
CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING**PAGE(S) 17**

CLAIMS FILING

Greater New Orleans Community Health Connection 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**

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17****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 <u>must</u> 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	

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17**

Locator#	Description	Instructions	Alerts
5	Patient's Address	Leave Blank	
6	Patient Relationship to Insured	Leave Blank	
7	Insured's Address	Leave Blank	
8	Patient Status	Leave Blank	
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	

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17**

Locator#	Description	Instructions	Alerts
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	
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	

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17**

Locator#	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	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.
22	Medicaid Resubmission Code	Leave Blank	
23	Prior Authorization Number	Leave Blank	

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

Locator#	Description	Instructions	Alerts
24	Supplemental Information	<p>Situational – Applies to the detail lines for drugs and biologicals only.</p> <p>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 <u>shall be entered</u> in the shaded section of 24A through 24G. <u>Claims for these drugs shall include the NDC from the label of the product administered.</u></p> <p>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.</p> <p>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.</p> <p>The following qualifiers are to be used when reporting NDC units:</p> <p>F2 International Unit ML Milliliter GR Gram UN Unit</p>	<p>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.</p> <p>This information must be entered in addition to the procedure code(s).</p>

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

Locator#	Description	Instructions	Alerts																								
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	<p>Six-digit or 8-digit dates can be used on paper claims.</p> <p>Only 8-digit dates can be used for electronic (EDI) claims.</p>																								
24B	Place of Service	<p>Required -- Enter the appropriate place of service code for the services rendered.</p> <p>Acceptable Place of Service Codes are:</p> <table><tr><th>Code</th><th>Definition</th></tr><tr><td>04</td><td>Homeless Shelter</td></tr><tr><td>11</td><td>Office</td></tr><tr><td>12</td><td>Home</td></tr><tr><td>15</td><td>Mobile Unit</td></tr><tr><td>49</td><td>Independent Clinic</td></tr><tr><td>50</td><td>Federally Qualified Health Center</td></tr><tr><td>53</td><td>Community Mental Health Center</td></tr><tr><td>57</td><td>Non-Residential Substance Abuse Treatment Facility</td></tr><tr><td>71</td><td>State or Local Public Health Clinic</td></tr><tr><td>72</td><td>Rural Health Clinic</td></tr><tr><td>81</td><td>Independent Laboratory</td></tr></table>	Code	Definition	04	Homeless Shelter	11	Office	12	Home	15	Mobile Unit	49	Independent Clinic	50	Federally Qualified Health Center	53	Community Mental Health Center	57	Non-Residential Substance Abuse Treatment Facility	71	State or Local Public Health Clinic	72	Rural Health Clinic	81	Independent Laboratory	
Code	Definition																										
04	Homeless Shelter																										
11	Office																										
12	Home																										
15	Mobile Unit																										
49	Independent Clinic																										
50	Federally Qualified Health Center																										
53	Community Mental Health Center																										
57	Non-Residential Substance Abuse Treatment Facility																										
71	State or Local Public Health Clinic																										
72	Rural Health Clinic																										
81	Independent Laboratory																										
24C	EMG	Leave Blank																									

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17**

Locator#	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered. The appropriate modifier must be appended to the encounter code. The primary care encounter does not have a modifier. Use TF for the Basic Behavioral Health Encounter and TG for the SMI Behavioral Health Encounter. The primary care encounter and one behavioral health encounter may be billed on the same date of service if both types of visits occur.</p> <p>Enter the GNOCHC encounter procedure code on the first line.</p> <p>Encounter Code = T1015</p> <p>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.</p> <p>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)</p>	<p>The encounter code must be present on the claim, accompanied by at least 1 detail line for a covered service.</p> <p>All services should be included as detail lines.</p> <p>If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 is required.</p>
24E	Diagnosis Pointer	<p>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17**

Locator#	Description	Instructions	Alerts
24F	\$Charges	Required -- Enter usual and customary (U&C) charges <u>or</u> zero for detail lines.	
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.
24J	Rendering Provider I.D. #	Required - Enter the Rendering Provider's Medicaid Provider Number in the shaded portion of the block. Entering the Rendering Provider's NPI in the non-shaded portion of the block.	
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.	

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION**APPENDIX C: CLAIMS FILING****PAGE(S) 17**

Locator#	Description	Instructions	Alerts
29	Amount Paid	Leave Blank	
30	Balance Due	Leave Blank	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Required -- The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. Required -- Enter the date of the signature.	The claim will be rejected if an original signature or original initial (for stamped or computer generated signatures) is not present.
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.

