CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING PAGE(S) 16

CLAIMS FILING

Hard copy billing of applied behavior analysis (ABA) services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

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 to:

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

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

ISSUED: 05/01/17 REPLACED: 09/28/15

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

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CMS 1500 (02/12) Billing Instructions for Applied Behavior Analysis

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		
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six 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	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		
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 coverage, the state assigned 6-digit TPL carrier code is required in this field. 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.	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.

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Locator #	Description	Instructions	Alerts
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 Sex	Situational – Complete if appropriate or leave blank.	
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	Unlabeled	Situational – Enter if applicable or leave blank.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

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Locator #	Description	Instructions	Alerts
			The most specific diagnosis code must be used. General codes are not acceptable.
21	ICD Indicator Diagnosis or Nature of Illness or Injury	Required Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper 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.	ICD-9 diagnosis codes must be used for claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. 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	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	Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). 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.

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Locator #	Description	Instructions	Alerts
23	Prior Authorization (PA) Number	Required –When prior authorization is required for services, the prior authorization number must be entered in this field.	For authorized services, the PA number MUST be entered here.
24	Supplemental Information	Situational – Complete if appropriate or leave blank.	
24 A	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.	
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). Acceptable procedure codes are located in Appendix B of this manual chapter. (1 unit = 1 hour)	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required Enter usual and customary charges for the service rendered.	

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Locator #	Description	Instructions	Alerts
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D	Refer to 24D
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional.	
24 J	Rendering Provider ID#	Situational – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is required if the Provider's Medicaid ID number is entered above.	
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?	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. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional The original signature of the provider is no longer required.	
	Date	Enter the date of the signature.	

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Locator #	Description	Instructions	Alerts
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Optional.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required – Enter the billing provider's 10-digit NPI number.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit LA Medicaid provider number must be entered here.

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING **PAGE(S) 16**

ABA – Example Claim Form for Individual Billing with ICD-9 Diagnosis Code (**Dates BEFORE 10/1/15**)

INSTER			
EALTH INSURANCE	CE CLAIM FORM ORM CLAIM COMMITTEE (NUCC) 02	9112	
PICA	SKW CEAN COMMITTEE (NOCC) 02		PICA
MEDICARE MEDICAID	TRICARE CHA	MPVA GROUP FECA OTH HEALTH PLAN BLK LUNG	IER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid	#) (ID#/DoD#) (Merr	nber ID#) (ID#) (ID#) (ID#)	9876543210123
PATIENT'S NAME (Last Name	e, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
AYCO, TRAVIS		07 31 2001 M X F	
PATIENT'S ADDRESS (No., S	itreet)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Y	STA	Self Spouse Child Other TE 8 RESERVED FOR NUCC USE	CITY STATE
T	517	8. RESERVED FOR NOCC USE	CITY
CODE	TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Indude Area Code)
	()		()
THER INSURED'S NAME (L	ast Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
THER INSURED'S POLICY	OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
ESERVED FOR NUCC USE		YES NO	M F
LOUR VED FOR MODE USE		b. AUTO ACCIDENT? PLACE (St	b. OTHER CLAIM ID (Designated by NUCC)
ESERVED FOR NUCC USE			c. INSURANCE PLAN NAME OR PROGRAM NAME
		YES NO	
SURANCE PLAN NAME OF	PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
	EX	AMPLE OF I	YES NO If ves. complete items 9, 9a and 9d.
READ ATIENT'S OR AUTHORIZEI	BACK OF FORM BEFORE COMPLE D PERSON'S SIGNATURE Lauthoriz	TING & SIGNING THIS FORM. The the release of any medical or other information neces	YES NO If vas. comodete items 9. 9a and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize sary payment of medical benefits to the undersigned physician or supplier for
process this claim. I also req	uest payment of government benefits e	ither to myself or to the party who accepts assignment	services described below.
SIGNED		DATE	SIGNED
	S, INJURY, or PREGNANCY (LMP)	15.OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY
	DIAI	QUAL MM DD YY	FROM TO TO MM DD YY
- i	VIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
		71b. NPI	FROM TO TO
ADDITIONAL CLAIM INFOR!	MATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
			YES NO
DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY Relate A-L	to service line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.
30000	В	C D	A 02 4087156789100
	F	G. H.	23. PRIOR AUTHORIZATION NUMBER 456789123
A. DATE(S) OF SERVICE		K. L. L. E. COCEDURES, SERVICES, OR SUPPLIES E.	
From		(Explain Unusual Circumstances) DIAGNO 7HCPCS MODIFIER POINT	F. G. H. I. J. DA YS BEROT DI. RENDERING FAMILY DIAL PROVIDER ID. #
00 11 11111	o ii sama and	WO SO WOOD TO STATE	Office Annual Literature
28 14 03 2	28 14 11 H	2019 A	150 00 10 NPI
1 1 1			NPI NPI
			NPI NPI
			NPI
			NPI NPI
			NPI NPI
FEDERAL TAXID. NUMBER	R SSN EIN 28. PATIE!	IT'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT Shot claims, see bad)	NPI
		(For govt. claims, see back) YES NO	NPI
FEDERAL TAX I.D. NUMBER	OR SUPPLIER 32. SERVIO	AT'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT (Fig. gov. caims, we load) YES NO.	NPI
SIGNATURE OF PHYSICIAN NCLUDING DEGREES OR (I certify that the statements or	I OR SUPPLIER 32. SERVIO	YES NO	NPI
SIGNATURE OF PHYSICIAN	I OR SUPPLIER 32. SERVIO	YES NO	NPI
SIGNATURE OF PHYSICIAN NCLUDING DEGREES OR (I certify that the statements or	OR SUPPLIER 32. SERVION the reverse a part thereof.)	YES NO	NPI

