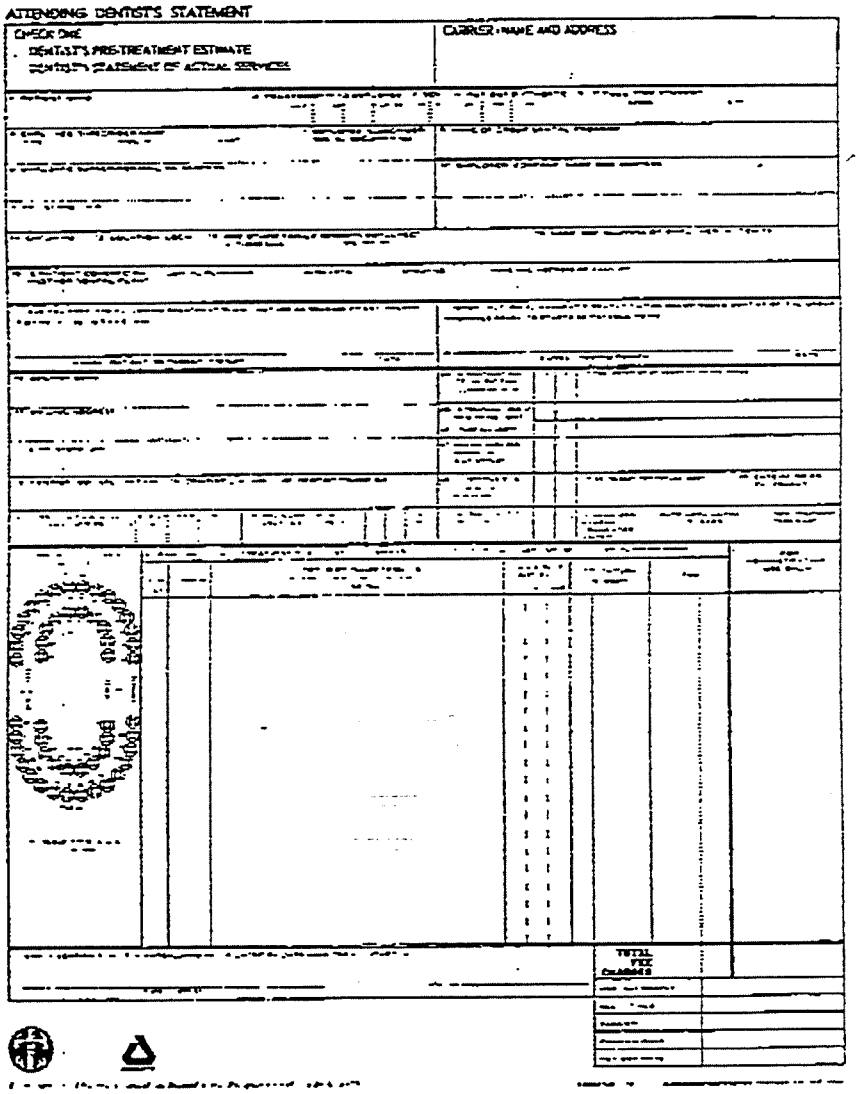
UNIFORM HOSPITAL BILLING FORM — UB-92 HCFA-1450, (Exhibit III), developed under the auspices of the Health Care Financing Administration of the Department of Health and Human Services.

LONG-TERM DISABILITY INCOME — APS-LT/P&T DIS (75), (Exhibit IV), developed by the Standard Forms Committee of the Health Insurance Association of American Council on Consumer and Professional Relations and approved by the American Medical Association Committee on Health Care Financing.

VISION INSURANCE CLAIM FORM — VICF (75), (Exhibit V), developed by the Standard Forms Committee of the Health Insurance Association of American Council on Consumer and Professional Relations and approved by the American Optometric Association. (Department of Insurance; Reg 24, Sec 2; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 529)

