# 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

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 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 a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

## CMS 1500 (02/12) INSTRUCTIONS FOR HOME AND COMMUNITY – BASED WAIVER SERVICES

| 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 ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.<br><br>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. | |
| 2 | Patient's Name | Required – Enter the recipient's last name, first name, middle initial. | |
| 3 | Patient's Birth Date<br><br>Sex | Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).<br><br>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.<br><br>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.<br><br>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. |
| 9b | RESERVED FOR NUCC USE | Leave Blank. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 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: | 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<br><br>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 | 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 | Unlabelled | Situational – Complete if applicable. | |
| 17b | NPI | Situational – Complete if applicable. | |
| 18 | Hospitalization Dates Related to Current Services | Optional. | |
| 19 | ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | Leave Blank. | |
| 20 | Outside Lab? | Optional. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 21 | ICD Ind.<br><br>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.<br>9 ICD-9-CM<br>0 ICD-10-CM<br><br>Required – Enter the most current ICD diagnosis code.<br><br>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 codes must be used. General codes are not acceptable.<br><br>Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD-10-CM codes will be announced at a later date. |
| 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.<br><br>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.<br><br>Appropriate reason codes follow:<br><br><u>Adjustments</u><br>01 = Third Party Liability Recovery<br>02 = Provider Correction<br>03 = Fiscal Agent Error<br>90 = State Office Use Only – Recovery<br>99 = Other<br><br><u>Voids</u><br>10 = Claim Paid for Wrong Recipient<br>11 = Claim Paid for Wrong Provider<br>00 = Other | 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).<br><br>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 Number | Required – Enter the 9-Digit PA number in this field. | |
| 24 | Supplemental Information | Situational | |
| 24A | Date(s) of Service | Required -- Enter the date of service for each procedure.<br><br>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. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 24C | EMG | Leave Blank. | |
| 24D | Procedures, Services, or Supplies | Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).<br><br>If a modifier(s) is required, enter the appropriate modifier in the correct field. | |
| 24E | Diagnosis Pointer | Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.<br><br>More than one diagnosis/reference number may be related to a single procedure code. | |
| 24F | $Charges | 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 | |
| 24H | EPSDT Family Plan | Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral. | |
| 24I | I.D. Qual. | Optional. If possible, leave blank for Louisiana Medicaid billing. | |
| 24J | Rendering Provider I.D. # | Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required.<br>Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional. | In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required. |
| 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. | |

| 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.<br><br>If TPL does not apply to the claim, leave blank. | |
| 30 | Rsvd for NUCC use | Leave Blank. | |
| 31 | Signature of Physician or Supplier Including Degrees or Credentials<br><br>Date | Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required.<br><br>Required -- Enter the date of the signature. | |
| 32 | Service Facility Location Information | Situational – Complete as appropriate or leave blank. | |
| 32a | NPI | Optional. | |
| 32b | Unlabelled | Situational – Complete if appropriate or leave blank. | |
| 33 | Billing Provider Info & Ph # | Required -- Enter the provider name, address including zip code and telephone number. | |
| 33a | NPI | Optional. | |
| 33b | Unlabelled | Required – Enter the billing provider's 7-digit Medicaid ID number.<br><br>ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing. | The 7-digit Medicaid Provider Number must appear on paper claims. |

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

**A sample form is on the following page**

## SAMPLE WAIVER CLAIM FORM

# WAIVER

**HEALTH INSURANCE CLAIM FORM**

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (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: M X 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 | ZIP CODE | TELEPHONE (Include Area Code) ( )

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. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

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.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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

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

**SAMPLE FORM FOR EXAMPLE ONLY**

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 3510 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 4123123123

| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 03 31 14 | 03 31 14 | 12 | | S5125 | UN | | A | 90 00 | 30 | | NPI | |
| 2 | 04 02 14 | 04 02 14 | 12 | | S5125 | UN | | A | 75 00 | 25 | | NPI | |
| 3 | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 165 00

29. AMOUNT PAID $

30. BALANCE DUE $

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 Jane Doe DATE 4/5/14

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # ( 225 ) 555-4957
Here For You Waiver
200 Main St
Any Town, LA 70000
a. 1239876543 b. 1239876

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM CMS-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 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.
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.

## A sample form is on the following page

## SAMPLE WAIVER CLAIM FORM ADJUSTMENT

# WAIVER

**HEALTH INSURANCE CLAIM FORM**

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (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 M X 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

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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

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

**SAMPLE FORM FOR EXAMPLE ONLY**

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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 Relate A-L to service line below (24E) ICD Ind. 9

A. 3510 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 00 ORIGINAL REF. NO.: 4094198765400

23. PRIOR AUTHORIZATION NUMBER: 4123123123

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 03 31 14 | 03 31 14 | 12 | | S5125 | UN | A | 75 00 | 25 | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 75 00

29. AMOUNT PAID $

30. BALANCE DUE $

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 Jane Doe DATE 4/9/14

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # ( 225 ) 555-4957
Here For You Waiver
200 Main St
Any Town, LA 70000
a. 1239876543 b. 1239876

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)