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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.)

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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.
la	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	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).	
	Sex	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	

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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	

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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	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.

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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 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).

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Locator#	Description	Instructions	Alerts
		Required Enter the date of service for each procedure.	Six-digit or 8-digit dates can be used on paper claims.
24A	Date(s) of Service	Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	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.

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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.

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Locator#	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	Required - Enter the Rendering Provider's Medicaid Provider Number in the shaded portion of the block, if available. Otherwise, leave blank. Entering the Rendering Provider's NPI in the non-shaded portion of the block.	An attending provider number/NPI must be entered. If the attending provider is a type that cannot enroll in Louisiana Medicaid, enter the GNOCHC billing provider number/NPI as the attending provider. If provider cannot be an attending provider or does not have an official linkage to the GNOCHC provider, 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.	

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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	Optional. Optional.	It is no longer necessary for providers to sign claim forms submitted to legacy Medicaid and Bayou Health Shared Health Plans.
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.

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1500 HEALTH INSURANCE CLAIM FOI APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08 TTTPICA	A IA A A LUMBA A	-
1. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP HEALTH PLAN BLKLUNG	R 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicald #) (Sponsor's SSN) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	(Member ID#) (SSN or ID) (SSN) (ID) 3. PATIENT'S BIRTH DATE SEX	5632147896325 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Betsey Ross	01 05 10 M F 🗙	
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	CITY STATE
ZIP CODE TELEPHONE (Include Area	Single Married Other	ZIP CODE TELEPHONE (Include Area Code)
	Employed Full-Time Part-Time	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a, INSURED'S DATE OF BIRTH MM DD YY
TPL carrier code if applicable		M
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State	b. EMPLOYER'S NAME OR SCHOOL NAME
EMPLOYER'S NAME OR SCHOOL NAME	0. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
. INSONANSE PEAN NAME OF PROGRAM NAME	IVA. RESERVED FOR LOCAL USE	YES NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE C 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 to process this claim. I also request payment of government b below.	OMPLETING & SIGNING THIS FORM. uthorize the release of any medical or other information necessary enefits either to myself or to the party who accepts assignment	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT: MM DD YY INJURY (Accident) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNES GIVE FIRST DATE MM DD YY	S. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE	17b. NPI	FROM TO 20. OUTSIDE LAB? \$ CHARGES
19. HESERVED FOR LOCAL USE		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat	e Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 149.0	3	23. PRIOR AUTHORIZATION NUMBER
2.	4	Prior auth # if applicable
24. A DATE(S) OF SERVICE B. C. From To PLACE OF MM DD YY MM DD YY SERVICE EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOS CPT/HCPCS I MODIFIER POINTER	F. G. H. I. J. IS DAYS FROT ID. RENDERING OR Family ID. PROVIDER ID. #
MM DD YY MM DD YY SERVICE EMG	CPT/HCPCS MODIFIER POINTER	R \$ CHARGES UNTS AND PROVIDER ID. #
08 10 12 08 10 12 72	T2025	0 00 NPI 1236559876
08 10 12 08 10 12 72	99213	90 00 NPI 1236559876
		NPI
		NPI
		NPL
		INP 1
25 FEDERAL TAX LD NUMBER SSN EIN 26 L	PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. I	PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 90 00 \$ \$ 4 4
INCLUDING DEGREES OR CREDENTIALS	SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		Always Open GNOCHC Clinic '
9 ma Biller 9/1/12		Any Town, LA 70000
SIGNED DATE a.	N PI b.	a 1326547895 b 1234567