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

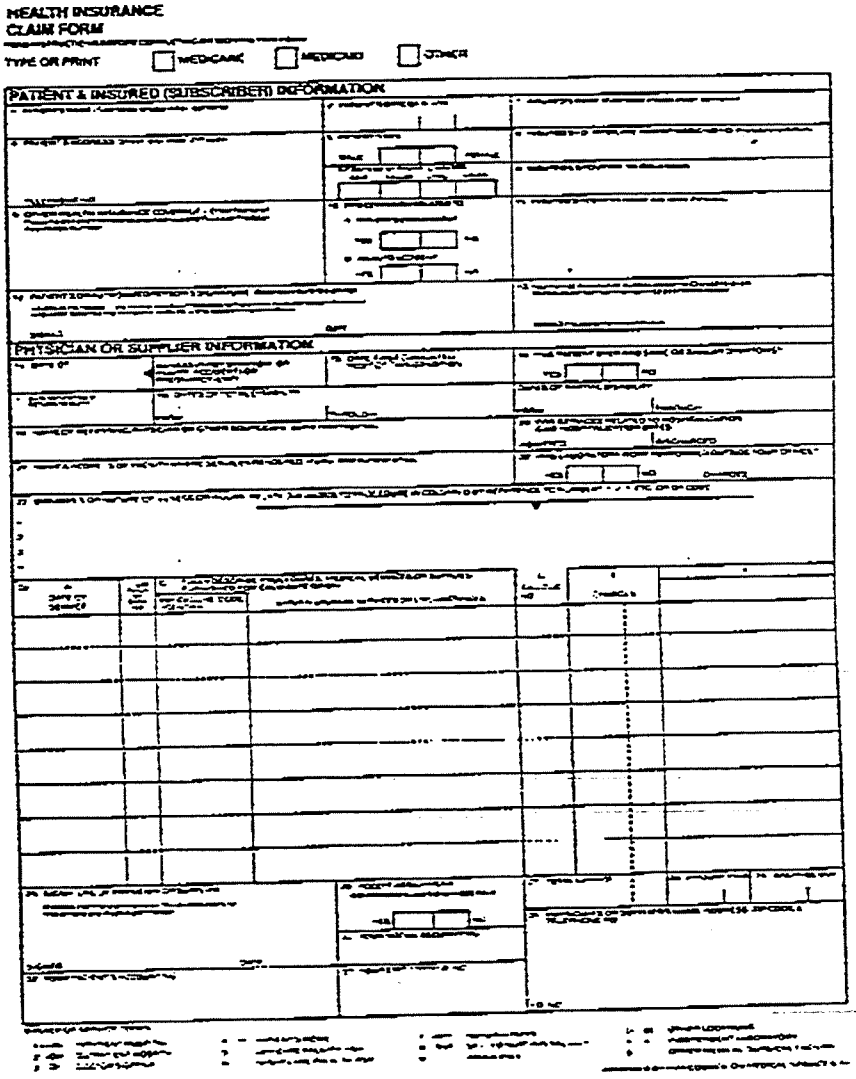
EXHIBIT 1



6/80

5-5

EXHIBIT II


HEALTH INSURANCE
CLAIM FORM

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

6/80

5-6

GENERAL PROVISIONS

EXHIBIT II — Continued

HEALTH INSURANCE CLAIM FORM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the carrier, if this is less than the charge submitted.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare regulations.

For services to be considered as 'incident to' a physician's professional service 1) they must be rendered under the physician's immediate personal supervision by his employee, 2) there was a covered physician's service rendered of which the other services are an integral, although incidental part, 3) they must be kinds commonly furnished in physicians' offices, and 4) the services of nonphysicians must be included on the physicians' bill.

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal laws.

MEDICAID PAYMENTS: I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payment claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.

