CLAIMS FILING

Claims for Adult Day Health Care Services must be filed by electronic claims submission 837I or on the UB 04 claim form.

This appendix includes the following:

- Instructions for completing the UB 04
- Sample of UB 04 claim form

Instructions for Completing the UB04 for Adult Day Health Care

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility.	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: *1st Digit - Type of Facility* 8 = Special Facility (LOC=Adult Day Health Care) *2nd Digit - Classification* 9 = Other (Adult Day Health Care - ADHC) *3rd Digit – Frequency Definition* 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment. 3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	

Locator #	Description	Instructions	Alerts
5	Federal Tax No.	**Optional.**	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	**Leave blank.**	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	**Required.** Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required**. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	**Leave blank.**	
14	Type Admission	**Leave blank.**	
15	Source of Admission	**Leave blank.**	
16	Discharge Hour	**Leave blank.**	

Locator #	Description	Instructions	Alerts
17	Patient Status	**Required.** Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6). **Valid Codes** 01 = Discharged to home or self care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/Discharged Due to Death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 = Discharged/transferred to a long term care hospital	
18-28	Condition Codes	**Leave blank.**	
29	Accident State	**Leave blank.**	
30	Unlabeled Field	**Leave blank.**	
31-34	Occurrence Codes/Dates	**Leave blank.**	
35-36	Occurrence Spans (Code and Dates)	**Leave blank.**	
37	Unlabeled	**Leave blank.**	
38	Responsible Party Name and Address	**Optional.**	

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	**Required**. Enter the appropriate Value Code (listed below). *80 = Covered days *Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.	
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. Revenue Code & Description *(Corresponding Level of Care)* 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	
43	Revenue Description	**Required.** Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	**Leave blank.**	
45	Service Date	**Required.** Enter the day of service for each day services are provided (e.g., 01-01, 02-02, 03-03, etc) for each revenue code indicated. Enter a service line for each service day. **Required**. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	**The CREATION DATE replaces the Date of Provider Representative Signature**
46	Units of Service	**Required.** Enter 1 unit/day for each day of service. **Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided as individual detail lines.**	
47	Total Charges	**Leave Blank.**	
48	Non-Covered Charges	**Leave Blank.**	

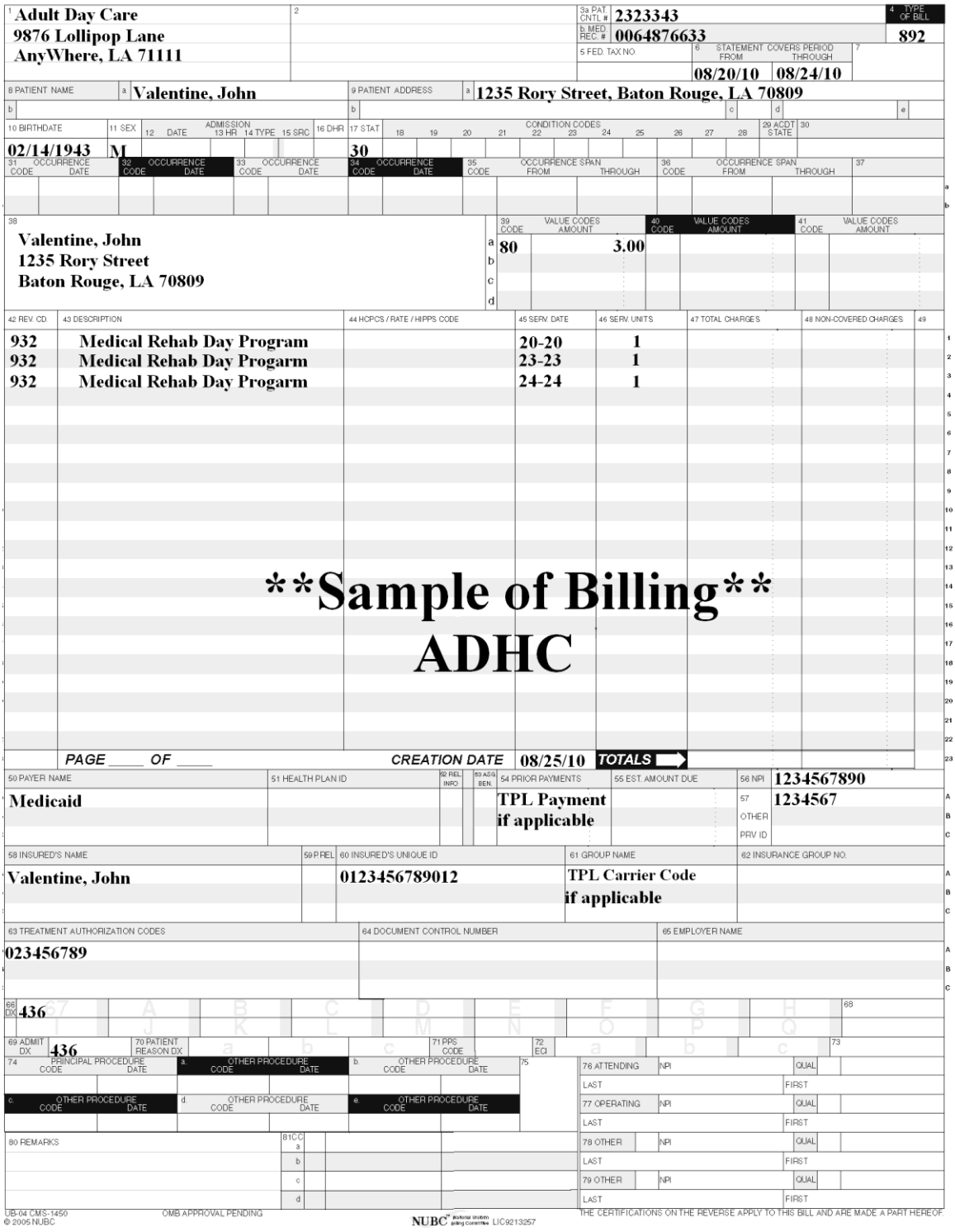
Locator #	Description	Instructions	Alerts
49	Unlabeled Field (National)	**Leave Blank.**	
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter ‘0’ or ‘0.00’ in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider’s National Provider Identifier (NPI)	**The 10-digit NPI must be entered here.**
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58-A,B,C	Insured's Name	**Required.** Enter the recipient’s name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	

