

CLAIMS RELATED INFORMATION

Hard copy billing of waiver 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 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 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, 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 9: ADULT DAY HEALTH CARE WAIVER

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CMS 1500 (02/12) INSTRUCTIONS FOR
ADULT DAY HEALTH CARE (ADHC) SERVICES

**You must write “WAIVER” at the top center
of the claim form!**

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / 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 ID Number	Required – Enter the beneficiary's 13-digit Medicaid I.D. number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS, or REVS. NOTE: The beneficiaries' 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 beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the beneficiary'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). Enter an “X” in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the beneficiary'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	Leave Blank	

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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	<p>Situational – If beneficiary has no other coverage, leave blank.</p> <p>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.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	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.	
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:	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.	

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Locator #	Description	Instructions	Alerts
14	Date of Current Illness / Injury / Pregnancy	Leave Blank.	
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	Other ID#	Leave Blank.	
17b	NPI	Situational – If 17 or 17a is completed, this field is required.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Leave Blank.	
21	<p>ICD Indicator</p> <p>Diagnosis or Nature of Illness or Injury</p>	<p>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.</p> <p>0 ICD-10-CM</p> <p>Required – Enter the ICD 10 diagnosis code Z76.89.</p> <p>NOTE: The ICD-10-CM "external cause of injury diagnosis codes V, W, X, and Y will be accepted as non-primary diagnosis codes.</p>	<p>Diagnosis Code Z76.89 may be used on all ADHC claims.</p>

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Locator #	Description	Instructions	Alerts
22	Resubmission and/or Original Reference Number	<p>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.</p> <p>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.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>VOIDS</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	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.
23	Prior Authorization (PA) Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational - Complete if appropriate or leave blank.	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure. Bill one date of service per claim line.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p> <p>A separate claim must be billed for each month if the beneficiary's dates of service cross the end of a calendar month.</p>	Note: Claims must be split billed at the end of each month.
24B	Place of Service	<p>Required -- Enter the appropriate place of service code for the services rendered.</p> <p>99 Other</p>	
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	
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	\$ Charge	Required -- Enter usual and customary charges for the service rendered.	
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.	Reminder: 1 Unit is equal to 15 minutes of service
24H	EPSDT Family Plan	Leave Blank.	
24I	ID Qualifier	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID #	Leave Blank.	
25	Federal Tax ID Number	Optional.	
26	Patient's Account No.	Situational -- Enter the provider specific identifier assigned to the beneficiary. 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.	

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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. 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 Date	Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI#	Optional.	
32b	Other ID#	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.	The 10-digit NPI <u>must</u> appear on paper claims.
33b	Other ID#	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	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

 **WAIVER** **HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/21

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

USE ONLY

1. MEDICARE ☐ **MEDICAID** ☒ **TRICARE** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN** ☐ **FECA SK/LONG** ☐ **OTHER** ☐ **1a. INSURED'S I.D. NUMBER** (For Program in Item 1)
(Medicare#) (Medicaid#) (TRICARE#) (Number ID#) (ID#) (ID#) (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
JAYCO, TRAVIS

3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 **SEX** M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMERGENCY (ICD-9-CM 930-939) YES ☐ NO ☐
b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐
c. OTHER ACCIDENT? YES ☐ NO ☐
d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OR FECA 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 after the payment of this party's responsibility.
SIGNED: DATE: 12/15/2018

13. INSURED'S DATE OF BIRTH MM DD YY 07 31 72 **SEX** M ☐ F ☒

14. OTHER INSURED'S POLICY OR GROUP NUMBER
a. TPL CODE IF APPLICABLE
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME

15. OTHER DATE MM DD YY 17a. NR 17b. NR

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ **\$ CHARGES**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Please A-L to service line below (44E) ICD-9-CM
A. Z76.89 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
PRIOR AUTH NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY **B. PLACE OF SERVICE** **C. D. PROCEDURES, SERVICES, OR SUPPLIES** (Explain Unusual Circumstances) **E. DIAGNOSIS** **F. \$ CHARGES** **G. DATES OF USE** **H. ICD-9-CM** **I. ID. QUAL** **J. RENDERING PROVIDER ID. #**

25. FEDERAL TAX I.D. NUMBER **30. 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)
BILLED 12/15/2018
SIGNED: DATE: 12/15/2018

26. PATIENT'S ACCOUNT NO. 12345 **27. ACCEPT ASSIGNMENT?** YES ☒ NO ☐ **28. TOTAL CHARGE** \$ 288.00 **29. AMOUNT PAID** \$ **30. Resd for NUCC Use**

31. SERVICE FACILITY LOCATION INFORMATION
ADULT DAY CARE
9876 LOLLIPOP LANE
ANYWHERE, LA 71111

32. BILLING PROVIDER INFO & PH# (225) 555-4957

33. NPI a. 1234567890 b. 1234567

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMS-0935-1197 FORM 1500 (02-12)

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:

- 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
- 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.


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) (COBRA) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jayco, Travis		3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
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 TPL Code if Applicable 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 (Yes/No) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 <input type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. 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 legally assigned to them. 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	
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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES: _____		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Please A-L to service line below. (48) (ICD Ind: _____) A. Z7689 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____	
22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 8347198798700		23. PRIOR AUTHORIZATION NUMBER Prior Auth # _____	
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) MODIFIER E. DIAGNOSIS F. \$ CHARGES G. DAYS IN UNITS H. PRO T RY P# 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. 1234 27. ACCEPT ASSIGNMENT? (For good claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 84.00 29. AMOUNT PAID \$ 30. Rev'd 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.) Biller 12/17/18 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. 1123456	
33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000 a. 1234509876 b. 1123456			

NUCC Instruction Manual available at: 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 <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'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"/>										7. INSURED'S ADDRESS (No., Street) CITY STATE 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 <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																																							
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 <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																																							
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. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER _____																																							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON UNITS H. FIRST Party Plan I. ID. QUAL J. RENDERING PROVIDER ID. # MM DD YY MM DD YY EMG CPT/HCPCS MODIFIER																																																											
25. FEDERAL TAX I.D. NUMBER SBN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> (For gov. benefits, see back)										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.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # () a. NPI b. _____																																							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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.

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