Washington State Health Care Authority

Washington Apple Health (Medicaid)

Birth Doula Services

January 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If the broken link is in the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide*

This new publication takes **effect January 1, 2025**.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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* This publication is a billing instruction.

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Washington State Health Care Authority

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Resources Available

Topic	Contact
Policy or program questions	• Visit HCA's Doula webpage • Contact HCA via the Billers, providers, and partners "Contact us" webpage. • Contact the Birth Doula Program at: hcadoulas@hca.wa.gov.
Information regarding support services covered during and post pregnancy	See HCA's **Maternity Support Services/Infant Case Management Billing Guide**.
Information regarding childbirth education	See HCA's **Childbirth Education Billing Guide**.
Information on deliveries in a birthing center or in a home birth setting	See HCA's **Planned Home Births and Births in Birthing Centers Billing Guide**.
Information on withdrawal management services during pregnancy	See HCA's **Substance-Using Pregnant Person (SUPP) Program Billing Guide**.
Information on contraception and family planning services	See HCA's Family Planning Billing Guide.
Information on pregnancy-related services	See HCA's Pregnancy-Related Services Billing Guide.
Additional HCA resources	• Visit HCA's Billers, providers, and partners webpage or contact the Medical Assistance Customer Service Center (MACSC). • Visit HCA's Pregnancy services webpage. • Visit HCA's Pregnancy care resources webpage. • Visit HCA's Postpartum and newborn resources webpage.

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Antepartum – Relating to the period before birth. Also known as prenatal care.

Birth doula - A nonmedical support person certified under Chapter 246-835 WAC and trained to provide physical, emotional, and informational support to birthing persons, their infants, and their families.

Birth doula services - Preventive services, as defined by 42 C.F.R. 440.130(c), provided by a birth doula to pregnant and post-pregnant people, their infants, and their families. Services include advocating for and supporting the birthing person and their family to self-advocate by helping them to know their rights and make informed decisions.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

Care coordination - Collaboration and communication between the client's birth doula provider and other medical or health and social services providers, including Indian health care providers, or both, to partner with and address the individual client's and family's needs.

CPT – See Current Procedural Terminology (CPT®).

Culturally congruent care - See WAC 246-835-010.

Current Procedural Terminology (CPT®) - CPT® codes provide a uniform nomenclature for coding medical procedures and services. Medical CPT® codes are critical to streamlining reporting and increasing accuracy and efficiency, as well as for administrative purposes such as claims processing and developing guidelines for medical care review. The American Medical Association develops and manages CPT® codes on a rigorous and transparent process led by the CPT® Editorial Panel, which ensures codes are issued and updated regularly to reflect current clinical practice and innovation in medicine.

Department of Health (DOH) - The state agency that works with others to protect and improve the health of all people in Washington State and which certifies the birth doula profession under Chapter 246-835 WAC.

HCPCS- See Healthcare Common Procedure Coding System.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Health care record - See WAC 182-502-0020 for health care record requirements.

In person - The client and the provider are face-to-face in the same location.

Lived experience – Having first-hand knowledge and insight gained from navigating challenges similar to those faced by the people in the community. This

can include shared experiences like cultural backgrounds, socioeconomic status, health conditions, or barriers accessing the health and social service systems.

Medically necessary – See WAC 182-500-0070.

Postpartum period - The period lasting until the end of the 12th month after the pregnancy ends.

Provider – See WAC 182-500-0085.

Washington apple health - See WAC 182-500-0120.

Client Eligibility

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in HCA's **ProviderOne Billing and Resource Guide**.

If the patient is eligible for Apple Health, proceed to Step 2. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's **Program benefit packages and scope of services webpage**.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Clients enrolled in HCA-contracted managed care plans are eligible for birth doula services outside of their plan. HCA pays for birth doula services through its fee-for-service system. Providers must bill HCA directly. To verify eligibility when the client is enrolled in a Medicaid HCA-contracted managed care plan, view the managed care enrollment on the client benefit inquiry screen of ProviderOne.

Birth Doula Services

About the services

Birth doula services improve and promote healthy pregnancy, birth, postpartum, and infant outcomes. A birth doula delivers services to eligible pregnant and post-pregnant people, their infants, and their families.

Who is eligible for birth doula services?

Clients are eligible to receive birth doula services during any point in pregnancy, childbirth (inclusive of any end-of-pregnancy outcome), or during the postpartum period up to 12-months.

> **For example:** A client remains eligible to receive birth doula services in labor or the postpartum period, or both, even if birth doula services were not initiated during the prenatal period. As long as clients fall within one of the eligibility periods, they remain eligible for birth doula services, regardless of when they first initiate care with their birth doula, whether it's during pregnancy, during labor, or the postpartum period.

