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CLAIMS FILING

Hard copy billing of waiver services are 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

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid website 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.

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CMS 1500 (02/12) INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC) SERVICES EFFECTIVE WITH DATE OF SERVICE 4/1/16

You must write "WAIVER" at the top center of the claim form!

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 #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
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 must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2. 	Formerly UB-04 Locator 60.
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	Formerly UB-04 Locator 8 & 58.
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).	Formerly UB-04 Locator 10 & 11.
	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.	Formerly UB-04 Locator 9.
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		

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Locator #	Description	Instructions	Alerts
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 commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. 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.	Formerly UB-04 Locator 61. ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9с	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:	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	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Leave Blank.	

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Locator #	Description	Instructions	Alerts
15	OTHER 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	Unlabeled	Leave Blank.	
17b	NPI	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank <u>.</u>	
20	Outside Lab?	Leave Blank.	
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. 0 ICD-10-CM Required – Enter the ICD 10 diagnosis code Z76.89. NOTE: The ICD-10-CM "V", "W", "X", and "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	Formerly UB-04 Locator 66. Formerly UB-04 Locator 67. Diagnosis Code Z76.89 may be used on all ADHC claims.

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Locator #	Description	Instructions	Alerts
		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	Formerly UB-04 Locator 64.
		"Original Ref. No." portion of this field. Appropriate reason codes follow:	To adjust or void more
22	Resubmission Code	Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other	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.
		<u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	
23	Prior Authorization (PA) Number	Required – Enter the 9-Digit PA number in this field.	Formerly UB-04 Locator 63.
24	Supplemental Information	Situational - Complete if appropriate or leave blank.	
24A	Date(s) of Service	Required Enter the date of service for each procedure. Bill one date of service per claim line. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	Formerly UB-04 Locator 45.
		A separate claim must be billed for each month if the recipient's dates of service cross the end of a calendar month.	Note: Claims must be split billed at the end of each month.
24B	Place of Service	Required Enter the appropriate place of service code for the services rendered. 99 Other	
24C	EMG	Leave Blank.	

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Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). S5100 – ADHC Services	Formerly UB-04 Locator 44.
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.	
24F	Amount Charged (\$ Charge)	Required Enter usual and customary charges for the service rendered.	Formerly UB-04 Locator 47.
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D NOTE: ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) per week.	Formerly UB-04 Locator 46. Reminder: 1 Unit is equal to 15 minutes of service
24H	EPSDT Family Plan	Leave Blank.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank.	
25	Federal Tax I.D. Number	Optional.	Formerly UB-04 Locator 5.
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.	Formerly UB-04 Locator 3A.
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.	Formerly UB-04 Locator 47.

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Locator #	Description	Instructions	Alerts
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.	Formerly UB-04 Locator 54.
		If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
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.	Formerly UB-04 Locator 1.
33a	NPI	Required – Enter the billing provider's 10-digit NPI number.	Formerly UB-04 Locator 56. The 10-digit NPI must appear on paper claims.
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	Formerly UB-04 Locator 57. The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

REMINDER: MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

Sample forms are on the following pages

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SAMPLE ADHC CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

HEALTH INSURANCE CLAIM FORM	WAIVE	
PICA MEDICARE MEDICAID TRICARE CHAMF (Madicaradi)	- HEALTH PLAN - BLKTUNG -	PICA PICA
2. PATIENT'S NAME (Last Name, Rist Name, Midde Initial)		INSURED S NAME (Last Name, First Name, Middle Initial)
JAYCO, TRAVIS	07 31 72 M× F	
5. PATIENT'S ADDREBS (No., Efrest)	6. PATIENT RELATIONSHIP TO INSURED 7. Set Spouse Child Other	INSURED'S ADDRESS (No., Street)
CITY STATE		ITY BTATE
ZIP CODE TELEPHONE (Include Area Code)	ZIF	P CODE TELEPHONE (Indude Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle hillia)	10. IS PATIENT'S CONDITION RELATED TO: 11	I. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable	a. EMPLOYMENT? (Current or Previous) a.	
b. RESERVED FOR NUCC USE	Fyamnle of	OTHER CLAIMID (Designated by NUCC)
C. RESERVED FOR NUCC USE		INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE FLAN NAME OR PROGRAM NAME		
	Uriginal Clai	YES NO <i>Hyes</i> , complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLET 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize th to process this dalm. Laiso request payment of government benefits after telow.	e release of any medical or other information necessary	 INSURED'S OR AUTHORIZED FERSION'S SIGNATURE Lauthorize payment of medical benefits to the unidersigned physician or supplier for services described below.
SIGNED	DATE	8IGNED
MULLIND VV	UAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		B. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIMINFORMATION (Designated by NJCC)	7a NPI 20	FROM TO
		YES NO
21. DIAGNOSIS CE NATURE OF ILLNESS CE INJURY Relate AL to se A LZ76.89 E I C	icolina.	2. RESUBMISSION CODE ORIGINAL REF. NO.
	HL	3. PRIOR AUTHORIZATION NUMBER
I J K. 24. A. DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E.	987654321
	lain Unusual Circumstances) DIAGNOBIB	F. G. H. I. J. DAYS BEAT ID. RENDERING OR Family QUAL PROMDERID. #
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04 04 10 04 04 10 99 351	A 00	96,00 32 NPI
04 05 16 04 05 16 99 \$51	00 A	120,00 40 NPI
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		NPI
25. FEDERALTAX I.D. NUMBER SIRV EIN 26. PATIENTS		3. TOTAL CHARGE 29. AMOUNT PAID 30. Riskd for NUCC Use 5. 288.00 s
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SIGNED DATE a. N		1234567890 1234567
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0936-1197 FORM 1500 (02-12

