CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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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 <u>www.lamedicaid.com</u>, 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.

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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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 | Required – Enter the recipient's 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS. NOTE: The recipients' 13-digit Medicaid 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. | |
| 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. |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|---|--|--------|
| 9b | RESERVED FOR NUCC | Leave Blank. | |
| 9с | RESERVED FOR NUCC | 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. | |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|--|--|--|
| 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. | The most specific diagnosis code must be used. General codes are not acceptable. ICD-9 diagnosis codes must be ued fon 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- |
| 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 | 10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com). 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. |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|--------------------------------------|---|--------|
| 23 | Prior Authorization (PA) Number | Required – All services billed must be prior authorized. The prior authorization number must be entered in this field. | |
| 24 | Supplemental Information | Situational – Complete if appropriate or leave blank. | |
| 24A | Date(s) of Service | Required Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable. | |
| 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). Procedure Codes: H2019: Therapeutic Behavior Service Up to 24 units per day (6 hours); 3- 5 days per week (1 Unit = 15 minutes) No Modifier for BCBA Modifier HM = Para-Professional G9012: Other Specified Case Management Service NOS A maximum of 4 units per week (1 unit = 15 Minutes) H0032: Mental Health Services Plan Development by Non-Physician – Initial Evaluation 1 hour allowed for the session/visit. Once every 180 days. (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. | |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

| 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. | |
| 24J | 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. | |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

| 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

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

| 1690 1995 1995 | | | | | | |
|--|---|--|--|---------------------------|---|---|
| EALTH INSURANCE CLAIM FC | | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER | 1a. INSURED'S I.D. NUMBER | PICA (For Program in Item 1) |
| (Medicare #) X (Medicaid #) (ID#/DoD#) | (Member ID#) | (124+) | (10#) | (ID#) | 9876543210123 | |
| . PATIENT'S NAME (Last Name, First Name, Middle I JAYCO, TRAVIS | nitial) 3. | 07 31 20 | Y 101 M X | F | 4. INSURED'S NAME (Last Name, Firs | t Name, Middle Initial) |
| PATIENT'S ADDRESS (No., Street) | - | PATIENT RELATION | | - | 7. INSURED'S ADDRESS (No., Street) | |
| ſΥ | | Self Spouse RESERVED FOR NU | Child Ot JCC USE | her | СЛТҮ | STATE |
| P CODE TELEPHONE (Includ | e Area Code) | | | | ZIP CODE TEL | EPHONE (Indude Area Code) |
| OTHER INSURED'S NAME (Last Name, First Name | Middle Initial) 1 | 0. IS PATIENT'S CO | | D TO: | 11. INSURED'S POLICY GROUP OR F | |
| OTHER INSORED 5 NAME (Las Name, Fis Name | Middle minal) | U. IS PATIENT 3 CO | NOTION REDATE | 010. | The INSURED'S POLICE GROUP OR P | ECANOMBER |
| OTHER INSURED'S POLICY OR GROUP NUMBER | a. | EMPLOYMENT? (O | urrent or Previous) NO | | a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F |
| RESERVED FOR NUCC USE | b. | AUTO ACCIDENT? | | CE (State) | b. OTHER CLAIM ID (Designated by N | UCC) |
| RESERVED FOR NUCC USE | c. | OTRACAL | /1714 | | c. INSURANCE PLAN NAME OR PRO | GRAM NAME |
| INSURANCE PLAN NAME OR PROGRAM NAME | | YES | | | J.ISTHERE ANOTHER HEALTH BEN | |
| | EXA | MPI | EÔF | : [(| | |
| READ BACK OF FORM BEF PATIENT'S OR AUTHORIZED PERSON'S SIGNAT to process this claim. I also request payment of gover | ORE COMPLETING & JRE I authorize the rele ment benefits either to m | SIGNING THIS FOR ease of any medical on self or to the party w | N. or other information | necessary nent | YES NO If vas. (13. INSURED S OR AUTHORIZED PEI payment of medical benefits to the u services described below. | RSON'S SIGNATURE I authorize indersigned physician or supplier for |
| below. SIGNED | | DATE | | | SIGNED | |
| DATE OF CURRENT ILLNESS, INJURY, or PREGMM DD YY | | ER DATE MN | I DD YY | | 16. DATES PATIENT UNABLE TO WO MM DD YY | |
| QUAL. NAME OF REFERRING PROVIDER OR OTHER S | QUAL. | | | | FROM 18. HOSPITALIZATION DATES RELAT | то |
| | 71b. N | PI | | | FROM | то |
| ADDITIONAL CLAIM INFORMATION (Designated b | y NUCC) | | | | 20. OUTSIDE LAB? YES NO | \$ CHARGES |
| DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Relate A-L to servic | e line below (24E) | ICD Ind. 9 | | | GINAL REF. NO. |
| . 30000 В. | C | | D | | A 02 4087 23. PRIOR AUTHORIZATION NUMBER | 156789100 |
| F J | G K | | н. <u> </u> | | 456789123 | • |
| . A. DATE(S) OF SERVICE B. From To PLACE OF M DD YY MM DD YY SERVICE | | IRES, SERVICES, OI Unusual Circumstan MODIF | ces) D | E. IAGNOSIS POINTER | F. G. H. DA YS EPSOT OR Family \$ CHARGES UNITS Plan | I. J. ID. RENDERING QUAL. PROVIDER ID. # |
| 3 28 14 03 28 14 11 | H2019 | 1 1 1 | | А | 150 00 10 | NPI |
| | | | | | | |
| | | | | | | |
| | | | | | | NPI |
| | | | | | | NPI |
| | | | | | | NPI |
| | | | | | | |
| FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACC | COUNT NO. 27 | . ACCEPT ASSIG (For govt. claims, see | NMENT? | | NPI 30. BALANCE DUE |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse | 32. SERVICE FACIL | LITY LOCATION INF | YES N | 10 | \$ 150 00 \$ 33. BILLING PROVIDER INFO & PH# JOHN DOE, ABA | \$ (800) 233-3333 |
| apply to this bill and are made a part thereof.) | | | | | 500 ALBERT RD SMILEY, LA 70528 | |