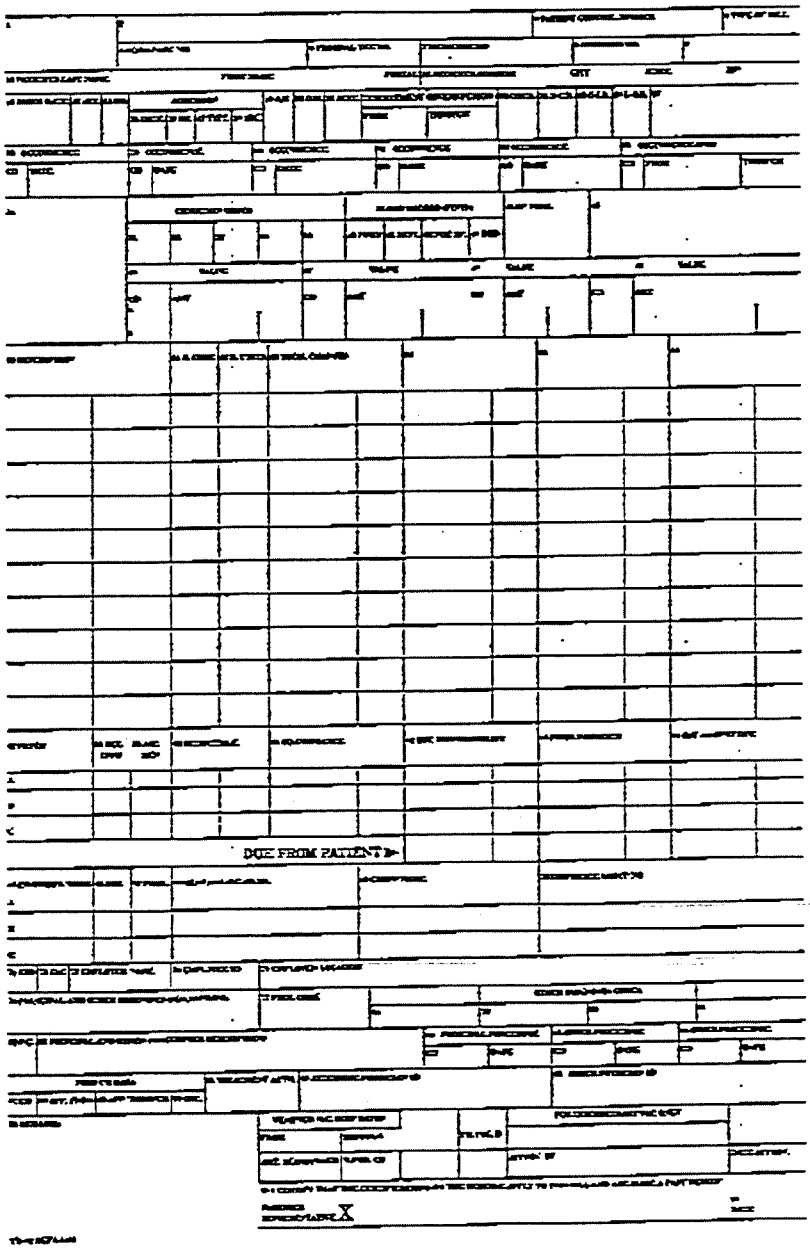
Revised 12/7[illegible]

Additional forms may be purchased from:
Order Department OP-40[illegible]
American Medical Association
PO Box 821
Monroe, WI 53566

[illegible]

5-1

EXHIBIT III



GENERAL PROVISIONS

EXHIBIT III – Continued

SPACE FOR ADDITIONAL BILLING REQUIREMENTS AS NEEDED

Certifications Relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this bill:

1. If third party sponsor benefits are indicated as being assigned, on the face hereof; appropriate assignments by the insured and signature of patient or parent or legal guardian covering authorization to release information are on file. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds based in whole or in part upon an assertion that no valid assignment of the benefits to the hospital was made.

2. If patient occupied a private room for medical necessity, any required certifications are on file.

3. Physician's certifications and recertifications, if required by contract regulations, are on file.

4. For Christian Science Sanitariums, verifications and if necessary, recertification of the patient's need for sanitorium services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal regulations and, if required by other contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained, and necessary information will be furnished to a governmental agency upon request.

7. For Medicare purposes: If the patient has indicated that other Health Insurance or State Medical Assistance Agencies will pay part of his medical expenses, and he wants information about this claim released to them upon their request, necessary authorization is on file.

8. For Medicaid purposes: This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealments of a material fact, may be prosecuted under applicable Federal or State laws.

9. For CHAMPUS purposes:

This is to certify that:

(a) the foregoing information is true, accurate, and complete;

(b) The patient has represented that by a reported residential address greater than 40 miles distance he or she does not live within 40 miles of a military or U.S. Public Health Service medical facility, or if the patient resides within 40 miles of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

(c) the patient or sponsor has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

(d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

(e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

(f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

ESTIMATED CONTRACT BENEFITS

EXHIBIT IV

ATTENDING PHYSICIAN'S STATEMENT

(OPTIONAL — This space can be utilized by carriers to explain the employee's occupation; make a statement relative to eligibility; give any mailing instructions the carrier desires; make a statement that the patient is responsible for obtaining completion of the form at no expense to the Company, etc.) This space can also be used to state the purpose of the form to the doctor and make reference to specific information that would be needed to determine disability.

