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

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**	

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**	

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**	

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**	

Locator#	Description	Instructions	Alerts
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).**

<table>
<tr><th>Locator#</th><th>Description</th><th>Instructions</th><th>Alerts</th></tr>
<tr><td>24A</td><td>Date(s) of Service</td><td>Required -- Enter the date of service for each procedure.

Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</td><td>Six-digit or 8-digit dates can be used on paper claims.

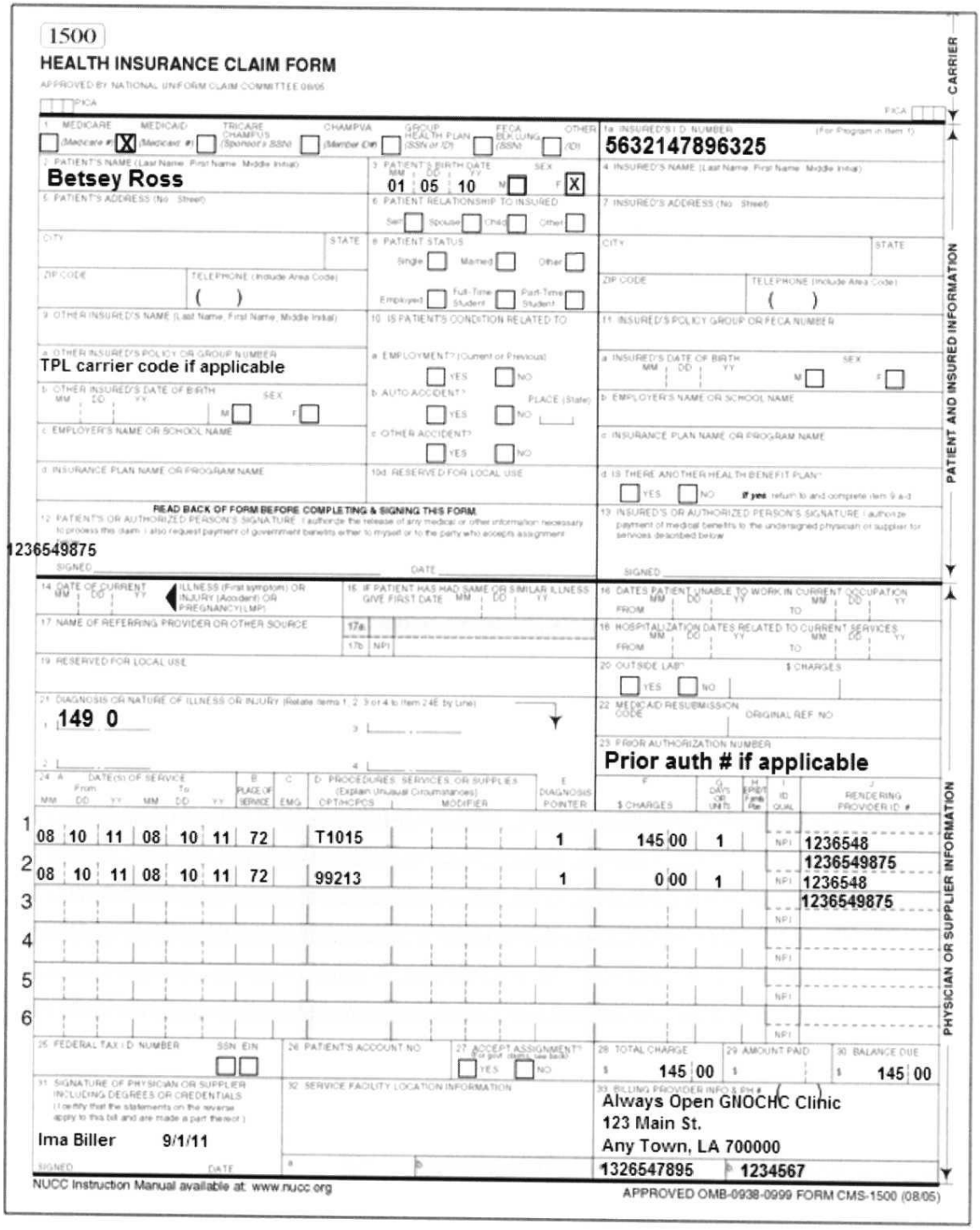
Only 8-digit dates can be used for electronic (EDI) claims.</td></tr>
<tr><td>24B</td><td>Place of Service</td><td>Required -- Enter the appropriate place of service code for the services rendered.

Acceptable Place of Service Codes are:
<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></td><td></td></tr>
<tr><td>24C</td><td>EMG</td><td>Leave Blank</td><td></td></tr>
</table>

Locator#	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	**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. Enter the GNOCHC encounter procedure code on the first line. **Encounter Code = T1015** 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 1 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.**
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.	

Locator#	Description	Instructions	Alerts
24F	$Charges	**Required** -- Enter usual and customary (U&C) charges or 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.	

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.**



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X] (Medicare #) MEDICAID (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:

6. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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.

1236549875

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

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

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

2. 3. 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 11	08 10 11	72		T1015		1	145 00	1		NPI	1236548
2 08 10 11	08 10 11	72		99213		1	0 00	1		NPI	1236549875
3										NPI	1236548
4										NPI	1236549875
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: $ 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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:

a. b.