Locator #	Description	Instructions	Alerts
59-A,B,C	Pt's. Relationship Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational**. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational**. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	

Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.**
65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. **Note**: **Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	

Locator #	Description	Instructions	Alerts
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank**.	
72- A B C	ECI (External Cause of Injury)	**Leave blank**.	
73	Unlabeled.	**Leave blank**.	
74 74 a – e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank**.	
75	Unlabeled	**Leave blank**.	
76	Attending	**Leave blank**.	
77	Operating	**Leave blank**.	
78	Other	**Leave blank**.	
79	Other	**Leave blank**.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	**Leave blank.**	

Signature is not required on the UB-04.



1 Adult Day Care 9876 Lollipop Lane AnyWhere, LA 71111	2	3a PAT. CNTL # 2323343 b. MED REC. # 0064876633	4 TYPE OF BILL 892
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 08/20/10 THROUGH 08/24/10

8 PATIENT NAME a. Valentine, John		9 PATIENT ADDRESS a. 1235 Rory Street, Baton Rouge, LA 70809	
10 BIRTHDATE 02/14/1943	11 SEX M	12 ADMISSION DATE	13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 30
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH		36 OCCURRENCE SPAN CODE FROM THROUGH	37
38 Valentine, John 1235 Rory Street Baton Rouge, LA 70809		39 VALUE CODES CODE AMOUNT a 80 3.00	40 VALUE CODES CODE AMOUNT
			41 VALUE CODES CODE AMOUNT