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING **PAGE(S) 16**

ABA – Example Claim Form for Group Billing with ICD-9 Diagnosis Code (**Dates BEFORE 10/1/15**)

I I X TEN IEALTH INSURANCE CLAIM FORM			
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			PICA
MEDICARE MEDICAID TRICARE CHAMPVA	GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare #) ★ (Medicaid #) (ID#/DoD#) (Member ID#)	(ID#) (ID#) (ID#)	9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3.	PATIENT'S BIRTH DATE SEX MM DD YY O7 31 2001 M X F	4. INSURED'S NAME (Last Name, First Name,	, Middle Initial)
JAYCO, TRAVIS 5. PATIENT'S ADDRESS (No., Street) 6.	07 31 2001 M X F PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
	Self Spouse Child Other	(,,	
TTY STATE 8.1	RESERVED FOR NUCC USE	СПҮ	STATE
IP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHON	E (Indude Area Code)
()		()
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	D. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA N	UMBER
OTHER MOUREN'S DOLLOW OR CROWN MILES		- INCLINEDIO DATE OF DIDTA	SEX
OTHER INSURED'S POLICY OR GROUP NUMBER a.	EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY	SEX F
RESERVED FOR NUCC USE b.	AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	•
	SAMPHE		
RESERVED FOR NUCC USE c.	OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM I	NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	A 18 THERE ANOTHER HEALTH REVIEW B	I AN2
FXAI	MPIF OF IC	d IS THERE MOTHER HEALTH BENEFIT PI	e items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING & S PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Lauthorize the rele	SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S	SIGNATURE I authorize
to process this claim. I also request payment of government benefits either to m		 payment of medical benefits to the undersig services described below. 	ned physician or supplier for
below. SIGNED	DATE	SIGNED	
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0TH	ER DATE MM . DD . YY	16. DATES PATIENT UNABLE TO WORK IN C	CURRENT OCCUPATION
MM DD YY QUAL. QUAL.	MM DD YY	FROM DD YY TO	MM DD YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO	CURRENT SERVICES
71b. NF	9	FROM TO 20. OUTSIDE LAB? \$ CHA	
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		YES NO	RGES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service	e line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL F	REE NO
<u>а. [</u> 30000 в. [с. [D. <u> </u>		
E F G	н	23. PRIOR AUTHORIZATION NUMBER	
I J K	L. L. E. RES, SERVICES, OR SUPPLIES E.	456789123	
From To PLACE OF (Explain MM DD YY MM DD YY SERVICE EMG CPT/HCPCS	Unusual Circumstances) DIAGNOSIS MODIFIER POINTER	F. G. H. I. DAYS EPSOT ID. OR Family S CHARGES UNITS Pan QUAL.	RENDERING PROVIDER ID. #
			1234567
03 27 14 03 27 14 11 H0032	Α	180 00 1 NPI	1234567891
03 28 14 03 28 14 11 H2019		180 00 12 NPI	1234567 1234567891
12013	1 1 1 7	100 00 12	1234567
04 01 14 04 01 14 11 G9012	Α	72 00 4 NPI	
		100000 00 00 00 00	1234567
04 04 14 04 04 14 11 H2019	A	120 00 8 NPI	1234567891
		NPI	
			The second secon
		NPI	
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACC	(For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PA	The state of the s
	YES NO	28. TOTAL CHARGE 29. AMOUNT P/ \$ 552 00 \$	\$
I1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACIL	COUNT NO. 27. ACCEPT AS SIGNMENT? (For your calms, see buds) YES NO JTY LOCATION INFORMATION	28. TOTAL CHARGE 29. AMOUNT P/ \$ 552 00 \$ 33. BILLING PROVIDER INFO & PH # (8	\$ 000) 233-3333
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACIL	YES NO	28. TOTAL CHARGE 29. AMOUNT P/ \$ 552 00 \$	\$ 000) 233-3333
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLIDING DEGREES OR CREDENTIALS (I certify that beatements on the reverse)	YES NO	28. TOTAL CHARGE 29. AMOUNT P/ \$ 552 00 \$ 33. BILLING PROVIDER INFO & PH# (8 ABC BEHAVIORAL ANALYSIS	\$ 000) 233-3333

