PAGE(S) 14

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 <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.

PAGE(S) 14

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 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. 	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	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). 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.	

09/28/15 04/30/14

Locator #	Description	Instructions	Alerts
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 	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:	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 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.	

Locator #	Description	Instructions	Alerts
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabeled	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.	
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. 9 ICD-9-CM 0 ICD-10-CM Required – Enter the most current ICD diagnosis code. 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. ICD9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD codes must be used on claims for dates of service on or after 10/1/15. Refer to the provider notice concerning the federally required implementation of ICD- 10 coding which is posted on the ICD-10 Tab at the top of the Home page at (www.lamedicaid.com)

Locator #	Description	Instructions	Alerts
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. 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. Appropriate reason 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	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). 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	
24A	Date(s) of Service	Required Enter the date of service for each procedure. 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.	
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	

Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.	
		More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	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.	
241	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 . 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.	
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.	

PAGE(S) 14

Locator #	Description	Instructions	Alerts
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	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit Medicaid Provider Number <u>must</u>
555		ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	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

PAGE(S) 14

SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

回鉄編 HEALTH INSURANCE CLAIM FORM	WAIVER		
IEALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PRCA			PICA
1. MEDICARE MEDICAID TRICARE CHAMPV		1a. INSURED'S I.D. NUMBER (For Progr	am in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member I	ID#) (ID#) (ID#) (ID#)	9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
JAYCO, TRAVIS	07 31 72 M × F		
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)	
DITY STATE	8. RESERVED FOR NUCC USE	СПУ	STATE
STATE	6. RESERVED FOR NOCC USE		SIALE
IP CODE TELEPHONE (Include Area Code)	-	ZIP CODE TELEPHONE (Indude Are	a Code)
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	
,			
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	