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)

| EALTH INSUR | | | | | UCC) 02/12 | | | | | | | | | | | |
|---|----------------|---------|----------------|-----------|---------------------------------|--------------|-------------------------|--------------------------|-----------------------------------|---------------------------|----------|------------|------------------|-----------|-----------------|-----------------------------|
| | DICAID | TOP | CARE | | CHAMPVA | OBC | NUD | FEC | A OTHER | R 1a. INSURED | 0.10 N | 111050 | | | | m in Item 1) |
| (Medicare #) X (Me | | | MDoD#) | | (Member ID# | HEA |)UP LTH PLAN | BLK (ID#) | LUNG | 98765432 | | | | () | -or Progra | m in item 1) |
| PATIENT'S NAME (Las | | t Name | e, Middle | Initial) | | | r's Birth I DD , Y | | SEX | 4. INSURED'S | | | ne, First Na | me, Midd | le Initial) | |
| AYCO, TRAVIS | | | | | | 07 | 31 20 | 001 M > | × F | | | | | | | |
| PATIENT'S ADDRESS | (No., Street) | | | | 6 | PATIEN | RELATIO | NSHIP TO | INSURED | 7. INSURED'S | ADDRE | ESS (No., | Street) | | | |
| | | | | | | Self | Spouse | Child | Other | | | | | | | |
| TY | | | | | STATE 8 | RESERV | ED FOR N | UCC USE | | СПҮ | | | | | | STATE |
| P CODE | TEL | EPHO | NE (Inclu | de Area | Code) | | | | | ZIP CODE | | | TELEPH | ONE (Inc | dude Area | Code) |
| | (| |) | | | | | | | | | | (|) | | |
| OTHER INSURED'S N | AME (Last N | ame, Fi | irst Name | e, Middle | Initial) | 10. IS PAT | IENT'S CO | NDITION | RELATED TO: | 11. INSURED | S POLIC | CY GROU | P OR FEC | NUMBE | R | |
| | | | | | | | | | | | | | | | | |
| OTHER INSURED'S P | OLICY OR G | ROUP | NUMBE | R | a | . EMPLOY | MENT? (C | | ^o revious) | a. INSURED | DD DD | E OF BIRT | пн | | SEX | _ |
| RESERVED FOR NUC | CUSE | | | | | | YES | | NO | b. OTHER CL | AIM ID 4 | Designate | d by NUCC | M | | F |
| | | | | | E. | | | ЛП | PLACE (State |) IS OTHER CL | Ham ID (| Designate | a by NOCC | , | | |
| RESERVED FOR NUC | C USE | | | | | | ACCIDENI | (1 m | LE | c. INSURANC | E PLAN | NAME OF | R PROGRA | M NAME | | |
| | | | | | | | YES | | NO | | | | | | | |
| NSURANCE PLAN NA | ME OR PRO | GRAM | INAME | | | od. RESE | RVED FOR | LOCAL | | | NOTHE | ER HEALT | H BENEFI | PLAN? | | |
| | | | | E | XAI | VI | 2L | | <u>」ト I(</u> | | | NO I | fyes, comp | dete item | is 9, 9a an | d 9d. |
| PATIENT'S OR AUTH | DRIZED PER | RSON'S | S SIGNA | TURE I | OMPLETING & authorize the re | lease of a | ny medical | or other inf | formation necessa | 13. INSURED payment of | f medica | l benefits | | | | authorize r supplier for |
| to process this claim. I a below. | also request p | baymen | nt of gove | mment b | enefits either to r | nyself or to | o the party v | vho accept | s assignment | services de | escribed | below. | | | - | |
