Dear Provider,

Thank you for your participation in the Louisiana Medicaid Program.

Payment may be made to your provider type for recipients who also have Medicare coverage. For these recipients, Louisiana Medicaid will only pay up to the Medicare co-insurance and deductible amounts on Medicare crossover claims for which assignment has been accepted. Medicaid uses a cost comparison methodology to determine payment of these claims, and payment may be less than but will never be more than the Medicare co-insurance and/or deductible.

Participation in this program requires the recipient to be enrolled in both Medicare and Medicaid. **No payment will be made for recipients with Medicaid coverage only.**

As a rule, Medicare claims should cross automatically from the Medicare carrier to Medicaid with no action required on your part. Enclosed is information to be used in billing Louisiana Medicaid **for claims which do not cross over electronically to Medicaid from Medicare**. Please allow 45 days from the Medicare payment date for claims to cross automatically before submitting the claim directly to Medicaid.

This packet includes basic Medicaid information and billing instructions. In general, bill Louisiana Medicaid using the same claim form and procedure codes required by Medicare. Be sure to attach a copy of the Medicare Explanation of Benefits to each claim form you are filing to Medicaid.

Crossover claims should be submitted to Molina Medicaid Solutions, P.O. Box 91020, Baton Rouge, LA 70821.

Telephone inquiries may be directed to our Provider Services Department at (800) 473-2783 or (225) 924-5040.

Sincerely,

Molina Medicaid Solutions
Provider Services Department

OVERVIEW OF MEDICARE CROSSOVER BILLING

Professional services are billed on the CMS-1500 (02/12) claim form. A copy of a sample CMS-1500 form and instructions is attached.

Items to be completed are either **required** or **situational**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required (but only in certain circumstances as detailed in the instructions that follow).

Paper claims should be submitted only in circumstances when claims are not crossed automatically from Medicare to Medicaid. All Medicare Advantage Plans must be submitted hard copy as they do not cross over. Hard copy claims should be submitted to:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

For your provider type, payment may be made for Medicare crossover claims on which Medicare assignment is accepted

Louisiana Medicaid uses a cost-comparison methodology to pay these claims. We compare the Medicaid allowable fee to the Medicare payment and will only pay the Medicaid allowable amount **up to** the equivalent Medicare co-insurance and deductible. Medicaid may pay less, but will never pay more than the Medicare co-insurance and deductible amounts. Claims may be paid at '0' if the Medicare payment exceeds the Medicaid allowable amount. These are considered claims that are paid in full.

No payment will be made to you for recipients with Medicaid coverage only.

SAMPLE CMS 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

SAMPLE ONLY NOT FOR USE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

INSTRUCTIONS FOR BILLING MEDICARE CROSSOVER SERVICES

CMS-1500 (02/12) Instructions

CMS 1500 (02/12) INSTRUCTIONS FOR BILLING MEDICARE CROSSOVER SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	**The beneficiary's HIC number must be replaced with the 13-digit Medicaid ID number in this field.**
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	**Required** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	

Locator #	Description	Instructions	Alerts
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Reserved for NUCC Use	**Leave Blank.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	**If a recipient has both Medicare and private insurance, this information is required.** **ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE**
9b	Reserved for NUCC Use	**Leave Blank.**	
9c	Reserved for NUCC Use	**Leave Blank.**	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
	Sex		
11b	OTHER CLAIM ID (Designated by NUCC)	**Leave Blank.**	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	Other Date	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable.	
17a	Other ID#	**Situational** – Enter if appropriate.	
17b	NPI	**Situational –** Enter if appropriate.	
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab?	**Optional.**	
21	ICD Ind.	**Required** – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper	The most specific diagnosis codes must be used. General codes are not acceptable.