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING **PAGE(S) 16**

ABA – Example Claim Form for Individual Billing with ICD-10 Diagnosis Code (**Dates ON OR AFTER 10/1/15**)

EALTH INSU PROVED BY NATION					UCO AGUA											
PICA PICA	IAL UNIFORM	CLAIM	COMMIT	TEE (N	UCC) 02/12										PI	CA TT
	EDICAID		CARE		CHAMPVA	GROU! HEALT	P H PLAN	FECA BLK LU	NG (IDIII)	1a. INSURED'S I.D. NU				(For F	nogram in	Item 1)
(Medicare #) X (M		,	//DoD#)	nital)	(Member ID#)	(IDII)	BIRTH C	(ID#)	SEX	1234567890123 4. INSURED'S NAME (L		ne. First	Name.	Middle In	itial)	
DALAM, MAR	Y			,			1 ŏ		FX							
PATIENT'S ADDRES	S (No., Street)			6. PA			NSHIP TO IN Child		7. INSURED'S ADDRES	SS (No.,	Street)				
TY							pouse FOR NU	JOC USE	Other	CITY					STA	TE
PCODE	l we	ERIO								ZIP CODE		I was as				
PCODE	(NE (Induc)	de Area	Code)					ZIPCODE		TELE	PHONE	: (inciua)	Area Cod	9)
OTHER INSURED'S	NAME (Last N		,	, Middle	Initial) 10. I	SPATIE	NT'S CO	NDITION RE	LATED TO:	11. INSURED'S POLICY	GROU	P OR FE	ECA NU	MBER		
OTHER MELINENIS	DOLLOV OR A	200UD	AN INAPPER							a laighteeric pare	VE DID.	TU			SEX	
OTHER INSURED'S PL Code if app		SKOUP	NUMBER		a. EX	MYLOYM	ENT7(CI YES	urrent or Pre N	vious) IO	a. INSURED'S DATE	WYY.	111	М		F	
RESERVED FOR NU					b. Al	то АСС			PLACE (State)	b. OTHER CLAIM ID (D	esignate	d by NU	CC)			
ESERVED FOR NU	ICC USE					SA	M	ИΡ	'LE	c. INSURANCE PLAN N	AME O	R PROG	RAM N	IAME		
_ JETTED FOR NO					6. 0	, ()	YES	N	10							
NSURANCE PLAN N	NAME OR PR	OGRAN	NAME		10d.	RESERV	ED FOR	LOCAL USE		d. IS THERE ANOTHER	_					
	READ BAC	KOFF	ORM BE	ORE		A LG D	US DEN	F) F	1 INSI SEE A OR A					9a and 9d. URE I auth	ndze
PATIENT'S OR AUT o process this claim. selow.	HORIZED PE	RSON'S	SIGNAT	ure 1 nment b	authorize me releas en efits either to myse	e of any elfortoth	medical c e party w	n coner inform tho a coepts a	nation necessary ssignment	payment of medical services described b	penents elow.	to the ur	ndersig	ned phys	ician or sup	plier for
SIGNED						DAT	E			SIGNED						