ISSUED: 09/13/11
REPLACED: 09/01/11

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/05

PICA ☐

PICA ☐

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> Medicare # <input checked="" type="checkbox"/> Medicaid # <input type="checkbox"/> TRICARE (Spouse's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID#) <input type="checkbox"/> FECA (EMPLOYER'S SSN) <input type="checkbox"/> OTHER (ID#)		14. INSURED'S ID NUMBER (For Program in Item 1) 5632147896325	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial) Betsey Ross		3. PATIENT'S BIRTH DATE MM/DD/YYYY 01/05/10 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. PATIENT'S ADDRESS (No. Street) City STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER & DATE OF BIRTH MM/DD/YYYY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM/DD/YYYY SEX M <input type="checkbox"/> F <input type="checkbox"/>		B. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		4. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes return to and complete item 9 and d	
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 (First symptom) OR INJURY (Accident) OR RESUMPTION (LUMP) FROM MM/DD/YYYY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM/DD/YYYY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YYYY TO MM/DD/YYYY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (State items 1, 2, 3 or 4 to item 24E by Line) 149.0		22. METHOD OF RESUBMISSION ORIGINAL REF NO	
23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES OR SUPPLIES (Explain unusual circumstances) E. DIAGNOSIS PORTED F. CHARGES G. DAYS OR UNITS H. SPENT PER DAY I. ID QUAL J. RENDERING PROVIDER ID #			
1 08 10 11 08 10 11 72 T1015 1 145.00 1		1234567	
2 08 10 11 08 10 11 72 99213 1 0.00 1		1236548901	
3		1234567	
4		1236548901	
5			
6			
25. FEDERAL TAX ID NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO	
27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 145.00	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 145.00	
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 9/1/11		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH# Always Open GNOCH Clinic 123 Main St. Any Town, LA 700000		34. BILLING PROVIDER ID# 1236547895	
35. BILLING PROVIDER ID# 1234567			

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

ADJUSTMENTS AND VOIDS

Completing the 213 Adjustment/Void Form

The 213 adjustment/void form is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Molina Medicaid Solutions by calling Provider Relations at (800) 473-2783 or at www.lamedicaid.com using the Forms/Files/User Guides link. Instructions and an example of a completed 213 adjustment form are shown on the following pages.

If a claim has been paid using the 837P claim transaction, an adjustment or void may be submitted electronically or by using the Molina 213 adjustment/void 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 07/17/2010, ICN 0266156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2010, ICN 0035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (0035126742100) and RA date (12/11/2010) 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. An example of an adjustment appears within this document.

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).

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING**PAGE(S) 17**

Filing Adjustments for a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare reimburses the claim, and 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 claims may “crossover” from Medicare to Medicaid, but cannot be automatically processed by Medicaid (as the electronic crossover claim appears to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy adjustment claim (Molina Form 213) with Medicaid. These should be sent with a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached to:

**Molina Medicaid Solutions
Attention: Crossover Adjustments
P.O. Box 91023
Baton Rouge, LA 70821**

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.

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING**PAGE(S) 17**

Instructions for Completing the 213 Adjustment/Void Form

1. **REQUIRED** ADJ/VOID – Check the appropriate block
2. **REQUIRED** Patient's Name
 - a. Adjust – Print the name exactly as it appears on the original claim if not adjusting this information.
 - b. Void – Print the name exactly as it appears on the original claim.
3. **REQUIRED** Patient's Date of Birth
 - a. Adjust – Print the date exactly as it appears on the original claim if not adjusting this information.
 - b. Void – Print the name exactly as it appears on the original claim.
4. **REQUIRED** Medicaid ID Number – Enter the 13 digit recipient ID number
5. Patient's Address and Telephone Number
 - a. Adjust – Print the address exactly as it appears on the original claim.
 - b. Void – Print the address exactly as it appears on the original claim.
6. Patient's Sex
 - a. Adjust – Print this information exactly as it appears on the original claim if not adjusting this information.
 - b. Void – Print this information exactly as it appears on the original claim.
7. Insured's Name – Leave blank
8. Patient's Relationship to Insured – Leave blank
9. Insured's Group No. – Complete if appropriate or leave blank
10. Other Health Insurance Coverage – Complete with 6-digit TPL carrier code if appropriate or leave blank