Provider requirements

To be eligible to provide birth doula services to clients, a birth doula must meet all the following:

- Be 18 years of age or older
- Be a resident of the state of Washington or a bordering city as specified in WAC 182-501-0175
- Possess current certification as a birth doula with the Washington state Department of Health under Chapter 246-835 WAC
- Be enrolled as an eligible birth doula provider with HCA (see WAC 182-502-0010)
- Meet the general requirements found in Chapter 182-502 WAC and the billing and documentation requirements found in this guide
- Meet the standards required by state and federal laws governing the privacy and security of personally identifying information
- Participate in care coordination activities throughout pregnancy and the postpartum period with the client's prenatal clinical care provider and, if applicable, their First Steps Maternity Support Services (MSS) provider. See HCA's First Steps enhanced services webpage.

Note: Examples of care coordination activities include but are not limited to referrals to specific healthcare providers such as a pregnancy provider or mental health provider; connecting clients to a variety of support groups during their pregnancy and postpartum period; and helping access resources and services such as transportation and childcare services.

- Provide culturally congruent care to the client and the client's family
- Have lived experience that aligns with and provides a connection between the birth doula and the community being served

Documentation requirements

All providers must satisfy the documentation requirements in WAC 182-502-0020 and this guide, regardless of whether the provider maintains hand-written or electronic client health care records. All documentation must be maintained for at least six years and must be submitted to HCA upon request.

The following must be documented in the client's health care record:

- Consent for services to be signed at the initiation of care
- The date and time/duration of services and information substantiating the services provided.
- The nature of the care and service(s) provided during each visit
- Any coordination with medical or other care providers
- Any referrals and coordination efforts with community resources or community supports
- If screening is provided using a validated screening tool, the name of the tool, the score, and any communication following a positive screening including referrals to community resources, coordination with clinical care team, etc.

Charting overview

Each provider must maintain a client health care record for each client that states the services provided and justifies how those services support provider reimbursement.

Prenatal intake visit

The following are required components of the prenatal intake visit and must be documented in the client's health care record:

- The date and time/duration of services, minimum two-hour visit
- A completed and signed consent for services form
- Provide an overview of the Apple Health birth doula benefit
- Co-design a plan of care across antepartum, delivery, and postpartum periods, as appropriate

- Initiate discussion and implementation of birth plan or client/family preferences for care
- Support the client in establishing care as needed, including clinical pregnancy care, behavioral health services, dental services, etc. Coordinate with the MCO, if needed, to assist the client in accessing desired services, timely appointments, or any other care coordination or case management need
- Review the client's health history including any previous pregnancies, births, and loss of life
- Coordinate with medical providers regarding mental and emotional health screenings, and if appropriate, support symptom reduction through care navigation or peer support. See Screening of mental health conditions during pregnancy and postpartum in HCA's Pregnancy-Related Services Billing Guide

Note: Coordination of care around perinatal mental health is broad and includes but is not limited to the following:

- Discussing with the client the screening they should receive from their clinical pregnancy provider
- Discussing and referring the client to available community supports or resources
- Making a plan for the client to bring up concerns with the clinical pregnancy provider
- The birth doula attempting to directly contact the provider

- Review social determinants of health (SDOH) and other social-related health needs. Provide resources and support guided by client or family priorities
- Assess family and other relational support networks

What is covered?

HCA covers birth doula services with limitations. Birth doula services must meet all the following:

- Be preventive in nature according to 42 C.F.R. 440.130(c)
- Provide physical, emotional, and informational support to pregnant, birthing, and postpartum people

HCA pays for the following birth doula services:

- One prenatal intake visit billed only once per pregnancy
- Continuous labor and delivery support billed only once per pregnancy
- One comprehensive postpartum visit per pregnancy

- Additional prenatal and postpartum visits limited to 20 hours per pregnancy

Birth doula coverage tables

Prenatal intake visit

The following table includes information for billing HCA for the prenatal intake visit:

Service	CPT® code/ Modifier	Diagnosis code	Comments
Prenatal intake visit	59899 with U1 modifier	Z322	• Limited to one per client, per pregnancy. • Must be in person. • Direct service time must be a minimum of 2 hours. • Paid at a flat rate. See fee schedule.

Note: For a list of components of the prenatal intake visit, see Documentation requirements.

Labor and delivery support

The following table includes information for billing HCA for the labor and delivery support:

Service	HCPCS code/ Modifier	Diagnosis code	Comments
Labor and delivery support	T1033	Z379	• Limited to one per client, per pregnancy. • Must be in person and provided to one client at a time. • Support must be continuous. • Paid at a flat rate. See fee schedule.

Additional prenatal and postpartum visits

The following table includes information for billing HCA for additional prenatal and postpartum visits. A maximum of 20 hours (80 units) are available across the prenatal and postpartum periods.