Locator #	Description	Instructions	Alerts
	Diagnosis or Nature of Illness or Injury	right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM **Required** – Enter the most current ICD diagnosis code. **NOTE:** The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid. **NOTE:** ICD-10 code series V, W, X, and Y should not be used when billing LA Medicaid.	**ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.** **ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.** Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
22	Medicaid Resubmission Code	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**Adjustment/Void are submitted using the CMS 1500 (02/12) form.** **To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.**
23	Prior Authorization	**Situational –** Complete if appropriate	

Locator #	Description	Instructions	Alerts
	Number	or leave blank.	
24	Supplemental Information	**Situational –** Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.** To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**Physicians and other provider types who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only.** **This information must be entered in addition to the procedure code(s).**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	

Locator #	Description	Instructions	Alerts
24C	EMG	**Situational** – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	**Situational** – If applicable, entering the Rendering Provider’s Medicaid Provider Number in the shaded portion of the block is **required**. If applicable, entering the Rendering Provider’s NPI in the non-shaded portion of the block is **required**.	**Both the 7-digit Medicaid provider number and the 10-digit NPI numbers are required when entering a rendering provider.** **Rendering =Attending**
25	Federal Tax I.D. Number	**Optional.**	
26	Patient’s Account No.	**Optional** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	

Locator #	Description	Instructions	Alerts
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (excluding any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare or Medicare Replacement plan payments in this field.**	**Do not report Medicare or Medicare Replacement plan payments in this field.**
30	Reserved for NUCC Use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional.** – The practitioner or the practitioner's authorized representative's original signature is no longer required. Enter the date of form completion.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	
32b	Other ID#	**Situational –** Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Required –** Enter the billing provider's 10 digit NPI number.	**The 10-digit NPI Number must appear on paper claims.**
33b	Other ID#	**Required** – Enter the billing provider's 7-digit Medicaid ID	**The 7-digit Medicaid Provider Number must appear on paper**

Locator #	Description	Instructions	Alerts
		number. **ID Qualifier - Optional.** If possible, leave blank for Louisiana Medicaid billing.	**claims.**

A sample form follows.

SAMPLE CLAIM FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail To:
Molina
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU, JANNIE

3. PATIENT'S BIRTH DATE: 06 | 11 | 81 SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. G809 B. R252 C. Z451 D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: PA # IF APPLICABLE

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1																1236548
	09	08	16	09	08	16	11		62370		ABC	500 00	1		NPI	1236549875
	N458281056302 GR.8 LIORESAL															1236548
2	09	08	16	09	08	16	11		J0475		ABC	5000 00	8		NPI	1236549875
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 5500 00

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JANE DOE, MD

SIGNED 9/12/16 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (800) 233-3333

ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000

a. 1326547895 b. 1987654

COMPLETING THE CMS 1500 (02/12) AS AN ADJUSTMENT/VOID

If a claim has been paid using the 837P claim transaction, an adjustment or void may be submitted by using the CMS 1500 (02/12) form.

Only **one** claim line can be adjusted or voided on each adjustment/void form.

Only a **paid** claim can be adjusted or voided. Denied claims must be corrected and resubmitted—not adjusted or voided.

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

1. A claim is approved on the remittance advice dated 07/17/2017, ICN 7266156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2017, ICN 7035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (7035126742100) and RA date (12/11/2017) must be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column.

To file a void, the provider must enter all the information from the original claim exactly as it appeared on the original claim. When the void claim is approved, it will be listed under the "void" column of the RA and a corrected claim may be submitted (if applicable).

Filing Adjustments for a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare reimburses the claim, then the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible and/or co-insurance/co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should rebill Medicare for a corrected payment. These claim adjustments electronically “cross over” from Medicare to Medicaid.

If a Medicare adjustment should fail to cross electronically from Medicare, it is necessary for the provider to file a hard copy adjustment claim (CMS 1500 (02/12)) with Medicaid. These should be sent to Molina Medicaid Solutions, Attention: Crossover Adjustments, P.O. Box 91020, Baton Rouge, LA 70821, and should have a copy of the most recent Medicare explanation of benefits and the original Medicare explanation of benefits attached. In addition, the provider should write “2X7” at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

SAMPLE ADJUSTMENT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Mail To:
Molina
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU,JANNIE

3. PATIENT'S BIRTH DATE: 06 | 11 | 81 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. [ ]

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. G809 B. R252 C. Z451 D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 6259012345600

23. PRIOR AUTHORIZATION NUMBER: PA # IF APPLICABLE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	09	08	16	09	08	16	11		62370		ABC	500 00	1			1236548
														NPI	1236549875
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 500.00

29. AMOUNT PAID: $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JANE DOE, MD

SIGNED 9/12/16 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH# (800) 233-3333

ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000

a. 1326547895 b. 1987654