PL Code if applicable	YES NO	MM DD TT M	F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT?PLACE(State)	b. OTHER CLAIM ID (Designated by NUCC)	
RESERVED FOR NUCC USE	a OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES NO		
. INSURANCE PLAN NAME OR PROGRAM NAME	104, RECEIVED FOR LOCAL UPS	I PEHERE OTHER HEALTH BENEFIT PLAN?	
EXA		YES NO Hyes complete items 9 9a a	ind 9d
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the to process this claim. I also request payment of government benefits either t below.	to myself or to the party who accepts assignment	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE payment of medical benefits to the undersigned physician services described below. 	
SIGNED	DATE	SIGNED	
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0 MM DD YY	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OC MM DD YY MM DD	CUPATION
QUAL. QUAL		FROM DD YY TO MM DD	ΥΥ
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SE	RVICES
71b.	NPI	FROM TO	
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	1
		YES NO	
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	ervice line below (24E) ICD Ind. 9	22. RESUBMISSION CODE ORIGINAL REF. NO.	
_{А. [} 3510 в С	D.	SODE -	
E. F. G.]	н	23. PRIOR AUTHORIZATION NUMBER	
I. J. K.	L	4123123123	
4. A. DATE(S) OF SERVICE B. C. D.PROCE	EDURES, SERVICES, OR SUPPLIES E. plain Unusual Circumstances) DIAGNOSIS	F. G. H. I. DAYS EPSOT ID. RE	J. NDERING
From To PLACE OF (EXC MM DD YY MM DD YY SERVICE EMG CPT/HOP	plain Unusual Circumstances) DIAGNOSIS PCS MODIFIER POINTER		VIDER ID. #
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03 31 14 03 31 14 12 S512			
	the second second second	, , , , <u>, , , , , , , , , , , , , , , </u>	
	25 UN A	75 00 25 NPI	
	5 UN A		
	25 UN A	75 00 25 NPI	
	25 UN A		
04 02 14 04 02 14 12 S512		NPI NPI NPI NPI NPI	
04 02 14 04 02 14 12 S512	ACCOUNT NO. 27, ACCEPT AS SUGNIELMTY 27, ACCEPT AS SUGNIELMTY	NPI NPI NPI NPI NPI 28. TOTAL CHARGE 29. AMCUNT PAID 30. B	ALANCE DUE
04 02 14 04 02 14 12 S512	ACCOUNT NO. 27. ACCEPT AS SIGNMENT? (70 ppd. cam. seb ad) XY YES NO	NPI NPI NPI NPI NPI State 165 165 165	ALANCE DUE
04 02 14 04 02 14 12 S512	ACCOUNT NO. 27, ACCEPT AS SUGNIELMTY 27, ACCEPT AS SUGNIELMTY	NPI NPI NPI NPI NPI 28. TOTAL CHARGE 29. AMCUNT PAID 30. B	
04 02 14 02 14 12 S512 1 1 12 S512 14 12 S512 1 1 1 12 S512 14 12 S512 1	ACCOUNT NO. 27. ACCEPT AS SIGNMENT? (70 ppd. cam. seb ad) XY YES NO	NPI 28. TOTAL CHARGE 29. AMOUNT PAID 30. BLUING PROVIDER INFO & PH# (225) 555- Here For You Waiver 250	
04 02 14 12 S512 04 02 14 12 S512 0 0 0 0 0 0 0 0 <td< td=""><td>ACCOUNT NO. 27. ACCEPT AS SIGNMENT? (70 ppd. cam. seb ad) XY YES NO</td><td>NPI 28. TOTAL CHARGE 29. AMOUNT PAID 30. B 33. BILING PROVIDER INFO & PH# (225.) 555- Here For You Waiver 200 Main St.</td><td></td></td<>	ACCOUNT NO. 27. ACCEPT AS SIGNMENT? (70 ppd. cam. seb ad) XY YES NO	NPI 28. TOTAL CHARGE 29. AMOUNT PAID 30. B 33. BILING PROVIDER INFO & PH# (225.) 555- Here For You Waiver 200 Main St.	
4 02 14 02 14 12 S512 4 02 14 12 S512 5 5 5 5 5 6 6 6 6 6 7 7 7 7 7 8 7 7 7 7 9 7 7 7 7 9 7 7 7 7 9 7 7 7 7 9 7 7 7 7 9 7 7 7 7 9 7 7 7 7 9 7 7 7 7 9 7 7 7 7 7 9 7 7 7 7 7 9 7 7 7 7 7 9 7 7 7 7	ACCOUNT NO. 27. ACCEPT AS SIGNMENT? (70 ppd. cam. seb ad) XY YES NO	NPI 28. TOTAL CHARGE 29. AMOUNT PAID 30. BLUING PROVIDER INFO & PH# (225) 555- Here For You Waiver	

