SECTION 17

APPENDIX

ITEM 1 - LANGUAGE ASSISTANCE FORM

Interpreter Documentation Form for Contracted Providers

In compliance with the Department of Managed Health Care (DMHC) Language Assistance Regulations, this form provides contracted providers a method to document that referred-limited English proficient (LEP) Kaiser Permanente members were offered interpreter services and whether those services were used or refused. Please note -- LEP members may require interpreter services anytime critical information is conveyed.

Documentation Instructions
1. Once interpreter services have been provided, please document the offer, use or refusal of interpreter services either through documentation in the patient care record or by completing the bottom section of this form.
2. In the event that it is required, we may request documentation from you regarding the provision of interpreter services for KP members.

Provision of Interpreter Services: This section is to be completed at the time patient care is initiated.

**TO BE COMPLETED BY CONTRACTED PROVIDER OR STAFF ONLY AND RETAINED IN PATIENT CARE RECORD**

Member Name: __________
Member Record Number: ______
Provider Name: ______________

Interpreter services offered: □ Yes □ No

1. If interpreter services were accepted, check the type of interpreter services utilized:
   □ Qualified bilingual staff □ Professional staff interpreter □ Outside contract interpreter service
   □ Phone interpreting □ Other: ____________________________
   I don’t understand the difference between “Qualified bilingual staff” and “Professional staff interpreter” and “Outside contract interpreter service” and “Phone interpreting”. I would suggest “Language Line”, “Language People” and “Qualified bilingual staff”

2. Name of interpreter: ________________________________

3. Interpreter’s unique identifying number: ________________________________

4. If interpreter services were refused, check the appropriate reason for refusal:
   □ Patient preferred to use relative/friend (over 18 yrs)
   □ Patient preferred to use own English skills
   □ Patient preferred/received in-language care from bilingual provider (huh?) don’t understand this
   □ Other: ___________________________________________ what would be an “other”
   □ Patient declined to state reason
ITEM 2 – DOTS SAMPLE

DOTS Faxed Order Sample

MRN: 11-0000000000 Order #: 0001234567

Section I

KCI - MOON
1234 LUNAR LANE
MOON , MM 99999

Section II

Order ID#: 0001234567
MRN: 11-0000000000
DOE, JOHNATHAN
1950 FRANKLIN ST
OAKLAND , CA , 94612

Section III

Pay Source: Kaiser Prime
H/C #: Ext: 
Eff Date:

Section IV

DME Designee: Kaiser Staff
Managing Fac: OAK
Approving MD: DOCTOR, JOE
ICD-9 Code: 780.57 UNSPECIFIED SLEEP APNEA

Section V

Deliver following equipment to:
DOE, JOHNATHAN
1800 HARRISON ST
OAKLAND , CA 94612

Section VI

E0562 - HUMIDIFIER, HEATED, USED WITH
POSITIVE AIRWAY PRESSURE DEVICE
Service Begin Date: 06/06/2006
Delivery Type: Standard
Pay State: Invoiceable
1 Each Rental
Medicare Share: $ 0.00 KP Share: $ 0.00 Member Share: $ 313.60

Section VII

E0601 - CONTINUOUS AIRWAY PRESSURE
(CPAP) DEVICE
Service Begin Date: 06/15/2006
Delivery Type: Advanced
Pay State: Invoiceable
1 Each Purchase
Medicare Share: $ 0.00 KP Share: $ 438.10 Member Share: $ 295.92

Section VIII

END OF ORDER # 0001234567

I Vendor Information V Delivery Address(es)
II Member Information VI Item(s) Being Ordered
III Billing Information VII Delivery Type / Date
IV Ordering Staff Information VIII Financial Liability Information
ITEM 3 – ADVANCED BENEFICIARY NOTICE

(A) Notifier(s):
(B) Patient Name: 
(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D)_______ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)_______ below.

<table>
<thead>
<tr>
<th>(D)</th>
<th>(E) Reason Medicare May Not Pay:</th>
<th>(F) Estimated Cost:</th>
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WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)_______ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the (D)_______ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- **OPTION 2.** I want the (D)_______ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- **OPTION 3.** I don't want the (D)_______ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:   (J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PLA Report Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)                Form Approved OMB No. 0938-0566
**ITEM 4 – CMS 1500**

**Revised CMS-1500 Health Insurance Claim Form (08/05)**


**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<td>1.</td>
<td>A. <strong>INSURED</strong> (Name, Address, City, State, Zip Code)</td>
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<td>B. <strong>INSURED</strong> (Name, Address, City, State, Zip Code)</td>
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<td>C. <strong>INSURED</strong> (Name, Address, City, State, Zip Code)</td>
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<td>26.</td>
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**NUCC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)

**APPROVED CMS-0936-0999 FORM CMS-1500 (08-05)**

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ITEM 5 – UB04

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