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

11. Was Condition Related to – Leave blank
12. Insured's Address – Leave blank
13. Date of – Leave blank
14. Date First Consulted You for This Condition – Leave blank
15. Has Patient Ever had Same or Similar Symptoms – Leave blank
16. Date Patient Able to Return to Work—Leave blank
17. Dates of Total Disability-Dates of Partial Disability – Leave blank
18. Name of Referring Physician or Other Source – Leave blank
- 18a. Referring ID Number – Leave blank.
19. For Services Related to Hospitalization Give Hospitalization Dates – Leave blank
20. Name and Address of Facility Where Services Rendered (if other than home or office) – Leave blank
21. Was Laboratory Work Performed Outside of Office – Leave blank
22. **REQUIRED** Diagnosis of Nature of Illness
 - a. Adjust – Print the information exactly as it appears on the original claim if not adjusting the information.
 - b. Void – Print the information exactly as it appears on the original claim.
23. Attending Number – Leave this space blank
24. Prior Authorization # - Enter the PA number
25. **REQUIRED** A through F
 - a. Adjust – Print the information exactly as it appears on the original claim if not adjusting the information.

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

- b. Void – Print the information exactly as it appears on the original claim.
26. **REQUIRED** Control Number – Print the correct Control Number as shown on the remittance advice
27. **REQUIRED** Date of remittance advice that Listed Claim was Paid – Enter MM DD YY from RA form
28. **REQUIRED** Reasons for Adjustment – Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.
29. **REQUIRED** Reasons for Void – Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.
30. **REQUIRED** Signature of Physician or Supplier – All Adjustment/Void forms must be signed.
31. **REQUIRED** Physician's or Supplier's Name, Address, Zip Code and Telephone Number – Enter the requested information appropriately plus the seven digit Medicaid provider number and provider NPI number.
32. Patient's Account Number – Enter the patient's provider-assigned account number.

REQUIRED items must be completed or form will be returned.

CHAPTER XX: GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

APPENDIX C: CLAIMS FILING

PAGE(S) 17

Example of Unisys 213 Adjustment

MAIL TO:
UNISYS
P.O. BOX 91092
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1. ADJ. ☒ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
Adalam, Mary

3. PATIENT'S DATE OF BIRTH
06/11/89

4. MEDICAID ID NUMBER
1234567891234

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

6. PATIENT'S SEX
MALE ☐ FEMALE ☐

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

8. INSURED'S NAME

9. INSURED'S GROUP NO. (OR GROUP NAME)

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

11. TELEPHONE NO.
060606

12. OTHER HEALTH INSURANCE COVERAGE: ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER

13. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ NO ☐
B. AN AUTO ACCIDENT
YES ☐ NO ☐

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. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ NO ☐

17. DATES OF TOTAL DISABILITY
FROM ☐ THROUGH ☐

18. DATES OF PARTIAL DISABILITY
FROM ☐ THROUGH ☐

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
CommunityCARE

20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
Authorization # (if needed)

21. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED ☐ DISCHARGED ☐

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

23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE
V222

24. ATTENDING NUMBER
1234567

25. PRECIPITATION AUTHORIZATION NO.

26. A. DATE(S) OF SERVICE
From ☐ To ☐
MM DD YY MM DD YY

27. B. PLACE OF SERVICE
72

28. C. PROCEDURE
T1015

29. D. DIAGNOSIS CODE
1

30. E. CHARGES
145.00

31. F. DAYS OR UNITS
1

32. EPISOT FAMILY PLAN
☐

33. TPL \$

34. CONTROL NUMBER
0076156789501

35. THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

36. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID
05/03/11

37. REASONS FOR ADJUSTMENT
01. THIRD PARTY LIABILITY RECOVERY
☒ 02. PROVIDER CORRECTIONS
03. FISCAL AGENT ERROR
90. STATE OFFICE USE ONLY - RECOVERY
99. OTHER - PLEASE EXPLAIN
Billed incorrect date.

38. REASONS FOR VOID
10. CLAIM PAID FOR WRONG RECIPIENT
11. CLAIM PAID TO WRONG PROVIDER
99. OTHER - PLEASE EXPLAIN

39. SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller 08/22/2011

40. YOUR PATIENT'S ACCOUNT NUMBER

41. PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
**Always Open GNOCHC Clinic
123 Smiley St.
Sunny, LA 70000
NPI #1234567897 Provider# 99999999**

FISCAL AGENT COPY

UNISYS - 213
5/97