PAGE(S) 14

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

PROVED BY NATIONAL UNIFO			ICO 02/12				_							
PICA		in new yea	00,0212											PICA
. MEDICARE MEDICAID	TRICARE		CHAMPVA	GROUP HEALTH	PLAN	FECA BLK LUNG	OTHER	1a. INSUREDS	S I.D. NUM	BER		F	For Progra	m in Item 1)
(Medicare#) X (Medicaid #			(Member ID#)	(ID#)		(ID#)	(IDII)	98765432						
PATIENT'S NAME (Last Name, AYCO, TRAVIS	First Name, Middle	+ Initial)		MM DD 07 31	72	M X	- -	4. INSURED'S	NAME (La	ist Nam	e, First f	lame, Midd	Je initial)	
PATIENT'S ADDRESS (No., St	eet)			ATIENT RE				7. INSURED'S	ADDRESS	S (No., S	Street)			
			s	self Spo	ouse C	hild C	ther							
ITY			STATE 8. R	ESERVED F	FOR NUCC	USE		CITY						STATE
IP CODE	FELEPHONE (Indu	ude Area ((ode)					ZIP CODE			TELEF	PHONE (Inc	dude Area	Code)
	()		,								()		
OTHER INSURED'S NAME (La	t Name, First Nam	ne, Middle	initial) 10.	IS PATIEN	T'S CONDIT	ION RELAT	ED TO:	11. INSUREDS	S POLICY	GROUF	OR FE	CANUMBE	R	
OTHER INSURED'S POLICY O	R GROUP NUMBE	ER	a. E	MPLOYME)	a. INSURED MM	DO DO	YY BIRT	н		SEX	F
PL Code if applicable RESERVED FOR NUCCUSE					YES VENT2	NO	ACE (State)	b. OTHER CLA	MID (De	sionates	1 by NUK	M		F
		EX		1D	YE	N		CD	11	n				
RESERVED FOR NUCC USE						U		INS RA ICE	E PL UN	V OF	PROG	RAM NAME		
					YES	NO								
INSURANCE PLAN NAME OR	ROGRAM NAME		100	I. RESERVE	D FOR LOC	ALUSE		d. IS THERE A						
READ	ACK OF FORM B	FEORE CO	MPLETING & SI	GNING THE	S FORM			YES 13. INSURED'S				mplete item		
 PATIENT'S OR AUTHORIZED to process this claim. I also requi below. 	PERSON'S SIGNA	TURE 1	authorize the release	ase of any m	edical or oth	ter informatio coepts assign	in necessary ment	payment of services de	medical b	enefits t	o the un	dersigned p	hysician o	or supplier for
SIGNED				DATE				SIGNED						
4. DATE OF CURRENT ILLNESS		GNANCY (R DATE	MM	DD T Y	,	16. DATES PA MN	TIENT UN	ABLE T	O WOR	K IN CURR	ENT OCC	UPATION
QI 7. NAME OF REFERRING PROV		SOURCE	QUAL. 17a.					FROM 18. HOSPITALI				10		
			71b. NPI					FROM	66		1007110	TO	00	AA.
9. ADDITIONAL CLAIM INFORM	TION (Designated	t by NUCC						20. OUTSIDE L	AB?			CHARGE	s ,	1
								YES	N	>				
1. DIAGNOSIS OR NATURE OF		RY Rel	ate A-L to service	line below (24E) ICD	Ind. 0		22. RESUBMIS	SION	1	ORIGI	NAL REF. N	NO.	
A. 1G5 10	B.		C		-	D.		23. PRIOR AU	THORIZAT		MRER			
E	F		G K. [-	н		Prior Auth						
4. A. DATE(S) OF SERVICE	B.	C.	D.PROCEDUR	ES, SERVIC	CES, OR SU	IPPLIES	E. DIAGNOSIS	F.		G. DAYS	H. EPSOT	L		J. IDERING
From To MM DD YY MM DI	YY SERVICE	EMG	CPT/HCPCS	Jnusual Circ	MODIFIER		POINTER	\$ CHARG	ES	G. DAYS OR UNITS	Plen	QUAL.	PROV	IDER ID. #
10 08 15 10 08	15 12		S5125	UN		1 1	Α	90	00	30	1 0	NPI		
10 09 15 10 09	15 12	1 1	S5125	UN		1	А	75	00	25	ΙΓ	NPI		
											шſ	NPI		
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1 I i		1 1		<u>i</u> i	i	1		1	<u> </u>					
											Ιſ	NPI		
												NPI	00.5	1 41105 515
25. FEDERAL TAX I.D. NUMBER	SSN EIN	^{26.}	PATIENT'S ACCO	JUNT NO.	27. AC (For X Y	CEPT ASSI govt. datms, s /ES	SNMENT? teback) NO	28. TOTAL O	165 0			NT PAID	30. BA	LANCE DUE 165 00
1. SIGNATURE OF PHYSICIAN (RSUPPLIER		34 SERVICE FACILI	TY LOCATIK				3 33. BILLING F				(225)) 555-4	
INCLUDING DEGREES OR CF (I certify that the statements on	the reverse							HERE FO		J WA	IVER			
apply to this bill and are made a	part thereof.)							200 MAIN		-				
								ANY TOV	WN, LA	7000	10			
SIGNED Ima Biller	DATE 10/15			b.				a. 1239	67654	t		10.0	39876	

PAGE(S) 14

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.

