

## CLAIMS RELATED INFORMATION

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 be processed. 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:

Gainwell Technologies  
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 [www.lamedicaid.com](http://www.lamedicaid.com), directory link “HIPAA Information Center, sub-link “5010v of the Electronic Transactions” – 837P Professional Guide”).

This appendix includes the following:

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

**CMS 1500 (02/12) Instructions for ADHC Waiver Services**

In order to access the CMS 1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link:

[https://www.lamedicaid.com/Provweb1/billing\\_information/CMS\\_1500.htm](https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm).

**NOTE:** You must write “WAIVER” at the top center of the claim form.

**ADJUSTING/VOIDING CLAIMS**

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.

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:

1. 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;  
or

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2. 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 Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary 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.

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.

Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website below for general information concerning topics relative to general claims filing. To access the General Information and Administration Provider Manual chapter, click here:

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>.


**Sample forms are on the following pages.**

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## SAMPLE WAIVER CLAIM FORM ADJUSTMENT

 **WAIVER** Mail completed form to:  
**Gainwell Technologies**  
**P.O. Box 91020**  
**Baton Rouge, LA 70821**

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ PICA ☐ PICA

1. MEDICAID <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRI-CARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BACKLUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (TRICARE) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9876543210123</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Jayco, Travis</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>07 31 72</b> SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>TPL Code if Applicable</b> b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMERGENCY? (Circle Yes or No) b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME 12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits due to me or to the party who is each assigned below. SIGNED _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> 17b. <input type="checkbox"/> NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. <b>8347198798700</b> 23. PRIOR AUTHORIZATION NUMBER Prior Auth #	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Please A-L to service line below (445) (ICD Ind.) A. <b>Z7689</b> B. C. D. E. F. G. H. I. J. K. L.		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MOOPIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS (or Units) H. PRO T (or Units) I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 11 06 18 11 06 18 12 S5125 UN A 84.00 28 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. <b>1234</b>	
27. ACCEPT ASSIGNMENT? (For good claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>84.00</b> 29. AMOUNT PAID \$	
30. Revid for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>Biller</b> 12/17/18 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b.	
33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000 a. <b>1234509876</b> b. <b>1123456</b>			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED UMB-0938-1197 FORM 1500 (02-12)

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## SAMPLE CLAIM FORM



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BOX LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M F										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street)																																							
CITY STATE										CITY STATE										CITY STATE																																							
ZIP CODE TELEPHONE (Include Area Code)										ZIP CODE TELEPHONE (Include Area Code)										ZIP CODE TELEPHONE (Include Area Code)																																							
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.																																							
9. OTHER INSURED'S POLICY OR GROUP NUMBER										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. OUTSIDE LAB? YES NO \$ CHARGES																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. RESUBMISSION CODE ORIGINAL REF. NO.										21. PRIOR AUTHORIZATION NUMBER																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.										22. F. \$ CHARGES G. DAYS ON UNITS H. FIRST Party Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER																																																											
25. FEDERAL TAX I.D. NUMBER SBN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? YES NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Paid for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ( )																																							
SIGNED DATE										a. NPI b. NPI										c. NPI d. NPI																																							

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