Name of patient _____ Date of birth ___ / ___ / ___ (Mo. / Day / Year)

Employer name _____ Group/Policy No. _____

I. HISTORY

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____ 19 _____

(b) Date patient ceased work because of disability Mo. _____ Day _____ 19 _____

(c) Has patient ever had same or similar condition? Yes ☐ No ☐ If "Yes" state when and describe

(d) Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐ Unknown ☐

(e) Subjective symptoms

II. DIAGNOSIS (including any complications)

(a) Date of last examination Mo. _____ Day _____ 19 _____

(b) Diagnosis (including any complications)

(c) Subjective symptoms

(d) Objective findings (including current X rays, EKG's, Laboratory Data and any clinical findings)

III. DATES OF TREATMENT

(a) Date of first visit Mo. _____ Day _____ 19 _____

(b) Date of last visit Mo. _____ Day _____ 19 _____

(c) Frequency Weekly ☐ Monthly ☐ Other (Specify) ☐ _____

IV. NATURE OF TREATMENT (including Surgery and medications prescribed, if any)

V. PROGRESS

(a) Has patient Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐

(b) Is patient Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐

(c) Has patient been hospital confined? Yes ☐ No ☐ If yes, give Name and Address of Hospital _____ Confined from _____ through _____

VI. CARDIAC (If Applicable)

(a) Functional capacity (American Heart Ass'n.) Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation) ☐

(b) Blood Pressure (last visit) ___ / ___ (SYSTOLIC / DIASTOLIC)

[Page 209 follows]

Added, 1988-1

7. PHYSICAL IMPAIRMENT (As defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 – No limitation of functional capacity; capable of heavy work. No restrictions. (0-10%)
- ☐ Class 2 – Medium manual activity (15-30%)
- ☐ Class 3 – Slight limitation of functional capacity, capable of light work. (35-55%)
- ☐ Class 4 – Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. (60-70%)
- ☐ Class 5 – Severe limitation of functional capacity, incapable of manual (sedentary) activity. (75-100%)

Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (if applicable)

(a) Please define "stress" as it applies to this claimant.

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations. (No limitations)
- ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight limitations)
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. (Moderate limitations)
- ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations)
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment. (Severe limitations)

Remarks:

Do you believe the patient is competent to endorse checks and does the one on the proceeds thereof? Yes ☐ No ☐

9. PROGNOSIS

	PATIENT'S JOB	ANY OTHER WORK
(a) Is patient now totally disabled?	Yes ☐ No ☐	Yes ☐ No ☐
(b) What duties of patient's job is he/she incapable of performing?		
Do you expect a fundamental or material change in the future?	Yes ☐ No ☐	Yes ☐ No ☐
(1) If yes, when will claimant resume sufficiently to perform duties	Mo. Day Yr. ☐ 1 Mo. ☐ 3 6 Mo. ☐ 1 2 Mo. ☐ Never ☐	Mo. Day Yr. ☐ 1 Mo. ☐ 3 6 Mo. ☐ 1 2 Mo. ☐ Never ☐
(2) If no, what is claim		

10. REHABILITATION

(a) Is claimant a suitable candidate for further rehabilitation services? (i.e., Cerebopulmonary program, speech therapy, etc.) Yes ☐ No ☐

(b) Can present job be modified to allow for handling with impairment? Yes ☐ No ☐

	PATIENT'S JOB	ANY OTHER WORK
(c) When could trial employment commence?	Mo. Day Yr. Full time ☐ Part time ☐	Mo. Day Yr. Full-time ☐ Part-time ☐
(d) Would vocational counseling and/or retraining be recommended?	Yes ☐ No ☐	