LOUISIANA MEDICAID PROGRAM

CHAPTER 14: CHILDREN'S CHOICE APPENDIX F – CLAIMS FILING

PAGE(S) 14

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.

PAGE(S) 14

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/01/15)

	JRANCE					-			/EF	-						
ROVED BY NATIO	NAL UNIFOR	M CLAIM	СОММП	TTEE (N	UCC) 02/12											
	MEDICAID	TR)	CARE		CHAMPVA	GROU	JP TH PLAN	FECA BLK L	OTHE	R 1a. INSURED	S I.D. NU	MBER		(For Progra	im in Item 1)
(Medicare #) 🗙		1	#/DoD#)		(Member ID	(ILM)		(10#)	(124)	98765432						
ATIENT'S NAME		irst Name	e, Middle	Initial)		3. PATIENT	S BIRTH D DD Y	Y	SEX	4. INSURED'S	SNAME (I	Last Nam	ne, First N	lame, Mide	dle Initial)	
YCO, TRAV		e0				07 C	31 7			7. INSURED'S	ADDRE	SS (No., 1	Street)			
							Spouse	Child	Other							
Y					STATE	8. RESERVE	D FOR NU	ICC USE		СПҮ						STATE
CODE	T	FI EPHO	NE (Inclu	de Area	Code)					ZIP CODE			TELEE	HONE (In	dude Area	Code)
		1)		,								()		,
THER INSURED'S	S NAME (Last	Name, F	irst Name	e, Middle	Initial)	10. IS PATI	ENT'S COM	NDITION F	RELATED TO:	11. INSURED	S POLIC	Y GROUI	PORFE	CANUMB	ER	
THER INSURED'S		00000	ALL IMPORT							- INCLIDE		05 001			SEX	
L Code if ap		GROUP	NUMBER	ĸ		a. EMPLOY	YES	rrent or Pi	NO	a. INSURED	DD	YY		м	SEA	F
ESERVED FOR N						b. AUTO AC	CIDENT?		PLACE (State	b. OTHER CL	AIM ID (D	esignate	d by NU(00)		-
						S	4A	ЛP	N .							
ESERVED FOR N	UCC USE					c. OTHER A	CCIDENTY	•••		c. INSURANC	EPLANI	VAME OF	RPROGE	RAM NAME	E	
SURANCE PLAN	NAME OR PI	ROGRAM	NAME	_		101. RESER	YES	LOCAL L	NO	I I I THERE	NOTHER	RHEALT	H BENE	FIT PLAN?	,	
				E	XA		2LI	Ε(JF I			10 1	fyes.co	mplete iten	ns 9. 9a ar	nd 9d.
ATIENT'S OR AU	READ BA	CK OF F	ORM BE	FORE C	OMPLETING authorize the	& SIGNING T	HIS FORM	I. r other info	ormation necessa	13. INSURED	'S OR AU f medical	THORIZE	ED PERS	ON'S SIG	NATURE I	authorize
o process this clain elow.	n. I also reques	t paymer	nt of gover	mment b	enefits either to	o myself or to	the party wi	ho accepts	assignment	services d	escribed b	elow.				
SIGNED						DA	TE			SIGNED	0					
ATE OF CURREN	YT ILLNESS, I	NJURY,	or PREG	NANCY	(LMP) 15.0	THER DATE	MM	, DD	YY	16. DATES P/ M		NABLE T	O WOR	K IN CURF		
	QUA RING PROVID	L.			QUA	L.				FROM				10		
NAME OF REFER	RING PROVIL	EROR	OTHERS	SOURCE	17a. 71b.	NPI				18. HOSPITAL	1241684	LIAN FR	RELATE	то	KEN DD	AVICES Y
ADDITIONAL CLA		ION (De	sign ated	by NUC	C)					20. OUTSIDE	LAB?	1	1	CHARGE	i IS	i
										YES		ю				
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PAGE(S) 14