| SIGNED | | | | | | D | ATE | | | SIGNED | | | | | | |
| DATE OF CURRENT I MM DD YY | LLNESS, IN. | JURY, | or PREG | NANCY | (LMP) 15.OTh | HER DATE | . MI | M DD | , YY | 16. DATES PA | TIENT | UNABLE T | TO WORK I | N CURR | ENT OCC | UPATION |
| | QUAL. | | | | QUAL | | | | 1 | FROM | | , | | го | | TT . |
| NAME OF REFERRIN | G PROVIDE | RORO | OTHER S | OURCE | Tra. | | | | | 18. HOSPITAL | | N DATES | RELATED | FO CURE | RENT SEF | VICES |
| | | | | | | IPI | | | | FROM | | | | го | | |
| ADDITIONAL CLAIM I | NFORMATIO | DN (De | signated | by NUC | C) | | | | | 20. OUTSIDE | LAB? | | \$0 | HARGE | s | |
| DIAGNOSIS OR NATU | IRE OF ILLN | IESS C | RINJUR | Y Re | late A-L to servi | œ line bel | ow (24E) | ICD Ind. | 0 | 22. RESUBMI CODE | SSION | NO | | | | |
| 30000 | B. | | | | C. | | | D. I | 9 | CODE | | - I | ORIGINA | L REF. I | NO. | |
| | E. | | | | G. | | | н I | | 23. PRIOR AU | THORE | ZATION N | UMBER | | | |
| | J. | | | | К. | | | LL | | 45678912 | 23 | | | | | |
| A. DATE(S) OF S From | ERVICE | | B. PLACE OF | C. | D.PROCED | | RVICES, O Circumstar | | ES E. DIAGNOSI | F. | | G. DAYS | H. I EPSOT II | à | REN | J. DERING |
| U DD YY MI | M DD | YY | SERVICE | EMG | CPT/HCPC: | S | MODI | FIER | POINTER | \$ CHARG | ES | UNITS | Plan QU | | PROV | IDER ID. # |
| 3 27 14 0 | 3 27 | 14 | 11 | | H0032 | | | | A | 180 | 00 | 1 | N | | 34567 345678 | 391 |
| | | | | | | | | i- | | | | | | | 34567 | |
| 3 28 14 03 | 3 28 | 14 | 11 | | H2019 | | | | A | 180 | 00 | 12 | N | | 345678 | 391 |
| | | | | | | | | | | | | | | | 34567 | |
| 4 01 14 04 | 4 01 | 14 | 11 | | G9012 | | | | A | 72 | 00 | 4 | N | _ | 345678 | 391 |
| | | 4.4 | 14 | | LIDOAD | | | | | 400 | | | 1 1.0 | | 34567 | 201 |
| 4 04 14 04 | 4 04 | 14 | 11 | | H2019 | | i | <u>i </u> | A | 120 | 00 | 8 | | PI 12 | 345678 | 991 |
| | | | | | | | | | | | | | N | PI | | |
| | | | | | | 1 | | | | | | | 1 1 | | | |
| | | | | | | | | | | | | | N | PI | | |
| FEDERAL TAX I.D. N | JMBER | SS | SN EIN | 26. | PATIENT'S AC | COUNT N | 0. 2 | 7. ACCEPT (For govt.) | TASSIGNMENT? claims, see back) | 28. TOTAL C | | | 9. AMOUNT | PAID | 30. BA | LANCE DUE |
| | | | | - | | | | YES | NO | \$ | 552 | | | | \$ | |
| SIGNATURE OF PHYS INCLUDING DEGREE | SICIAN OR S | ENTIA | ier Ls | 32. | SERVICE FAC | ILITY LOC | ATION INF | ORMATIC | NN . | 33. BILLING | | | | | 233-3 | 333 |
| (I certify that the staten apply to this bill and an | | | | | | | | | | ABC BEH 500 ALB | | | ANALYS | 515 | | |
| | | | | | | | | | | SMILEY, | | | | | | |
| _{GNED} Jane Doe | | DATE | 4/9/1 | 4 a. | | | b. | | | a. 1987 | | | b. | 212 | 23456 | |
| JCC Instruction M | | | | | | | | DOINT (| OR TYPE | | | | | | | 6-1500 (02- |