11. REMARKS

Name (Examining Physician) Degree

Street Address City or Town State or Province Zip Code

Signature Date

6/80

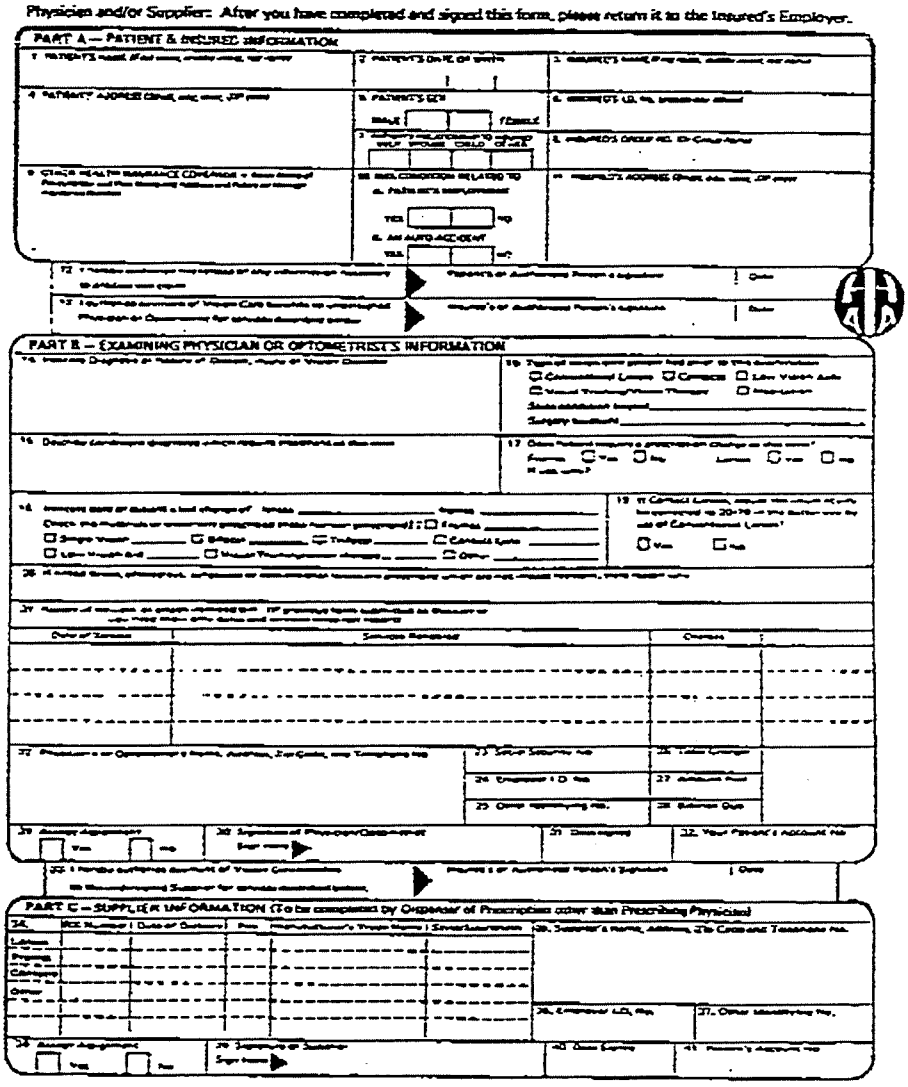
5-12

EXHIBIT V

VICF(75)

VISION INSURANCE CLAIM FORM

Physician and/or Supplier: After you have completed and signed this form, please return it to the Insured's Employer.



6/S0

5-13

1-23-3 Modification of forms

Sec. 3. Statements, instructions, or reports, such as those which are normally completed by claimants and policyholders, and needed in the administration of benefit payments, but not requiring information from providers, may be included on the reverse side of any of the approved forms. The approved forms shall not be changed by the addition of data elements or questions; however, the name and/or identifying symbol of the insuring or prepayment organization and/or the group policyholder and/or the professional organization furnishing the form, may be imprinted in the space provided.

Unneeded data elements or sections may be deleted and the space closed-up, except as follows:

Unneeded elements in the "PATIENT AND INSURED (SUBSCRIBER) INFORMATION" section of the Health Insurance Claim Form — (6-74), (Exhibit II) *[760 IAC 1-23-2]*, may be deleted and the space closed; however, unneeded items in the "PHYSICIAN OR SUPPLIER INFORMATION" section must be shaded-out so that the dimensions of this section and the sequence of the elements are not altered. Further, this section must be positioned on an 8½ × 11 sheet of paper so that the forms of two or more insuring or prepayment organizations may be completed together by the insertion of carbon paper between them. (Department of Insurance; Reg 24, Sec 3; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 529)

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

1-23-4 Additional information; approval of non-standard forms

Sec. 4. This regulation does not prohibit an insurer, service corporation or prepayment organization from requesting additional information from a provider of health care or treatment when such information is necessary for the proper administration of determining benefit payments. Further, if an insurer or prepayment organization needs a provider report form which differs in some respects from its approved counterpart, such forms shall be submitted to the Insurance Department for approval along with the reasons for the deviations. (Department of Insurance; Reg 24, Sec 4; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 530)