> **Note:** HCA has designated 6 units (90 minutes, 1 unit = 15 minutes) for a **comprehensive postpartum visit**, to support Apple Health (Medicaid) clients having tailored postpartum birth doula services. The remaining 74 units (18.5 hours) may be used for either additional prenatal or postpartum visits.

Service	CPT® code/ Modifier	Diagnosis code	Comments
Prenatal visits	T1032	Z322	• Limited to 18.5 hours (74 units) across the prenatal and postpartum visits). • 1 unit = 15 min. • See fee schedule.
Postpartum visits	T1032	Z392	• 1.5 hours (6 units) are designated to postpartum care only • Remaining available units from the prenatal period can be billed for postpartum visits.

What if my client needs additional units/services beyond coverage limitations?

HCA evaluates requests for authorization of covered services that exceed limitations on a case-by-case basis in accordance with WAC 182-501-0169. See Limitation extension (LE).

See Telemedicine for birth doula services not allowed via telemedicine.

Services not included in the birth doula benefit

HCA does not pay for the following services when provided by a birth doula:

- Childcare
- Chore services including, but not limited to, shopping and cooking
- Group services
- Phone calls, text messages, and emails
- Documentation time

- Travel time and mileage

What if my client requests noncovered services?

Before services are furnished, the client and provider must sign and date the Agreement to Pay for Healthcare Services form (HCA 13-879) if an Apple Health (Medicaid) client chooses to pay for a birth doula service for which HCA does not pay. See WAC 182-502-0160, Billing the Client for details.

Requesting an exception to rule (ETR) is optional for the client.

Payment

HCA pays for the following:

- Birth doula services when they are:
  - Provided to a client who meets the eligibility requirements in Who is eligible for birth doula services?
  - Provided to a client during a face-to-face encounter, including audio-visual telemedicine (see Telemedicine)
  - Provided and billed according to this guide
  - Documented in the client's health care record according to this guide
- Labor and delivery support provided by a birth doula to only one client at a time, as labor and delivery support is intended to be continuous

> **Note:** For clients age 20 and younger, providers must follow the rules for the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program. See Chapter 182-534 WAC.

How are billable units of service defined?

As described in this guide some birth doula services are paid at a flat rate (i.e., the prenatal intake visit and labor and delivery support) and other birth doula services are paid in 15-minute increments (1 unit = 15 min).

To be paid, providers must bill for the direct service delivery at the minimum time equivalent (e.g., a minimum of 15 minutes for 1 unit billed; a minimum of 30 minutes for 2 units billed, etc.)

> **Example:** A provider sees a client and provides eligible face-to-face services for 70 minutes. HCA would pay for 4 units (60 minutes) for this visit. The time spent does not hit the threshold to bill 5 units (75 minutes).

What do I need to know when I am billing the remaining units out of the 20 total units?

When billing the remaining units out of the 20 total units:

- The birth doula service benefit is limited to 20 hours (80 units) across the prenatal and postpartum visits, 6 of those units designated for postpartum care only.
- HCA recommends that birth doulas track the units billed on an eligible client to more easily determine the number of remaining units.
- The claim submitted that includes the final or 20th hour of service will only be payable up to the remaining allowable units.

Fee Schedule

For clients enrolled in a managed care organization (MCO) or fee-for-service (FFS) who are eligible for birth doula services, HCA pays for covered birth doula services through FFS using HCA's published Birth doula services fee schedule.

Maximum allowable fees for all codes, including CPT® codes and selected HCPCS codes, are listed in the fee schedule.

Telemedicine

Telemedicine requirements

HCA pays for birth doula services provided via telemedicine only when the following have been met:

- The prenatal intake visit has been provided in-person
- The first visit with a new birth doula has been provided in person if the client changes their birth doula
- The servicing provider for the telemedicine service uses the same billing provider's national provider identifier (NPI) used to bill for the in-person prenatal intake visit

Examples:

- An independent birth doula will have the same individual NPI for both billing and servicing provider.
- A group birth doula practice will have the same group billing provider NPI, but the individual servicing provider NPI can be different (e.g., three different birth doulas with three different servicing NPIs, but the group billing provider NPI will always be the same for telemedicine.

Services HCA does not pay for when provided via telemedicine

HCA does not pay for the following birth doula services provided via telemedicine:

- The prenatal intake visit
- The first visit with a new birth doula if the client changes their birth doula
- Labor and delivery support

> **Note:** Refer to HCA's Provider Billing Guides and Fee Schedules webpage, under *Telehealth*, for more information on the following:
>
> - Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
> - Audio-only procedure code lists, under *Audio-only telemedicine*

Payment when a client changes their birth doula

It is the client's discretion to discontinue working with a birth doula and receive services from a new birth doula. If a client changes their birth doula, the first visit with the new birth doula must be performed in person. HCA will not pay for the first visit via telemedicine. The change of birth doula must be documented in the client's health care record of both birth doulas.