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

EALTH INSURANCE CLAIM FORM	WAIVER	
PICA		PICA
. MEDICARE MEDICAID TRICARE CHAMI	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1
(Medicare #) X (Medicaid #) (ID#/DoD#) (Membe	er ID#) (ID#) (ID#) (ID#) 13. PATIENTS BIRTH DATE SEX	9876543210123
. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS	3. PATIENTS BIRTH DATE SEX MM DD YY 07 31 72 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
,	Self Spouse Child Other	
NTY STAT	E 8. RESERVED FOR NUCC USE	CITY STATE
IP CODE TELEPHONE (Indude Area Code)		ZIP CODE TELEPHONE (Include Area Code)
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
o mun no onu dio renne (Last renne, mist realite, Middle Misa)	A SEATENT OCONDITION RELATED TO:	The moundaidy Pocific Fordier on Powerband
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
PL Code if applicable	YES NO	MM BO H
RESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIMID (Designated by NUCC)
RESERVED FOR NUCC USE		C. INSURANCE PLAN NAME OR PROGRAM NAME
NSURANCE PLAN NAME OR PROGRAM NAME	YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM E FORT O M	N & G IN THIS FOR L	3. INS JRF /S OR UT O ZED PERSON'S SIGNATURE I authorize
PATIENTS OR AUTHORIZED PERSON'S SIGN. TORE 1 samprize to process this claim. I also request payment of government benefits eith	the release of any measured or other internation necessar, her to myself or to the party who accepts assignment	y payment of measure barrenits to the undersigned physician or supplier services described below.
below.		
SIGNED	DATE	SIGNED
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 1	15.OTHER DATE NUM DD VV	
		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
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PAGE(S) 14

09/28/15

04/30/14

SAMPLE CLAIM FORM

				PICA
. MEDICARE MEDICAID TRICARE CHAMP\ (Medicare#) (Medicald#) (ID#/DcD#) (Member)	- HEALTH PLAN - BLK LUNG -	a. INSURED'S I.D. NUMBER		(For Program in Item 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)		. INSURED'S NAME (Last Na	ime, First Name, Mi	ddle Initiel)
PATIENT'S ADDRESS (No., Street)		INSURED'S ADDRESS (No	., Street)	
TY STATE	8 BESERVED FOR NUCC USE C	яту	_	STATE
JAIL STATE	6. REGERVED FOR NUCL USE			UNIE
IP CODE TELEPHONE (Include Area Code)	ZI	IP CODE	TELEPHONE (Include Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: 11	1. INSURED'S POLICY GRO	UP OR FECA NUM	BER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) a.		M	SEX F
RESERVED FOR NUCC USE		OTHER CLAIM ID (Designa	ted by NUCC)	
RESERVED FOR NUCC USE	C. OTHER ACCIDENT?	INSURANCE PLAN NAME	OR PROGRAM NAM	Æ
	YES NO			
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC) d.	VES NO		17 tems 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETIN PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the to process this claim. I also request payment of government benefits either	A RIGHING THIS CODAL	3. INSURED'S OR AUTHORI		GNATURE I authorize
	release of any medical or other information necessary	perment of medical benefit		t physician or supplier for
to process this claim. I also request payment of government banefits either below.	release of any medical or other information necessary to myself or to the party who accepts sealinment	payment of medical benefit services described below.		t physiclen or supplier for
Below. SIGNED	DATE	services described below.	a to the undersigned	
BIGNED 4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. MIT OF DI	DATE	SIGNED	s to the undersigned	
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