CLAIMS FILING

Greater New Orleans Community Health Connection (GNOCHC) services are billed on the CMS-1500 claim form or electronically in the 837P transaction. 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).

Claims should be submitted to:

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

Specialty Care Reporting

GNOCHC primary care encounter payments are computed to allow for specialty physician services, specialty laboratory and radiology services. It is required that GNOCHC providers (excluding LSU Interim Public Hospital and behavioral health-only providers) report their direct expenditures related to payment for these types of services.

Providers must use procedure code T2025 on the first line of the claim with a $0 charge to designate that this is only to report expenses. The following claim lines will use individual Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes and the actual cost incurred by the provider. Even though these services will be processed as a claim, providers will not receive additional payments as a result of submission. Upon claims adjudication, providers should only be concerned about the T2025 code being approved. (See Appendix E, page 17, for a list of applicable HCPCS and CPT codes under Specialty Services.)

CMS 1500 BILLING INSTRUCTIONS FOR GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION 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 #).	**GNOCHC providers should mark the Medicaid indicator.**
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit GNOCHC ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit 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 13-digit GNOCHC number and the 13-digit Medicaid number are the same number.**
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Optional** – 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). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Leave Blank**	
5	Patient's Address	**Leave Blank**	
6	Patient Relationship to Insured	**Leave Blank**	
7	Insured's Address	**Leave Blank**	
8	Patient Status	**Leave Blank**	

Locator#	Description	Instructions	Alerts
9	Other Insured's Name	**Leave Blank**	
9a	Other Insured's Policy or Group Number	**Leave Blank**	
9b	Other Insured's Date of Birth Sex	**Leave Blank**	
9c	Employer's Name or School Name	**Leave Blank**	
9d	Insurance Plan Name or Program Name	**Leave Blank**	
10 a. b. c.	Is Patient's Condition Related To: Employment Auto Accident Other Accident	**Situational** – Complete if the services are related to the patient's employment, an auto accident or another type of accident.	
11	Insured's Policy Group or FECA Number	**Leave Blank**	
11a	Insured's Date of Birth Sex	**Leave Blank**	
11b	Employer's Name or School Name	**Leave Blank**	
11c	Insurance Plan Name or Program Name	**Leave Blank**	
11d	Is There Another Health Benefit Plan?	**Leave Blank**	

Locator#	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	**Leave Blank**	
13	Patient's or Authorized Person's Signature (Payment)	**Leave Blank**	
14	Date of Current Illness / Injury / Pregnancy	**Leave Blank**	
15	If Patient Has Had Same or Similar Illness Give First Date	**Leave Blank**	
16	Dates Patient Unable to Work in Current Occupation	**Leave Blank**	
17	Name of Referring Provider or Other Source	**Optional** – Enter the Rendering Provider ID for reporting purposes or leave blank	
17a	Unlabelled	**Leave Blank**	
17b	NPI	**Leave Blank**	
18	Hospitalization Dates Related to Current Services	**Situational –** Complete if appropriate or leave blank	
19	Reserved for Local Use	Reserved for future use. Do not use.	**Usage to be determined.**
20	Outside Lab?	**Leave Blank**	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	**The most current and specific diagnosis code(s) must be entered.**

Locator#	Description	Instructions	Alerts
22	Medicaid Resubmission Code	**Leave Blank**	
23	Prior Authorization Number	**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	**GNOCHC providers who administer drugs and biologicals must enter this drug-related information in the SHADED section of 24A – 24G of the appropriate detail line(s) for the drug or biological – not the encounter line.** **This information must be entered in addition to the procedure code(s).**

Locator#	Description	Instructions	Alerts
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.	**Six-digit or 8-digit dates can be used on paper claims.** **Only 8-digit dates can be used for electronic (EDI) claims.**
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	**Claims submitted with no Place of Service Code will deny.**
24C	EMG	**Leave Blank**	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered. Enter the GNOCHC Specialty Care Services encounter procedure code on the first line: **Encounter Code = T2025** Enter for Specialty Care Services In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered. Report in the encounter each CPT code for covered services ordered by the participating provider and provided to the enrollee, whether provided directly by the participating provider or indirectly by referral and paid for by the participating provider (i.e., lab, radiology and specialty services	**The encounter code must be present on the claim, accompanied by at least one detail line for a covered service.** **All services should be included as detail lines.** **If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 is required.** **When specialty care services are reported (T2025), the encounter should be billed with "0" charges and the detail lines should be billed with the actual incurred fee for each service as charges.**

Locator#	Description	Instructions	Alerts
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** – When specialty care services are billed (T2025), the encounter should be billed with “0” Charges and the detail lines should be billed with the actual fee for each service as Charges	**Use of encounter code T2025 is solely to report specialty care expenses incurred as required by the GNOCHC program.** **Providers should not expect direct compensation for any expenses listed.**
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	**Leave Blank**	
24I	I.D. Qual.	**Optional -** The I.D. Qualifier indicates what type of identifying provider number is being entered in 24J.	**This field can be left blank for GNOCHC.**

Locator#	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	**Required -** Enter the GNOCHC Provider ID in the shaded portion of the block. Entering the GNOCHC Provider's NPI in the non-shaded portion of the block.	**An attending provider number/NPI must be entered.** **Enter the GNOCHC billing provider number/NPI as the attending provider.**
25	Federal Tax I.D. Number	**Optional.**	
26	Patient's Account No.	**Situational** – 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.	
27	Accept Assignment	**Leave Blank -** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Leave Blank**	
30	Balance Due	**Leave Blank**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional.** **Optional.**	**It is no longer necessary for providers to sign claim forms submitted to legacy Medicaid and Bayou Health Shared Health Plans.**

Locator#	Description	Instructions	Alerts
32	Service Facility Location Information	**Leave Blank**	
32a	NPI	**Leave Blank**	
32b	Unlabelled	**Leave Blank**	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Required** – Enter the GNOCHC billing provider's NPI.	
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit GNOCHC Provider Number.	**Claims will be rejected if this information is not present on the claim form.**

Sample form showing a Specialty Care encounter

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 5632147896325

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 05 10 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. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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 carrier code if applicable

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 149 0 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Prior auth # 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 08 10 12	08 10 12	72		T2025			0 00			NPI	1234567 / 1326547895
2 08 10 12	08 10 12	72		99213			90 00			NPI	1234567 / 1326547895
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 $ 90 00

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

Ima Biller 9/1/12

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Always Open GNOCHC Clinic

123 Main St.

Any Town, LA 70000

a. 1326547895 b. 1234567

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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