
CHAPTER 7: COMMUNITY CHOICES WAIVER

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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. Effective for dates of service on or after April 1, 2016, the billing form used by Adult Day Health Care (ADHC) waiver services is being changed from the uniform bill (UB-04) claim form to CMS-1500 (02/12) claim form. 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 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:

DXC Technology
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 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 a 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.

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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	Leave Blank	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient 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:	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 CLAIMID (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	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	Unlabeled	Situational – Complete if applicable.	
17b	NPI	Situational – If 17 or 17a is completed, this field is required.	
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	<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>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>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.</p> <p>ICD-10-CM "V", "W", "X", and "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 codes must be used on claims for dates of service on or after 10/1/15.</p> <p>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)</p>

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	<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 Recipient 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.	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p>	
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	<p>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</p> <p>If a modifier(s) is required, enter the appropriate modifier in the correct field.</p>	

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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.	
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 . Entering the Rendering Provider's NPI in the non-shaded portion of the block is required when the seven-digit provider number is entered in the shaded portion.	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.	

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Locator #	Description	Instructions	Alerts
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	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	Required -- Enter the billing provider's 10-digit NPI number.	
33b	Unlabeled	Required -- Enter the billing provider's seven-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The seven-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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HEALTH INSURANCE CLAIM FORM

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

WAIVER

Mail completed forms to:

DXC Technology

P.O. Box 91020

Baton Rouge, LA 70821

<input type="checkbox"/> PICA												<input type="checkbox"/> PICA											
1. MEDICAID <input checked="" type="checkbox"/> (Medicaid) <input type="checkbox"/> (Medicare) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (GROUP HEALTH PLAN) <input type="checkbox"/> (FECA BULKING) <input type="checkbox"/> (OTHER)												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)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (For Workers' Compensation) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
11. INSURED'S POLICY GROUP OR FECA NUMBER												12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX <input type="checkbox"/> M <input type="checkbox"/> F											
13. INSURED'S POLICY OR GROUP NUMBER TPL Code if Applicable												14. OTHER CLAIM ID (Designated by NUCC)											
15. INSURANCE PLAN NAME OR PROGRAM NAME												16. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.											
17. 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 is properly assigned below. SIGNED _____												18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM/DD/YY QUAL												20. OTHER DATE MM/DD/YY QUAL											
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE												22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY											
23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												24. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to service line below (24E)) A. Z7689 B. C. D. E. F. G. H. I. J. K. L.												26. RESUBMISSION CODE ORIGINAL REF. NO.											
27. PRIOR AUTHORIZATION NUMBER Prior Auth #												28. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY											
29. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER												30. DIAGNOSIS POINTER											
31. \$ CHARGES												32. DAYS OF UNITS											
33. H. PROXY (Agency Ref)												34. I. ID. QUAL											
35. J. RENDERING PROVIDER ID. #												36. NPI											
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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.
- 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.

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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

HEALTH INSURANCE CLAIM FORM										MAILING INFORMATION									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12										Baton Rouge, LA 70821									
PICA _____										PICA _____									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BACKLUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1A. INSURED'S I.D. NUMBER 9876543210123									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jayco, Travis										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
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)										7. INSURED'S ADDRESS (No., Street)									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																			
CITY _____ STATE _____										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)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if Applicable										a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9a, 9b, and 9c.									
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 _____ DATE _____									
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 _____ 17b NPI _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE DELAY? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. Z7689 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 8347198798700									
24. A. DATE(S) OF SERVICE From DD YY To DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/NCPDS MODIFIER E. DIAGNOSIS POINTER F. G. DAYS OF UNITS H. SPRT Rpty Rate I. ID. QUAL J. RENDERING PROVIDER ID.#										23. PRIOR AUTHORIZATION NUMBER Prior Auth #									
11 06 18 11 06 18 12 S5125 UN A 84.00 28 NPI										\$ CHARGES 84.00 \$ NPMT PAID \$									
25. FEDERAL TAX I.D. NUMBER SSN EIN										29. TOTAL CHARGE 29. AMOUNT PAID 30. Rev'd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OF CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.) Biller 12/17/18 DATE										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000										34. 1234509876 35. 1123456									

PLEASE PRINT OR TYPE


APPROVED OMB-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

☐ PICA ☐ PICA ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLX (LUNG) ☐ OTHER ☐
(Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#) (ID#)

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

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

9. 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 ☐

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, 2a, 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. 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. _____
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 MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS CH UNITS H. ICD Ind. I. ID. QUAL. J. RENDERING PROVIDER ID. #

1 2 3 4 5 6

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐ 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For 27a, 27b, and 27c) YES ☐ NO ☐ 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Paid 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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()

SIGNED _____ DATE _____ a. NPI b. NPI

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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>