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

5-14

1-23-5 Revision of approved forms

Sec. 5. It is anticipated that reporting forms herein adopted for use in this state will require periodic revision resulting in new editions. In such event, the new editions will be acceptable for use in this state; provided, (1) such have been approved by the appropriate health care or treatment provider groups and organization as set forth in Section 2 *[760 IAC 1-23-2]* of this Regulation, and (2) such new editions have been filed with this Department. (Department of Insurance; Reg 24, Sec 5; filed Aug 9, 1977, 9:50 am: Rules and Regs. 1978, p. 530)

Authority: IC 27-1-3-7
Affected: IC 27-8-5.5-2

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary

Finance Institutions and Insurance
Statement Regarding House Bill 2216

I understand the purpose of House Bill 2216 is to mandate that all third party payors of medical claims utilized uniform claim forms. I would agree with this if hospital claim form (UB-82) and the professional claim form (HCFA-1500) is retained in its present form. These forms were developed as national uniform claims by input from Health Care Financing Administration (HCFA) for Medicare and Medicaid, CHAMPUS, Blue Cross/Blue Shield and other insurance companies such as Aetna and Security Benefit Life. The System Performance Review (SPR) conducted by HCFA requires the format of the UB-82 and the HCFA-1500. If Medicaid does not comply a monitary penalty of 5-10% could be assessed.

The cost of new claim forms would be $65,000 for the implementation cost and ongoing costs of $6,000 per month through 1995. An additional complication is that we would have to run a dual claims payment system to accept Medicare and out-of-state UB-82 and HCFA-1500 claim forms.

Claim forms for certain providers including pharmacy and dental are not mandated and could be modified.

John W. Alquest
Acting Commissioner
Income Support/Medical Services
(913) 296-6750

03/22/91

Attachment 6
FI + I
3/25/91

APPROVED OMB NO. 0938-0279

1	2	3 PATIENT CONTROL NUMBER	
4	5 BC BS PROV NO	6 FEDERAL TAX NO	7 MEDICARE NO	8 MEDICAID NO	9

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A H	20 D H	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 CONV D	24 N-C D	25 C-I D	26	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34	CONDITION CODES 35	36	37	BLOOD RECORD PINTS 38	39 RTURN	41 REPL	42 NOT RQ	43 DED	44 SP PROG	45

	46 VALUE CD	AMT	47 VALUE CD	AMT	VALUE CD	AMT	VALUE CD	AMT
a								
b								

50 DESCRIPTION	51 R CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 INS'D MRN	58 INS'D TYPE	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE
A							
B							
C							

DUE FROM PATIENT >

65 INSURED'S NAME	66 SEX	67 REL	68 CERT/SSN/HIC ID NO	69 GROUP NAME	70 INSURANCE GROUP NO
A					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID	75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN CODE	OTHER DIAGNOSES CODES 78	79	80

82 P C	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	85 OTHER PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE

PSRO UR DATA 87 CD	88 APP FROM	89 APP THROUGH	90 GRC	91 TREATMENT AUTH	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID

94 REMARKS

VERIFIED N-C STAY DATES FROM	THROUGH	FOR INTERMEDIARY USE ONLY PR ESC D		

AMT REIMBURSED	N-PYM CD			APPROV BY	DATE APPROV

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PROVIDER REPRESENTATIVE X

OR DATE

6-2

PAYER COPY

UB-82 HCFA-1450

UNIFORM BILL

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof:
Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof; appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 405.1663, 10 USC 1071 thru 1086, 32 CFR 199) and, if required by other contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the foregoing information is true, accurate, and complete:

   (b) The patient has represented that by a reported residential address greater than 40 miles distance he or she does not live within 40 miles of a military or U.S. Public Health Service medical facility, or if the patient resides within 40 miles of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or sponsor has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

ESTIMATED CONTRACT BENEFITS

PLEASE DO NOT STAPLE THIS

HEALTH INSURANCE CLAIM FORM

(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)

2. PATIENT'S DATE OF BIRTH

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

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

5. PATIENT'S SEX — MALE ☐ FEMALE ☐

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)

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

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO

A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐

B. ACCIDENT — AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11.a. CHAMPUS SPONSOR'S STATUS — ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE

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 DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

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

16.a IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY — FROM — THROUGH

DATES OF PARTIAL DISABILITY — FROM — THROUGH

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

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

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

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1
2
3
4

B
EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐

PRIOR AUTHORIZATION NO

24. A. DATE OF SERVICE FROM	TO	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 DAYS OR UNITS	G.* T.O.S.	H LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE:

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

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (SC) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

REFERS TO GOVERNMENT PROGRAMS ONL.