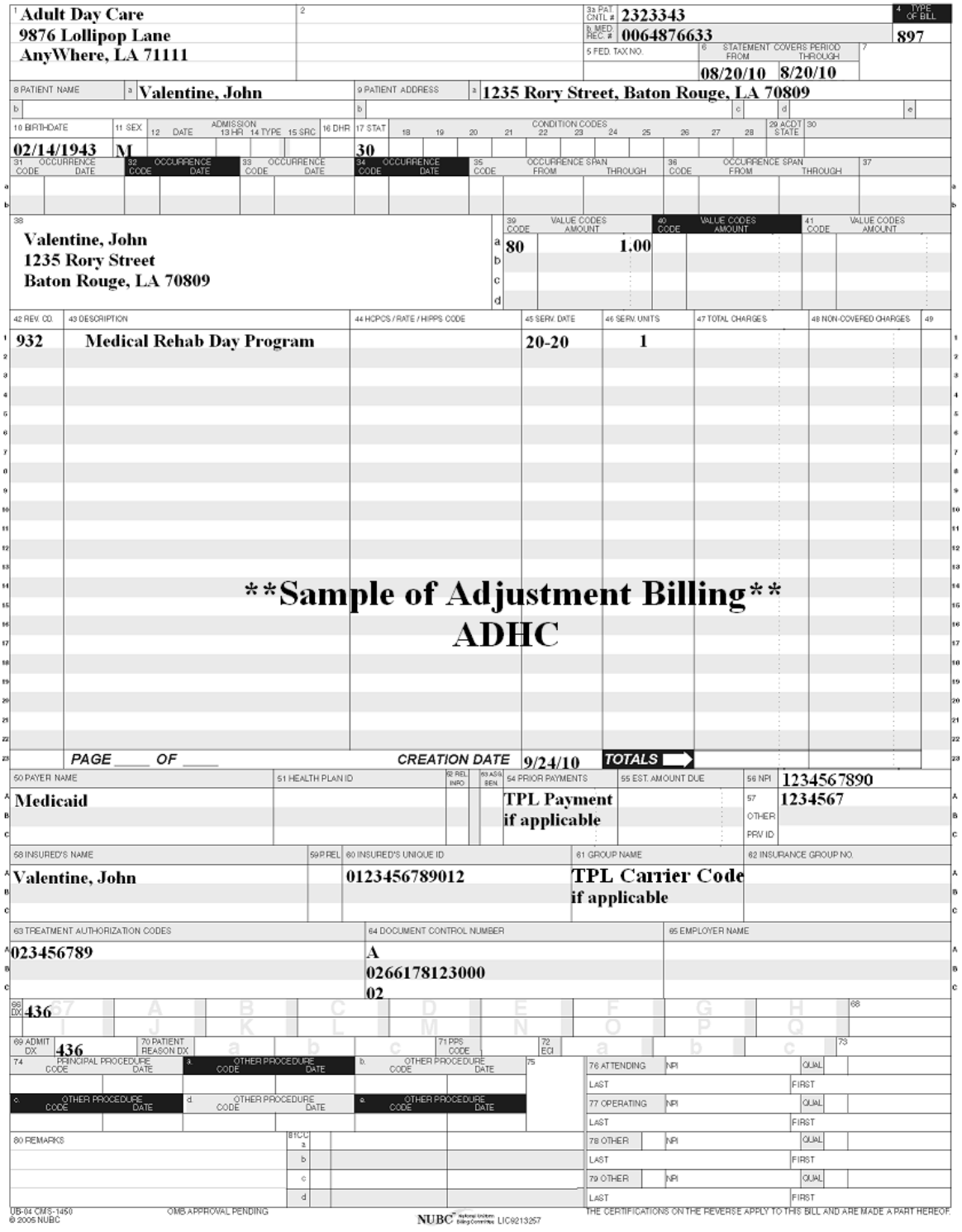
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
932	Medical Rehab Day Program		20-20	1			
932	Medical Rehab Day Progarm		23-23	1			
932	Medical Rehab Day Progarm		24-24	1			
	PAGE ____ OF ____		CREATION DATE 08/25/10	TOTALS			

****Sample of Billing****
ADHC

50 PAYER NAME Medicaid	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS TPL Payment if applicable	55 EST. AMOUNT DUE
56 NPI 1234567890 57 OTHER PRV ID 1234567					

58 INSURED'S NAME Valentine, John	59 P REL	60 INSURED'S UNIQUE ID 0123456789012	61 GROUP NAME TPL Carrier Code if applicable	62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES 023456789		64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
66 DX 436				
69 ADMIT DX 436	70 PATIENT REASON DX	a. b. c.	71 PPS CODE	72 ECI a. b. c.
74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI QUAL LAST FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL LAST FIRST
80 REMARKS	81CC a. b. c. d.			78 OTHER NPI QUAL LAST FIRST 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



1 Adult Day Care
9876 Lollipop Lane
AnyWhere, LA 71111

3a PAT. CNTL # 2323343
b. MED REC. # 0064876633
4 TYPE OF BILL 897
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/20/10 THROUGH 8/20/10

8 PATIENT NAME a Valentine, John
9 PATIENT ADDRESS a 1235 Rory Street, Baton Rouge, LA 70809
10 BIRTHDATE 02/14/1943
11 SEX M
17 STAT 30

38 Valentine, John
1235 Rory Street
Baton Rouge, LA 70809

39 VALUE CODES AMOUNT a 80 1.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
932	Medical Rehab Day Program		20-20	1		

****Sample of Adjustment Billing****
ADHC

PAGE ____ OF ____ CREATION DATE 9/24/10 TOTALS

50 PAYER NAME A Medicaid
54 PRIOR PAYMENTS TPL Payment if applicable
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME A Valentine, John
60 INSURED'S UNIQUE ID 0123456789012
61 GROUP NAME TPL Carrier Code if applicable

63 TREATMENT AUTHORIZATION CODES A 023456789
64 DOCUMENT CONTROL NUMBER A 0266178123000 02

67 DX 436
69 ADMIT DX 436

UB-04 CMS-1450 © 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.