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ADJUSTING/VOIDING CLAIMS

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.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

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.

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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.

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 WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

1. MEDICARE MEDICARD TRICARE CHAMPYA GROUP EECA Medicaraal X Medicaida (10.470.004) (10.66 (10.67) (10.67) (10.69)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123
2. PATIENT'S NAME (List Name, Rist Name, Midde Initia) (3. PATIENT'S BIFTH DATE SEX JAYCO, TRAVIS (07 31 72 M × F	4. INSURED S NAME (Last Name, First Name, Middle Initial)
JAYCO, TRAVIS 07 31 72 MX F 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT PELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Set Spouse Onic Other CITY STATE 8. RESERVED FOR NUCC USE	CITY STATE
ZP CODE TELEPHONE (indude Area Code)	ZIP CODE TELEPHONE (Indude Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle hills) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
. OTHER INSURED'S POLICY OR GROUP NUMBER 8. EMPLOYMENT? (Quirent or Previous) TPL Code if applicable	a. INSURED'S DATE OF BIRTH SEX
	M F D: OTHER CLAIM ID (Designated by NUCC)
INSURANCE FLAN NAME OF PROGRAM NAME AD UST PROPORTO C	YES NO <i>if yes</i> , complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 2. PATIENT'S CH AUTHORIZED PERECIVE SIGNITURE, I authorize there ease of any medical or other information necessary to process this datm. I also request payment of government identifies after to myself or to the party who accepts assignment below.	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED DATE	EIGNED
4 DATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LMP) 15. OF HER DATE MM DO YY CUAL OUAL DU YY	
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD VV MM DD VY FROM DD VV
9. ADDITIONAL CLAIMINFORMATION (Designated by NUCC)	20. OUTSIDELAE? \$CHARGES
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а [276.89 в.] с р	CODE ORIGINAL REF. NO. A 02 6105198765400 23. PRIOR AUTHORIZATION NUMEER
EL F.L GL HL L J.L KL LL	987654321
MA DATE(S) OF SERVICE B C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From To RACDT (Exclain Unusual Crounstances) DIAGNOSIS VM DD YY MM DD YY SBWCE EMG OPTHOPOSIS MODIFIER PONTER	F. G. H. I. J. DAVIS BROT ID. RENDERING OR FRINKY ID. RENDERING \$CHARGES UNITS PAIN QUAL PROMOERID.#
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5. FEDERALTAX I.D. NUMBER 33N EIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT?	28. TCTAL CHARGE 29. AMICUNT PAID 80. Revel for NUCCUs 5 96.00 5
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alaneo DATE a. NPI a UCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE	1234567890 1234567 APPROVED OMB-0936-1197 FORM 1500 (02-1

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SAMPLE CLAIM FORM

(Medicare#)	MEDICAID	TRICAP		_	CHAMP		HEA	TH PLAN	, 5 5	CA		1a. INSUR	ED'S I.D. N	UMBER			(For F	mangon	PICA in liem 1)
PATIENT'S NAME	(Medicald#) (Leat Name, Fir	(ID#/Dol at Name, Mk			Member		(IDW)		(11)	#) SI	(IDNI) EX	4. INSURE	D'S NAME	(Last Nam	16, First	Name,	Middle I	nitial)	
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CODE	Π	LEPHONE (Include A	Area Cod	die)							ZIP CODE			TEL	EPHON	E (Includ	le Area	Code)
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OTHER INSURED	'S POLICY OR	ROUP NUM	IBER			a. Ek	APLOYA		ument or	-)	a. INSUR				M		SEX	F
RESERVED FOR	NUCC USE					b. AL		CIDENTY		NO	ACE (State)	b. OTHER	CLAIM ID	Designate	d by N				•
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