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 INSURANCE CLAIM FORM | - | | | |
|---|--|--|---|--|
| PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/1 | 2 | | | PICA |
| MEDICARE MEDICAID TRICARE CHAMF | VA GROUP FECA HEALTH PLAN BLK LUNG | OTHER 1a. INSURE | D'S I.D. NUMBER | (For Program in Item 1) |
| (Medicare #) X (Medicaid #) (ID#/DoD#) (Membe | (LD#) (LD#) | (10) 1234567 | | |
| . PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENTS BIRTH DATE SEX | | S NAME (Last Name, Fi | rst Name, Middle Initial) |
| ADALAM, MARY | 06 11 00 M 6. PATIENT RELATIONSHIP TO INSURE | F X | S ADDRESS (No., Stree | 0 |
| | Self Spouse Child Oth | | | |
| STATE STATE | 8. RESERVED FOR NUCC USE | СІТҮ | | STATE |
| 3P CODE TELEPHONE (Indude Area Code) | | ZIP CODE | TC | LEPHONE (Include Area Code) |
| () | | ZIPCODE | 16 | () |
| OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED | TO: 11. INSURE | D'S POLICY GROUP OR | N / |
| | | | | |
| . OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) | a. INSURE MM | DO VY | SEX |
| Code if applicable RESERVED FOR NUCCUSE | YES NO b. AUTO ACCIDENT? PLAC | CE (State) b. OTHER C | LAIMID (Designated by I | M F |
| | | | a carrie prosignated by | 10 0 0 y |
| RESERVED FOR NUCC USE | | c. INSURAN | CEPLAN NAME OR PR | OGRAM NAME |
| | YES NO | | | |
| INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE | ANOTHER HEALTH BE | |
| READ BACK OF FORM BE ORE O IF | | | | , complete items 9, 9a and 9d. ERSON'S SIGNATURE I authorize |
| PATIENT'S OR AUTHORIZED PERSON'S SIGNATORE 1 autorize to process this claim. I also request payment of government benefits either | ne release of any medical or other information acto myself or to the party who accepts assignm | | of medical benefits to the described below. | undersigned physician or supplier for |
| below. | | | | |
| SIGNED | DATE | SIGNE | | |
| 4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 119 | 5.OTHER DATE NUL DO VV | 4.0. (0.4 (0.0)) | | |
| MM DO YY | | 16. DATES F | IM DD YY | ORK IN CURRENT OCCUPATION MM DD YY |
| MM DO YY QUAL C | AUAL | FROM | | 10 |
| MM DD YY QUAL C 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 12 | AUAL. | FROM | | |
| 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE | AUAL | FROM 18. HOSPITA FROM 20. OUTSIDE | LIZATION DATES RELA | |
| MM DD YY QUAL C 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 11 9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 2UAL 00 99 7a 00 15 NPI | FROM 18. HOSPITA FROM 20. OUTSIDE VE | | |
| MM DD YY QUAL C 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 11 71 9. ADD TIONAL QLAM INFORMATION (Designated by NUCC) 11 DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate AL to | ALAL AND TY Ta b NPI service line below (24E) ICD ind. 0 | FROM 18. HOSPITA FROM 20. OUTSIDE | | TO ITED TO CURRENT SERVICES TO |
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CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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