DATE OF CURREN	TILLNESS, IN QUAL		or PREGI	NANCY	(LMP) 15.OTHER QUAL.	DATE	MM	DD	YY	16. DATES PATIENT UI MM DD FROM	NABLE 1	TO WOR	K IN C	URRENT MM	DD V	TION
NAME OF REFERR	ING PROVIDE		OTHER S	OURCE	17a.			 i		18. HOSPITALIZATION	i DATĘŞ	RELATE		CURREN	T _r SERVIQ	ş
					71b. NPI					FROM	<u> </u>		то			<u> </u>
ADDITIONAL CLAIN	I INFORMATI	ON (De	signated t	by NUC	0)					20. OUTSIDE LAB? YES N	ю [\$ CHA	RGES		
DIAGNOSIS OR NA	TURE OF ILL	NESS C	R INJUR	Y Re	late A-L to service li	ne below	(24E)	ICD Ind. 0	Т	22. RESUBMISSION CODE	-	ORIG	INAL R	EF. NO.		
F4 19	В			_	C		_	D		23. PRIOR AUTHORIZA	TION N	IMPER				
	. F.			_	G. [_	н		23. PRIOR AUTHORIZA	HONN	UNIDER				
A. DATE(S) OF From M DD YY	SERVICE To MM DD	YY	B. PLACE OF SERVICE	C. EMG	D.PROCEDURE (Explain UI CPT/HCPCS			ces)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ereor Femily Plan	I. ID. QUAL.		J. RENDER PROVIDER	ING I ID. #
0 08 15	10 08	15	11		H0032				Α	180 00	1	Ι (NPI			
0 09 15	10 09	15	11		H2019				A	180 00	12	1 1	NPI			
	.5 00	,,,			12010					.00 00	,,,					
12 15	10 12	15	11		G9012				Α	72 00	4	Ш	NPI			
12 15	10 12	15	11		H2019	НМ			A	80 00	4	1 (NPI			
									,							
								<u> </u>				Ш	NPI			
1													NPI			
FEDERAL TAX I.D.	NUMBER	SS	N EIN		PATIENT'S ACCO	JNT NO.	27	ACCEPT A	SSIGNMENT?	28. TOTAL CHARGE		9. AMO	JNT PA	1	O. BALANO	100
SIGNATURE OF THE	IVSICIANI CO	el loo-	ED	_	234 SERVICE FACILIT	VICOAT	;	X YES	NO	\$ 512 C	_	\$ 2.DH#	/ 01			512 00
SIGNATURE OF PH INCLUDING DEGRE () certify that the stat apply to this bill and	EES OR CRED lements on the	DENTIA nevers	LS e	32.	OENVIOE PAGILIT	LOCAL	IUN INF	UNMATION		JOHN DOE, AE 500 ALBERT R SMILEY, LA 70	BA D	arn#	(8)	υυ) 2:	33-3333	•
_{IGNED} Ima Bille	r	DATE	10/20/1	5 8		b.				a. 123456789	_	b.		12345	67	
JCC Instruction I					c.org		EASE F	PRINT OF	RTYPE	APPROVED						00 (02-1

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING **PAGE(S) 16**

ABA – Example Claim Form for Group Billing with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

EALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NI.	IICC) 02H2			
PICA	300,0212			PICA
. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP HEALTH P	FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#)	(ID#) (ID#)	1234567890123	
. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIF MM , DD	TH DATE SEX	4. INSURED'S NAME (Last Nar	ne, First Name, Middle Initial)
ADALAM, MARY	06 11	00 M F X		
. PATIENT'S ADDRESS (No., Street)	Self Spou		7. INSURED'S ADDRESS (No.,	
ОПУ	STATE 8. RESERVED FO	R NUCC USE	CITY	STATE
P CODE TELEPHONE (Indude Area of	Code)		ZIP CODE	TELEPHONE (Include Area Code)
()				()
OTHER INSUREDS NAME (Last Name, First Name, Middle	Initial) 10. IS PATIENT'S	CONDITION RELATED TO:	11. INSURED'S POLICY GROU	P OR FECA NUMBER
OT 150 110 1050 00 101 01 00 000 10 11 11 1050			- NOUDEDO DATE OF DID	TH SEX
OTHER INSURED'S POLICY OR GROUP NUMBER FPL Code if applicable		? (Current or Previous)	a. INSURED'S DATE OF BIR	M F
RESERVED FOR NUCCUSE	b. AUTO ACCIDE	YES NO NT? PLACE (State)	b. OTHER CLAIM ID (Designate	
	CA	R. A D. L. E.		
RESERVED FOR NUCC USE	c. D. AC. II		c. INSURANCE PLAN NAME O	R PROGRAM NAME
		YES NO		
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED	FOR LOCAL USE	d. IS THERE ANOTHER HEAL?	TH BENEFIT PLAN?
EV	$^{\prime}$ Λ Λ Λ DI			If yes, complete items 9, 9a and 9d.
READ BACK OF FORM : #500 A PATIENTS OR AUTHORIZED PERSONS SIGNATURE 1 to process this claim. I also request payment of government be below.	Wice N a JG IN 5 THIS surnorize the release of any med an effs either to myself or to the pa	FOF t loal or other information necessary inty who accepts assignment	payment of medical benefits services described below.	ED PERSON'S SIGNATURE I authorize to the undersigned physician or supplier for
SIGNED	DATE		SIGNED	
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY ((LMP) 15.OTHER DATE	MM DD YY	16. DATES PATIENT UNABLE MM DD YY FROM	TO WORK IN CURRENT OCCUPATION TO MM DD YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		18. HOSPITALIZATION DATES	
	71b. NPI		FROM	то
ADDITIONAL CLAIM INFORMATION (Designated by NUCC	C)		20. OUTSIDE LAB? YES NO	\$ CHARGES
I. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Re	late A-L to service line below (24	E) ICD Ind. 0	22. RESUBMISSION CODE	ORIGINAL REF. NO.
, F4 19 B.	C. I	D. I	CODE	ORIGINAL REF. NO.
E.I F.I	G.I	н	23. PRIOR AUTHORIZATION N	IUMBER
J. L.	к.	L.		
4. A. DATE(S) OF SERVICE B. C. From To PLACE OF SERVICE EMG	D.PROCEDURES, SERVICE (Explain Unusual Circun CPT/HCPCS M	S, OR SUPPLIES E. nstances) DIAGNOSIS ODIFIER POINTER	F. G. DAYS OR S CHARGES UNITS	H. I. BPSDT ID. RENDERING Pan QUAL. PROVIDER ID. #
			3410	1234567
0 08 15 10 08 15 11	H0032	Α	180 00 1	NPI 1234567891
0 00 45 40 45 45 44 4	110040		400 1	1234567
0 09 15 10 09 15 11	H2019	A	180 00 12	NPI 1234567891
0 12 15 10 12 15 11	G9012	I A	72 00 4	1234567 NPI 1234567891
12 10 10 12 19 11	30012	^	72 00 4	1234567
0 12 15 10 12 15 11	H2019 HM	A	80 00 4	NPI 1234567891
	,			1.22.700.00
				NPI
				NPI
	PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. daims, see back) X YES NO		9. AMOUNT PAID 30. BALANCE DUE s 512 00
	34 SERVICE FACILITY LOCATION		\$ 512 00 33. BILLING PROVIDER INFO	. 0.2,00
1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS () cartify that the statements on the reverse	OLIVIOE PROILIT LOUATION	THE SHIMATION	ABC BEHAVIORAL	()
(i certify that the statements on the reverse apply to this bill and are made a part thereof.)			500 ALBERT RD	ANALIOIO
			SMILEY, LA 70528	
IGNED Ima Biller DATE 10/15/15 a.	b.		-	b. 2123456
UCC Instruction Manual available at: www.nuc		SE PRINT OR TYPE		0938-1197 FORM CMS-1500 (02-1

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Adjustments and Voids

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

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

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

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

ISSUED: 05/01/17 REPLACED: 09/28/15

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When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Sample forms are on the following pages.