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered a 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 3101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:
1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 (NH) - Nursing Home
8 (SNF) - Skilled Nursing Facility
9 - Ambulance
C - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - (ASC) - Ambulatory Surgical Center
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility
E - (COR) - Comprehensive Outpatient Rehabilitation Facility
F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:
1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
F - Ambulatory Surgical Center
H - Hospice
L - Renal Supplies in the Home
M - Alternate Payment for Maintenance Dialysis
N - Kidney Donor
V - Pneumococcal Vaccine
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

6-5

☆ U.S. G.P.O. 1984-709-367

Testimony By

Dick Brock, Kansas Insurance Department

Before the Senate Financial Institutions and Insurance Committee

on House Bill No. 2441

March 25, 1991

House Bill No. 2441 was proposed by the Insurance Department and introduced by the House Committee on Insurance at our request. It is a unique bill because it takes advantage of a rare opportunity for states to nullify a federal preemption of state insurance laws. Specifically, section 106 of the Secondary Mortgage Market Enhancement Act of 1984 provides in part "... securities that are offered and sold pursuant to section 4(5) of the Securities Act of 1933 or ... shall be exempt from any law of any State ..." However, this section of the act goes on to state: "Any State may, prior to the expiration of seven years after the date of enactment of this Act, enact a statute that specifically refers to this section and requires registration or qualification of any such security on terms that differ from those applicable to any obligation issued by the United States."

House Bill No. 2441 will take advantage of the opportunity afforded to avoid the federal preemption if it is enacted and becomes effective on or before October 3 of this year which is when the seven year period expires.

The Kansas legislature has enacted a body of laws which rather specifically identify the kinds of property and securities Kansas domestic insurers may acquire and own. These statutes also place limitations or specifications on the amount and quality of certain investments. As a result, we believe the interests of Kansas insurers and Kansans insured by or who might have occasion to make a claim against one of our domestic companies will be better served by retaining control over their investment alternatives. We can do this with the enactment of House Bill No. 2441. Without such enactment, the ability to control the investments of domestic insurers will be lost and we don't know what the ultimate impact might be.

Attachment 7
FI + I
3/25/91

Nevertheless, at least one prominent domestic insurer has exercised its rights under the federal law and has invested in the securities permitted under the current federal preemption. At least a portion of these investments would not now qualify under Kansas law.

Nothing in Kansas law requires a divestiture of assets which were authorized investments at the time of purchase. Also, the federal law contains a grandfather clause that, in essence, codifies this result. Consequently, nullifying the federal preemption will not disadvantage any domestic insurer with respect to the securities they now own. However, there is a desire that at least some authority to purchase securities of the nature permitted under the federal law be continued. Therefore, attached to my testimony is a balloon of a proposed amendment that will permit the Kansas legislature to nullify the federal preemption but, at least temporarily, continue to authorize the purchase of the securities under state law.

If House Bill No. 2441 is enacted with this amendment, the Kansas legislature will regain and retain its ability to control investments by domestic insurers; insurers will be permitted to continue to invest in the "federally authorized" securities pursuant to state law; and any necessary limitations or qualifications can be developed for consideration as specific amendments to the investment laws applicable to domestic companies by the 1992 and/or future Kansas legislatures.

Session of 1991

HOUSE BILL No. 2441

By Committee on Insurance

2-22

AN ACT relating to investments of insurance companies.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Notwithstanding the provisions of section 106 of the secondary mortgage market enhancement act of 1984, P.L. 98-440 (15 U.S.C. 77r-1), the provisions of articles 2a and 2b of chapter 40 of the Kansas Statutes Annotated relating to the qualifications, limitations and kinds of investments that insurance companies domiciled in Kansas may purchase and hold shall ~~continue to~~ apply Delete except as provided in section 2 of this act.

Sec. 2. Investments in securities that are:
(A) offered and sold pursuant to section 4(5) of the Securities Act of 1933 (15 U.S.C. 77d(5)),
(B) mortgage related securities as defined in section 3(a)(41) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(41)), or
(C) securities issued or guaranteed by the Federal Home Loan Mortgage Corporation or the Federal National Mortgage Association,
shall be considered to be obligations issued by the United States for purposes of article 2a and 2b of chapter 40 of the Kansas Statutes Annotated.

Sec. ~~2~~ 3. This act shall take effect and be in force from and after its publication in the statute book.