| EALTH INSURANCE CLAIM FORM | C) 02/12 | | | |
|--|---|---|--|---|
| PICA | | 550 L | | PICA |
| | CHAMPVA GROUP HEALTH PL Member ID#) (/D#) | AN BLKLUNG (ID#) | 1a. INSURED'S LD. NUMBER 1234567890123 | R (For Program in Item 1) |
| PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENTS BIRT | | | Name, First Name, Middle Initial) |
| ADALAM, MARY | 06 11 | 00 M F X | | in Aleman |
| . PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELAT Self Spous | TIONSHIP TO INSURED | 7. INSURED'S ADDRESS (N | io., Street) |
| тү | STATE 8. RESERVED FOR | | СІТҮ | STATE |
| 1P CODE TELEPHONE (Indude Area Co | 1 0) | | ZIP CODE | TELEPHONE (Include Ama Code) |
| | | | 2F CODE | () |
| OTHER INSURED'S NAME (Last Name, First Name, Middle Ini | tial) 10. IS PATIENT'S | CONDITION RELATED TO: | 11. INSURED'S POLICY GR | OUP OR FECA NUMBER |
| | | | | IRTH SEX |
| OTHER INSURED'S POLICY OR GROUP NUMBER | | (Currentor Previous) | a. INSURED'S DATE OF B | M F |
| RESERVED FOR NUCCUSE | b. AUTO ACCIDEN | | b. OTHER CLAIMID (Design | |
| | <u></u> ςΔι | | | |
| RESERVED FOR NUCC USE | c. Carle AC. 1 | | c. INSURANCE PLAN NAME | OR PROGRAM NAME |
| INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED F | OR LOCAL USE | d. IS THERE ANOTHER HEA | ALTH BENEFIT PLAN? |
| EV | | | CD 10 | If yes, complete items 9, 9a and 9d. |
| READ BACK OF FORM E SEOP (A) PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 and to process this claim. I also request payment of government bene below. | CC N & G IN 5 THIS E horize the release of any medic dis either to myself or to the par | OF 4 cal or other information necessary ty who accepts assignment | INE UP D'S OB UP to payment of medical benef services described below. | ZED PERSON'S SIGNATURE I authorize fits to the undersigned physician or supplier for |
| SIGNED | DATE | | SIGNED | |
| L DATE OF CURRENT ILLINESS, INJURY, & PREGNANCY (LN | | MM DD YY | 16. DATES PATIENT UNABL MM DD | |
| QUAL 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE | QUAL. 17a. | | | ES RELATED TO CURRENT SERVICES |
| | 71b. NPI | | FROM DD | TO MM DD YY |
| ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | 20. OUTSIDE LAB? | \$ CHARGES |
| DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate | A-L to service line below (24E |) ICD Ind. 0 | YES NO 22. RESUBMISSION CODE | |
| F4 19 B. | C. | D. | CODE | ORIGINAL REF. NO. |
| E. F. | G. | н | 23. PRIOR AUTHORIZATION | NUMBER |
| | K. | | F. G | |
| From To PLACE OF M DD YY MM DD YY SERVICE EMG | (Explain Unusual Circum: | | S CHARGES UNI | YS BISDT ID. RENDERING R Family QUAL. PROVIDER ID. # |
| | 100000 | | 400.00.1.4 | 1234567 |
| 0 08 15 10 08 15 11 | H0032 | A | 180 00 1 | NPI 1234567891 1234567 |
| 0 09 15 10 09 15 11 | H2019 | A | 180 00 12 | |
| | 00040 | 1 1 1 | | 1234567 |
| 0 12 15 10 12 15 11 | G9012 | A | 72 00 4 | 1234567891 1234567 |
| 0 12 15 10 12 15 11 | H2019 HM | A | 80 00 4 | |
| | | | · · · · | |
| | | | | NPI |
| | | | | NPI |
| | TIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO | 28. TOTAL CHARGE | 29. AMOUNT PAID 30. BALANCE DUE s 512 00 |
| . SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SE | RVICE FACILITY LOCATION I | | \$ 512 00 33. BILLING PROVIDER IN | |
| INCLUDING DEGREES OR CREDENTIALS () cardly that the statements on the reverse apply to this bill and are made a part thereof.) | | | ABC BEHAVIORAL 500 ALBERT RD SMILEY, LA 70528 | LANALYSIS |
| IGNED Ima Biller DATE 10/15/15 a. | b. | | a. 1987456123 | b. 2123456 |
| IGNED Ima Biller DATE 10/15/15 a. | | | | B-0938-1197 FORM CMS-1500 (02- |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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Adjustments and Voids

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

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

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.

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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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.