33. BILLING PROVIDER INFO & PH #:

Always Open GNOCHC Clinic
123 Main St.
Any Town, LA 700000

1326547895 b. 1234567

NUCC Instruction Manual available at: www.nucc.org

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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).

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.

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

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.

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.

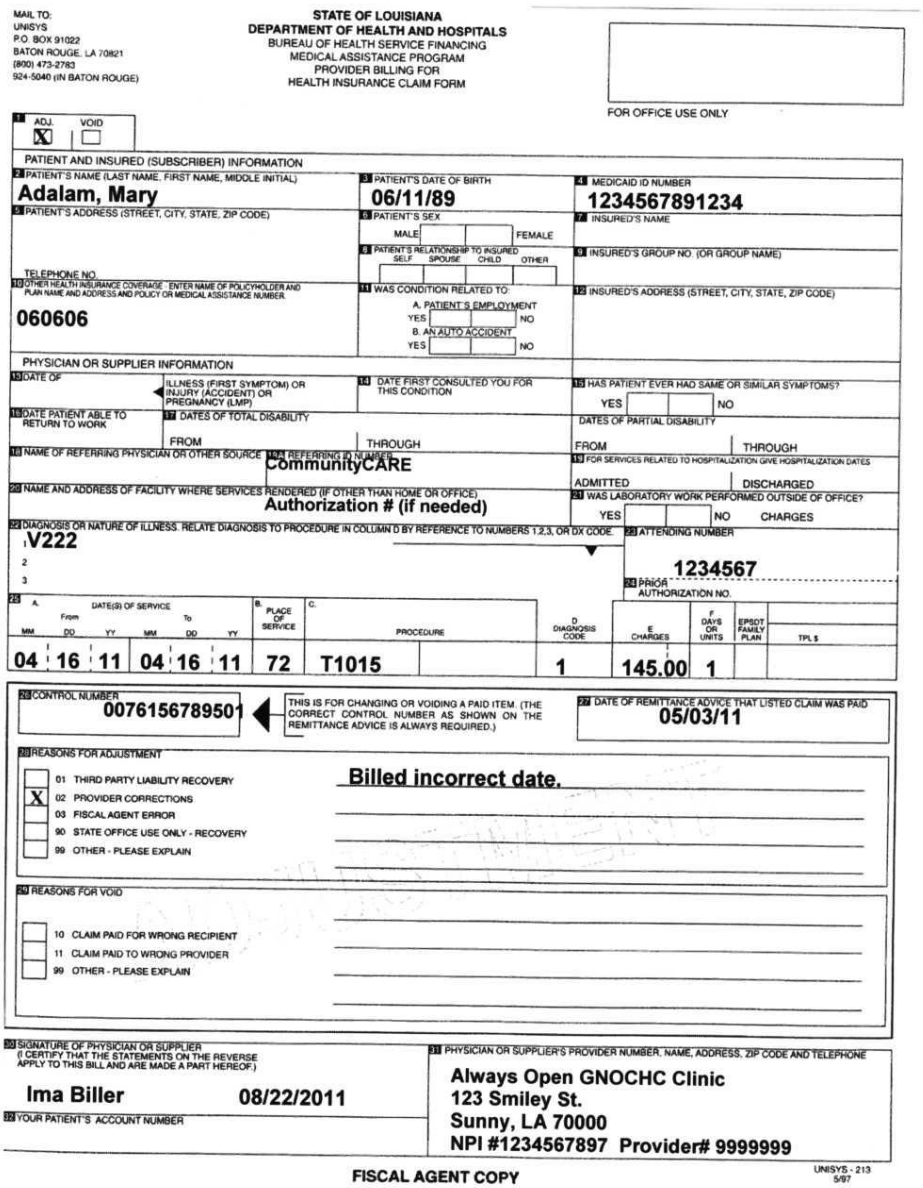
30. **REQUIRED** Signature of Physician or Supplier – All Adjustment/Void forms must be signed.

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 <u>form will be returned</u>.

Example of Unisys 213 Adjustment



MAIL TO:
UNISYS
P.O. BOX 91022
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. [X] 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)
TELEPHONE NO.
6. PATIENT'S SEX: MALE FEMALE
7. INSURED'S NAME
8. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
9. INSURED'S GROUP NO. (OR GROUP NAME)
10. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER: **060606**
11. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO
12. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14. DATE FIRST CONSULTED YOU FOR THIS CONDITION
15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16. DATE PATIENT ABLE TO RETURN TO WORK
17. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17A. REFERRING ID NUMBER: **CommunityCARE**
19. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): **Authorization # (if needed)**
21. WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES NO CHARGES
22. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE
1 **V222**
2
3
23. ATTENDING NUMBER: **1234567**
23. PRIOR AUTHORIZATION NO.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
04	16	11	04	16	11	72	T1015	1	145.00	1		

25. CONTROL NUMBER: **0076156789501**
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: **05/03/11**

28. REASONS FOR ADJUSTMENT
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[X] 02 PROVIDER CORRECTIONS — **Billed incorrect date.**
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN

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

30. 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**
32. YOUR PATIENT'S ACCOUNT NUMBER

31. 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# 9999999

FISCAL AGENT COPY

UNISYS - 213
5/97