If a client changes their birth doula what services are billable by the new birth doula?

It depends on which services have already been paid for by Apple Health. The limits on services described in this guide are per client, per pregnancy and are retained even if the client has chosen to transfer care to a new birth doula.

The new birth doula may attempt to contact the former birth doula and confirm what services have been delivered. The new birth doula may contact HCA to confirm which birth doula services/claims HCA has already paid for and to help determine which services may be remaining in the allowable Apple Health benefit.

Instructions on the process for birth doulas to contact HCA to confirm if HCA has already paid for services/claims may be found under Client service limits in the ProviderOne Billing and Resource Guide.

Note: Providers must bill HCA within 365 days from the date of service per WAC 182-502-0150 to be considered timely.

Authorization

Authorization is HCA's approval for covered services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), and limitation extensions (LE) are forms of authorization**.

Prior authorization (PA)

What is prior authorization (PA)?

Prior authorization (PA) is the process HCA uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. PA does not guarantee payment.

For examples on how to complete a PA request, see HCA's **Billers, providers, and partners** webpage.

> **Note**: HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

HCA reviews PA requests in accordance with WAC 182-501-0165. HCA uses evidence-based medicine to evaluate each request. HCA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HCA reviews all evidence submitted and will either:

- Approve the request.
- Deny the request if the requested service is not medically necessary.
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HCA will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, HCA will deny the requested service.

When HCA denies all or part of a request for a covered service or equipment, HCA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action HCA intends to take.
- Includes the specific factual basis for the intended action.
- Includes references to the specific WAC provision upon which the denial is based.

- Is in sufficient detail to enable the recipient to learn why HCA's action was taken.
- Is in sufficient detail to determine what additional or different information might be provided to challenge HCA's determination.
- Includes the client's administrative hearing rights.
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Documentation requirements for PA or LE

PA documentation

How do I obtain PA or an LE?

For all requests for PA or LEs, the following documentation is required:

- A completed, TYPED *General Information for Authorization* form, 13-835. This request form MUST be the initial page of the request.
- A completed *Fax/Written Request Basic Information* form, 13-756, if there is not a form specific to the service being requested, and all the documentation listed on the form with any other medical justification.

Fax the request to: (866) 668-1214.

See HCA's **Billers, provider, and partners** webpage.

See **Where can I download HCA forms?**

Requesting prior authorization (PA)

When a procedure's EPA criteria have not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's **prior authorization webpage** for details).

Fax

If providers choose to submit a faxed PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See **Where can I download HCA forms?** This form must be page one of the faxed request and must be typed.
- The program form, if available. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit faxed PA requests (with forms and documentation) to (866) 668-1214.

For a list of forms and where to send them, see **Documentation requirements for PA or LE**. Be sure to complete all information requested. HCA returns incomplete requests to the provider.

Limitation extension (LE)

What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides.

> **Note**: A request for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request an LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the **EPA criteria list** for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service.

The request must state the following:

- The name and ProviderOne Client ID of the client
- The provider's name, NPI, and fax number
- Additional service(s) requested – only requests for additional units (1 unit = 15 min) will be considered as other birth doula services paid at a flat rate are covered only once per pregnancy.
- The primary diagnosis code and CPT® or HCPCS code (either T1032 with dx code Z322 for prenatal visits or T1032 with dx code Z392 for postpartum visits)
- Client-specific clinical justification for additional services

What is clinical justification for additional birth doula services?

HCA reviews LE requests for additional birth doula services on a case-by-case basis. These requests are for a specific amount of billable units (1 unit =15 min).

HCA must stay within the funding allocated for birth doula services; therefore, HCA may approve only a limited number of additional units of service.

HCA will not approve additional units in situations where a client has changed birth doulas, and there is not further justification from the client perspective.

HCA may approve additional units in the following circumstances:

- Maternal physical health conditions that existed before pregnancy and/or developed or were exacerbated during the perinatal period
- Maternal behavioral health conditions that existed before pregnancy and/or developed or were exacerbated during the perinatal period
- Social risk factors that existed before pregnancy and/or developed or were exacerbated during the perinatal period, such as homelessness, housing instability, or food insecurity
- Health conditions of the newborn/infant, such as prematurity, NICU admission, or other special health care needs

General Billing

Note: All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's **ProviderOne Billing and Resource Guide** webpage and scroll down to *Paperless billing at HCA*. For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource*.

What are the general billing requirements?

Providers must follow HCA **ProviderOne Billing and Resource Guide**.

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill HCA for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

Billing claims electronically

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners** webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange (EDI)** webpage.