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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

| PROVED BY NATIONAL UNIF | | | 2 | | | | | | | | | |
|--|-------------------------------------|---------------------|---|-------------------------------|---------------------------|-----------------------------|---------------------------|--|-----------------------------------|----------------|-----------------|--------------------|
| PICA PICA MEDICARE MEDICAID (Medicare #) X (Medicaid | TRICARE | CHAMP | VA GROU HEALT | P 'H PLAN | FECA BLK LUN (ID#) | IG (ID#) | 1a. INSURED'S 98765432 | | | (Fo | r Program | PICA in Item 1) |
| PATIENT'S NAME (Last Nam | e, First Name, Middle | | 3. PATIENT'S MM | | E | SEX | 4. INSURED'S | | ame, First Nar | ne, Middle | e Initial) | |
| AYCO, TRAVIS | itreet) | | 6. PATIENT F | 1 2001 RELATIONSH | | URED | 7. INSURED'S | ADDRESS (No | ., Street) | | | |
| ITY | | STATE | | | Child | Other | СПУ | | | | 15 | TATE |
| | | | . I. RESERVET | POR NOC | , 03L | | | | | | | |
| IP CODE | TELEPHONE (Incl | lude Area Code) | | | | | ZIP CODE | | TELEPH | DNE (Indu) | ide Area C | ode) |
| OTHER INSURED'S NAME (L | ast Name, First Nan | ne, Middle Initial) | 10. IS PATIE | NT'S CONDI | ITION REL | ATED TO: | 11. INSURED'S | S POLICY GRO | UP OR FECA | NUMBER | २ | |
| OTHER INSURED'S POLICY | OR GROUP NUMBE | ER | a. EMPLOYM | ENT? (Curre | ent or Previ | ous) | a. INSURED | S DATE OF BI | RTH | | SEX | |
| RESERVED FOR NUCC USE | | | _ | YES | NC | | | | | м | | - |
| RESERVED FOR NOCC USE | | | b. AUTO ACC | | | PLACE (State) | b. OTHER CLA | IM ID (Designa | ted by NUCC | | | |
| RESERVED FOR NUCC USE | | | a OTHERAD | CIDENTY | | | c. INSURANCE | EPLAN NAME | OR PROGRA | MINAME | | |
| INSURANCE PLAN NAME OF | PROGRAM NAME | | 10d. RESERV | YES /ED FOR LO | NC CAL USE | | d. IS THERE A | NOTHER HEAL | TH BENEFIT | PLAN? | | |
| PEAD | BACK OF FORM B | EX | | | | F 10 | | NO OR AUTHORI | If ves. comp | | | |
| PATIENT'S OR AUTHORIZE to process this claim. I also rec | PERSON'S SIGNA | ATURE I authorize t | he release of any er to myself or to the | medical or of he party who | ther inform accepts as | ation necessary signment | payment of | medical benefit scribed below. | s to the under | signed ph | ysician or s | supplier for |
| below. SIGNED | | | DAT | E | | | SIGNED | | | | | |
| DATE OF CURRENT ILLNES | S, INJURY, or PRE | GNANCY (LMP) 15 | OTHER DATE | MM . | DD , | YY | 16. DATES PA | | TO WORK II | | | PATION |
| | UAL. | G | UAL. | | | | FROM 18. HOSPITALI | | 1 | 0 | | |
| | | | b. NPI | | | | FROM | | | O MM | DD | YY |
| ADDITIONAL CLAIM INFOR | MATION (Designated | d by NUCC) | | | | | 20. OUTSIDE L YES | AB? NO | \$ C | HARGES | 1 | |
| DIAGNOSIS OR NATURE O | FILLNESS OR INJU | RY Relate A-L to | service line below | (24E) ICI | D Ind. 9 | | 22. RESUBMIS | | ORIGINA | L REF. N | D. | |
| 30000 | В | C. | | | D | | A 02 23. PRIOR AU | | 4087156 | 78910 | 0 | |
| | F | G. К. | | | н <u> </u> | | 45678912 | | NUMBER | | | |
| A. DATE(S) OF SERVIC From M DD YY MM D | E B. To PLACE O DD YY SERVICE | F (E | CEDURES, SERV ixplain Unusual C CPCS | | 3) | E. DIAGNOSIS POINTER | F. \$ CHARGI | G. DAYS OR ES UNITS | B EPSOT ID Family S Plan QU | L AL. | RENDE PROVID | Ering Er ID. # |
| 3 28 14 03 2 | 8 14 11 | H20 | | | 1 | A | 150 | 00 10 | N | 기 | | |
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| | <u>i I</u> | <u> </u> | | <u>i i</u> | | 1 | | <u>i </u> | | | | |
| 5. FEDERAL TAX I.D. NUMBER | SSN EIN | 26. PATIENT | S ACCOUNT NO. | 27. A | CCEPT AS | SIGNMENT? s, see back) | 28. TOTAL CH | IARGE | 29. AMOUNT | 1 | 30. BALA | NCEDUE |
| | | | | | YES | s, seeback) NO | \$ | 150 00 | \$ | | \$ | |
| SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR ((I certify that the statements of apply to this bill and are made | REDENTIALS in the reverse | 32. SERVICE | FACILITY LOCA | TION INFOR | MATION | | JOHN DO 500 ALBE | RTRD | 0&PH# (| 800) | 233-33 | 33 |
| | | | | | | | | LA 70528 | | | | |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