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Sample CMS-1500 Form Billed as an Adjustment with ICD-9 Diagnosis Code (**Dates BEFORE 10/1/15**)

国(公司		
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA TT
MEDICARE MEDICAID TRICARE CHAMPV.	A GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member	ID#) (ID#) (ID#) (ID#)	9876543210123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
JAYCO, TRAVIS	07 31 2001 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
CITY STATE	8. RESERVED FOR NUCC USE	ZIP CODE TELEPHONE (Indude Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DO MY b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME
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)	a. INSURED'S DATE OF BIRTH SEX
	YES NO	M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	SAMPLE	
c. RESERVED FOR NUCC USE	C OTHER ACCIDENTY	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	NADIE OE I	d JS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If vas. comolete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING	28 SIGNING THIS LIDER	YES NO If ves. complete items 9. 9a and 9d. 13. INSURED S OR AUTHORIZED PERSON'S SIGNATURE I authorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize the	release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.	to mysell or to the party who accepts assignment	services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0	OTHER DATE MM . DD . YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY
QUAL. QU		FROM TO WINN BB
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
71b	NPI	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		YES NO
	ervice line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.
A. [30000 B.] C. [D	A 02 4087156789100
E F G	н.	23. PRIOR AUTHORIZATION NUMBER
I J K 24. A. DATE(S) OF SERVICE B. C. D.PROCI	L. L. EDURES, SERVICES, OR SUPPLIES . E.	456789123
From To PLACE OF (Ex	plain Unusual Circumstances) DIAGNOSIS	T. DAYS III. J. J. J. DAYS III. DAYS III. RENDERING OR Family QUAL. PROVIDER ID. #
MM DD YY MM DD YY SERVICE EMG CPT/HO	PCS MODIFIER POINTER	\$ CHARGES UNITS From QUAL. PROVIDER ID. #
03 28 14 03 28 14 11 H201	9 A	150 00 10 NPI
		NPI NPI
		NPI NPI
		F. DAYS PROT ID. RENDERING PROVIDER ID.# 150 00 10 NPI NPI NPI NPI NPI
		NPI NPI
		NET
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	YES NO	\$ 150 00 \$ \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE F. INCLUDING DEGREES OR CREDENTIALS	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (800) 233-3333
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		JOHN DOE, ABA
apply to alls bill and are made a part thereof.)		500 ALBERT RD
Labor Data A DA		SMILEY, LA 70528
SIGNED John Doe, ABA DATE 4/9/14 a.	b.	a. 1234567891 b. 1234567
IUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02-12

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING **PAGE(S) 16**

Sample CMS-1500 Form Billed as an Adjustment with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