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

| HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 | | | PICA |
|---|--|---|--|
| MEDICARE MEDICAID TRICARE CHAMPV. (Medicare #) ★ (Medicaid #) (IDM/DoD#) (Member I) | HEALTH PLAN BLK LUNG | 1a. INSURED'S LD. NUMBER 1234567890123 | (For Program in Item 1) |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENTS BIRTH DATE SEX MM DD YY | 4. INSURED'S NAME (Last Name, First Name | e, Middle Initial) |
| ADALAM, MARY 5. PATIENT'S ADDRESS (No., Street) | 06 11 00 M F X | 7. INSURED'S ADDRESS (No., Street) | |
| | Self Spouse Child Other | | |
| CITY STATE | 8. RESERVED FOR NUCC USE | СПУ | STATE |
| ZP CODE TELEPHONE (Indude Area Code) | - | ZIP CODE TELEPHO | NE (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 |
| TPL Code if applicable D. RESERVED FOR NUCCUSE | YES NO | | M F |
| - HEVEN HELF ON HOUS OF | b. AUTO ACCIDENT? PLACE (State) | b. OTHER CLAIMID (Designated by NUCC) | |
| a. RESERVED FOR NUCC USE | | C. INSURANCE PLAN NAME OR PROGRAM | I NAME |
| LINSURANCE PLAN NAME OR PROGRAM NAME | YES NO 104. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT | DLAND |
| | | | PLAN7 ete items 9, 9a and 9d. |
| READ BACK OF FORM BE ORE O TP CT 2. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE 1 authorize the to process this claim. I also request payment of government benefits either below. | LANN IC THIS DEN release of any medicar or other information hecessary to myself or to the party who a coepts assignment | 1 INSU REF SOR A TH R ED PERSON | 'S SIGNATURE I authorize signed physician or supplier for |
| SIGNED | DATE | SIGNED | |
| 4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0 | THER DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN MM DD YY | CURRENT OCCUPATION |
| QUAL QU 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a | | FROM TI 18. HOSPITALIZATION DATES RELATED T | ° |
| 71b | | FROM DD YY | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | HARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se | rvice line below (24E) ICD Ind. 0 | YES NO 22. RESUBMISSION CODE ORIGINAL | REF. NO. |
| A. [F4 19 B. C. L | D. | A 02 529919 | 8798700 |
| E. F. G.L | н | 23. PRIOR AUTHORIZATION NUMBER | |
| | EDURES, SERVICES, OR SUPPLIES E. Itain Unusual Circumstances) DIAGNOSIS | F. G. H. I. DAYS BISOT ID. | J. RENDERING |
| From To PUCEOF (Exp MM DD YY MM DD YY SERVICE EMG CPT/HC | PCS MODIFIER DIAGNOSIS POINTER | F. G. H. I. DAYS BRADT ID. OR Family \$ CHARGES UNITS Plan QUA | PROVIDER ID. # |
| 10 08 15 10 08 15 11 H003 | 2 A | 180 00 1 NP | 9 |
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| | | NP | 1 |
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| | | NP | 1 |
| | | NP | 9 |
| | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENTS 1234 | ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. datama, eee back) X YES NO | 28. TOTAL CHARGE 29. AMOUNT \$ 512 00 \$ | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS () cartify that the statements on the reverse | | | 800)233-3333 |
| apply to this bill and are made a part thereof.) | | 500 ALBERT RD SMILEY, LA 70528 | |
| SIGNED Ima Biller DATE 122815 a. | b. | a. 1234567891 b. | 1234567 |
| NUCC Instruction Manual available at: www.nucc.org | | APPROVED OMB-0938-119 | |

CHAPTER 4: APPLIED BEHAVIOR ANALYSIS APPENDIX C: CLAIMS FILING

PAGE(S) 16

Sample CMS-1500 Form

| PICA | ORM CLAIM COMMITTEE | (NUCC) 02/12 | | | | | | | | PICA |
|---|--|---------------------------------------|---|---|-----------------|---|------------------------------------|--------------|----------------------|---------------------------------------|
| I. MEDICARE MEDICAID | | CHAMPV | HEALTH | PLAN FECA | NG | 1a. INSURED'S I.D. N | UMBER | | (Fo | r Program in litern 1) |
| (Medicare#) (Medicald#) 2. PATIENT'S NAME (Last Name, | | (Member 8 | 3. PATIENT'S BI | | (IDW) SEX | 4. INSURED'S NAME | (Last Name | , First Na | me, Middi | e Initial) |
| 5. PATIENT'S ADDRESS (No., St | (teet) | | 6. PATIENT REL | ATIONSHIP TO IN | F | 7. INSURED'S ADDRI | 388 (No., 8 | ireel) | | |
| | | | Self Spo | | Other | | | 4 | | |
| SITY | | STATE | 8. RESERVED F | OR NUCC USE | | CITY | | | | STATE |
| ZIP CODE | TELEPHONE (Include Au | rea Code) | | | | ZIP CODE | | TELEPH | IONE (Inc | lude Area Code) |
| OTHER INSURED'S NAME (La | at Name, Firet Name, Mid | die Initial) | 10. IS PATIENT | S CONDITION FIEL | ATED TO: | 11. INSURED'S POLIC | CY GROUP | OR FEC | ANUMBE | R |
| L OTHER INSURED'S POLICY C | R GROUP NUMBER | | a. EMPLOYMEN | IT? (Current or Pre- | vioua) | a. INSURED'S DATE | OF BIRTH | | | SEX |
| | YES NO | | | MM DD YY M F | | | | | | |
| b. RESERVED FOR NUCC USE | | | b. AUTO ACCID | | PLACE (State) | b. OTHER CLAIM ID (Designized by NUCC) | | | | |
| RESERVED FOR NUCC USE | | | G. OTHER ACCI | | ю | C. INSURANCE PLAN | NAME OR | PROGRA | M NAME | |
| LINSURANCE PLAN NAME OR | 10d. GLAIM COR | YES NES (Designated by | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | | | | | | |
| READ | BACK OF FORM REFOR | | A SKONING THE | FORM. | | YES | | | | ns 9, 9a, and 9d. ATURE Lauthoriza |
| READ 2. PATIENT'S OR AUTHORIZED to process this claim. I also req below. | PERSON'S SIGNATURE weat payment of government | I authorize the nt benefits either | release of any med to myself or to the j | ical or other information accepts a | tion necessary | payment of medica services described | l benefita to below. | the unde | eralgned p | hysician or supplier for |
| SIGNED | - | | DATE | | | \$IGNED | | | | |
| 4. DATE OF CURRENT ILLNES | B, INJURY, or PREGNANC | CY (LMP) 15. QU | | MM DD | YY | 18. DATES PATIENT MM D | | WORK | IN CURRE MM TO | DD YY |
| 7. NAME OF REFERRING PRO | - | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | ENT SERVICES | | |
| 17b 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | n. NPI | | | FROM TO 20. OUTSIDE LAB? & CHARGES | | | ies | |
| | | | • | | | YEB | NO | | 1000000000 | |
| H. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line B C | | | | line below (24E) ICD Ind. | | | 22. RESUBMISSION ORIGINAL REF. NO. | | | |
| E | F. | G. L | | н. 📖 | | 23. PRIOR AUTHORI | TATION NU | MBER | | |
| A. A. DATE(S) OF SERVICI | J. B. C To PLACEOF | | DURES, SERVICE | | E. DIAGNOSIS | F. | Q. DAYS OR UNITS | | L. | J. RENDERING |
| MM DD YY MM D | | СРТИНСР | CS | MODIFIER | POINTER | \$ CHARGES | UNITS | Plan QL | | PROVIDER ID. # |
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| | | 11 | | | | | | N | PI | |
| | | A PATIENTS | CCOUNT NO. | 27. ACCEPT A | SSIGNMENT? | 28. TOTAL CHARGE | 29. | AMOUNT | PAID | 30. Ravel for NUCC I |
| 25. FEDERAL TAX I.D. NUMBER | SSN EIN 2 | | | YES | NO | \$ | | | | |