(228) (228)							
EALTH INSURANCE CLAIM FORI	M						
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE	(NUCC) 02/12						PICA CT
MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP	EECA	OTHER	1a. INSURED'S I.D. NUMBER	Fact	Program in Item 1)
(Medicare #) × (Medicaid #) (ID#/DoD#)	(Member ID)	GROUP HEALTH PLAN #) ((D#)	FECA BLK LUNG (IDM)	(IDII)	1234567890123	(FOFF	riogram in itam 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DA	4		4. INSURED'S NAME (Last Na	me, First Name, Middle In	itial)
DALAM, MARY		06 11 00		FΧ			
PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONS			INSURED'S ADDRESS (No.	, Street)	
тү	STATE 8	Self Spouse	Child Oth	Br	CITY		STATE
11	SIAIE	B. RESERVED FOR NUC	C 08E		CITY		SIATE
CODE TELEPHONE (Indude An	ea Code)				ZIP CODE	TELEPHONE (Include	Area Code)
()						()	
OTHER INSURED'S NAME (Last Name, First Name, Mid	dle Initial)	10. IS PATIENT'S CON	DITION RELATED	TO:	11. INSURED'S POLICY GROU	UP OR FECA NUMBER	
OTHER INSURED'S POLICY OR GROUP NUMBER					- INCUDENC DATE OF DIE	TU (SEX
PL Code if applicable	ľ	a. EMPLOYMENT? (Cun			a. INSURED'S DATE OF BIR	M	F
RESERVED FOR NUCCUSE		b. AUTO ACCIDENT?	NO PLAC	E (State)	b. OTHER CLAIM ID (Designat		-
		CAA	ΛDΪ	L.		, ,	
ESERVED FOR NUCC USE		a. OTHER & ICCN E. Th	/IPL		c. INSURANCE PLAN NAME C	OR PROGRAM NAME	
		YES	NO				
ISURANCE PLAN NAME OR PROGRAM NAME	[10d. RESERVED FOR L	OCAL USE		d. IS THERE ANOTHER HEAL	TH BENEFIT PLAN?	
	$\mathbf{X}\mathbf{\Delta}\mathbf{I}$	MDL	\mathbf{F}		1 INSU SET SOR A TH. RI	fyes, complete items 9,	
READ BACK OF FORM BE ORE ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of governmen elow.	authorize the nont benefits either to	elease of any medical or myself or to the party who	other information r a coepts assignment	recessary ant	payment of medical beneats services described below.	ED PERSON'S SIGNATI s to the undersigned phys	
SIGNED		DATE			SIGNED		
DATE OF CURRENT ILLNESS, INJURY, or PREGNANC QUAL	CY (LMP) 15.OT QUAL	THER DATE MM	DD YY		16. DATES PATIENT UNABLE MM DD YY FROM	TO WORK IN CURRENT TO	OCCUPATION DD YY
NAME OF REFERRING PROVIDER OR OTHER SOUR		NPI			18. HOSPITALIZATION DATES FROM	RELATED TO CURREN	T SERVICES
ADDITIONAL CLAIM INFORMATION (Designated by NU	JCC)				20. OUTSIDE LAB? YES NO	\$ CHARGES	
	Relate A-L to serv	vice line below (24E)	CD Ind. 0		22. RESUBMISSION CODE	ORIGINAL REF. NO.	
F4 19 B. L.	С		D		A 02	529919879870	0
F	G		н		23. PRIOR AUTHORIZATION I	NUMBER	
A. DATE(S) OF SERVICE B. C.	K D.PROCED	OURES, SERVICES, OR	SUPPLIES	E.	F. G.	H. L	J.
From To PLACEOF DD YY MM DD YY SERVICE EMO	(Expla	ain Unusual Circumstano	as) DIA	GNOSIS DINTER	F. G. DAYS S CHARGES UNITS	Fernity D. Plan QUAL.	RENDERING PROVIDER ID. #
08 15 10 08 15 11	H0032			Α	180 00 1	NPI	
		1 1 1	1 1			NPI	
						1 1111	
						NPI NPI	
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						, , , , , , , , , , , , , , ,	
						NPI NPI	
						NPI	
						NPI NPI NPI	
FEDERAL TAXLD NUMBER SSN EN	26. PATIENTS A	SCOUNT NO. 127	ACCEPT ASSIGN	MENT?	28 TOTAL CHARGE	NPI NPI NPI NPI	IO BALANCE DUF
	26. PATIENT'S AC	CCOUNT NO. 27.	ACCEPT ASSIGN For gov. dams, seet YES	MENT?	1	NPI	0. BALANCE DUE s 512 00
SIGNATURE OF PHYSICIAN OR SUPPLIER	1234	CCOUNT NO. 27.	YES NO	MENT?		NPI NPI NPI S9. AMOUNT PAID S	s 512 00
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS () cartily that the statements on the reverse	1234	×	YES NO	MENT?	\$ 512 00 33. BILLING PROVIDER INFO JOHN DOE, ABA 500 ALBERT RD	NPI NPI NPI S9. AMOUNT PAID S	s 512 00
	1234 32. SERVICE FAC	×	YES NO	MENT?	\$ 512 00 33. BILLING PROVIDER INFO JOHN DOE, ABA	NPI NPI NPI S9. AMOUNT PAID S	s 512 00 33-3333

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS

APPENDIX C: CLAIMS FILING **PAGE(S) 16**

Sample CMS-1500 Form

