### CHAPTER 7: COMMUNITY CHOICES WAIVER APPENDIX D: CLAIMS FILING

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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:

#### Molina Medicaid Solutions 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 <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 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.

05/11/16 09/28/15

ISSUED: REPLACED:

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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	<b>Required</b> 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	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	<b>Situational</b> – 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	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 <b>required</b> in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number. 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.	
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.	

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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 – 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	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-
		Medicaid.	10 coding which is posted on the ICD-10 Tab at the top of the Home page at (www.lamedicaid.com)

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	<ul> <li>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.</li> <li>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.</li> <li>Appropriate reason codes follow:</li> <li><u>Adjustments</u></li> <li>01 = Third Party Liability Recovery</li> <li>02 = Provider Correction</li> <li>03 = Fiscal Agent Error</li> <li>90 = State Office Use Only – Recovery</li> <li>99 = Other</li> <li><u>Voids</u></li> <li>10 = Claim Paid for Wrong Recipient</li> <li>11 = Claim Paid for Wrong Provider</li> <li>00 = Other</li> </ul>	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	<b>Required</b> – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational.	
24A	Date(s) of Service	<b>Required</b> 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	<b>Required</b> Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	<b>Required</b> 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.	

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Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	<b>Required</b> – 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	<b>Required</b> 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.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	<b>Situational</b> – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b> . Entering the Rendering Provider's NPI in the non-shaded portion of the block is <b>optional</b> .	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.	<b>Situational</b> – 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?	<b>Optional</b> . Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – 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	Description Instructions		
30	Reserved for NUCC use	Leave Blank.		
31	Signature of Physician or Supplier Including Degrees or Credentials	<b>Optional</b> 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 #	<b>Required</b> 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. 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 WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

〕 に し に に に に に に に に に に に に に	WAIVER	
IEALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA		
1. MEDICARE MEDICAID TRICARE CHAMPV	A GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item )
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member	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 5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Indude 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
5. O THER INSORED S NAME (Last Name, First Name, Middle Initial)	IV. IS PATIENT SCONDITION REDATED TO.	The INSORED'S POLICE SKODP OK PECK NOMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
TPL Code if applicable	YES NO	MM 60 TT M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
. RESERVED FOR NUCC USE		C. INSURANCE PLAN NAME OR PROGRAM NAME
A RESERVED FOR NUCL USE	C OTHER ACCIDENT?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		N PHERE NOTHER HEALTH BENEFIT PLAN?
EXA	IMPLE OF IC	YES NO If yes complete items 9 9a and 9d
READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	& SIGNING THIS FORM.     release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier
to process this claim. I also request payment of government benefits either below	to myself or to the party who accepts assignment	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 OCCUPATION
MM DD YY QUAL QU		FROM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	-	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
71b	. NPI	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	ervice line below (24E) ICD Ind. 9	YES NO
A.   3510 B.	D. I	22. RESUBMISSION CODE ORIGINAL REF. NO.
E. F. G.	D	23. PRIOR AUTHORIZATION NUMBER
LI JI KI	N	4123123123
	EDURES, SERVICES, OR SUPPLIES E. plain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. DAYS EVENT ID. RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HC	PCS MODIFIER POINTER	\$ CHARGES UNITS Plan QUAL. PROVIDER ID. #
03 31 14 03 31 14 12 5512	5 UN A	90 00 30 NPI
04 02 14 04 02 14 12 S512	25 UN A	75 00 25 NPI
		NPI
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S		28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DU
20. PATIENTS	ACCOUNTINO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	s 165 00 s s
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE F	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (225) 555-4957
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		Here For You Waiver
apply to this bill and are made a part thereof.)		200 Main St.
		Any Town, LA 70000
SIGNED Jane Doe DATE 4/5/14 a.		a. 1239876543 b. 1239876

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

	CLAIM FORM	1	• • /	AIVE	-1.			
PROVED BY NATIONAL UNIFORM	CLAIM COMMITTEE (	NUCC) 02/12						PICA
. MEDICARE MEDICAID	TRICARE	CHAMPVA	GROUP	FECA	OTHER	1a. INSURED'S I.D. NUMBER	For	Program in Item 1)
(Medicare #) 🗙 (Medicaid #)	(ID#/DoD#)	(Member ID#)	(DB)	(ID#)	UNG (IDIII)	9876543210123	ę	,
PATIENT'S NAME (Last Name, Firs	t Name, Middle Initial)	3.	MM DD	RTH DATE	SEX	4. INSURED'S NAME (Last Na	ame, First Name, Middle I	initial)
AYCO, TRAVIS			07 31	72 M ×	F			
PATIENT'S ADDRESS (No., Street)	)	6.	PATIENT REL	ATIONSHIP TO I	NSURED	7. INSURED'S ADDRESS (No.	., Street)	
			Self Spo	use Child	Other			
DITY		STATE 8.1	RESERVED F	OR NUCC USE		CITY		STATE
3P CODE TEL	EPHONE (Indude Are	(Code)				ZIP CODE	TELEPHONE (Induc	te Ama Code)
(	)	,					()	,
OTHER INSURED'S NAME (Last N	/ ame, First Name, Midd	e Initial) 10	). IS PATIENT	'S CONDITION R	ELATED TO:	11. INSURED'S POLICY GRO		
		,						
OTHER INSURED'S POLICY OR G	ROUP NUMBER	a.	EMPLOYMEN	IT? (Current or Pr	evicus)	a. INSURED'S DATE OF BI	RTH	SEX
TPL Code if applicable				YES	NO		м	F
. RESERVED FOR NUCCUSE				ENT?	PLACE (State)	b. OTHER CLAIMID (Designat	ted by NUCC)	
	F)	(ΔΛ	ΠΡΙ	YE	N) 🗖 🕹	<u>CD 10</u>		
RESERVED FOR NUCC USE		<b>~~~</b> 1  <b>¥</b>				INSTRATICE PL LIN W	OR PROGRAM NAME	
I. INSURANCE PLAN NAME OR PRO	VODAM NAME	10		YES D FOR LOCAL US	NO	d. IS THERE ANOTHER HEAL		
IL INSURANCE PLAN NAME OR PRO	Johnni HMME	10	u nebervel	SHOR LOUAL US				D On and Of
READ BACK	K OF FORM BEFORE	COMPLETING # 9	IGNING THE	FORM		13. INSURED'S OR AUTHORI	If yes, complete items 9 ZED PERSON'S SIGNAT	
<ol> <li>PATIENT'S OR AUTHORIZED PEF to process this claim. I also request p below.</li> </ol>	RSON'S SIGNATURE	I authorize the rele	ase of any me	idical or other info	rmation necessary assignment	payment of medical benefit services described below.	is to the undersigned phy	sician or supplier for
SIGNED			DATE			SIGNED		
4. DATE OF CURRENT ILLNESS, IN	JURY, or PREGNANC	(LMP) 15.OTH	ER DATE	MM DD	YY	16. DATES PATIENT UNABLE	TO WORK IN CURREN	IT OCCUPATION
QUAL		QUAL.				FROM	то	
17. NAME OF REFERRING PROVIDE	R OR OTHER SOURC	E 17a. 71b. NF				18. HOSPITALIZATION DATES	S RELATED TO CURRE MM	NT SERVICES
9. ADDITIONAL CLAIM INFORMATIC	DN /Designated by NU					20. OUTSIDE LAB?	\$ CHARGES	
		,				YES NO		
1. DIAGNOSIS OR NATURE OF ILLN	ESS OR INJURY R	elate A-L to service	e line below (2	4E) ICD Ind.	)	22. RESUBMISSION	ORIGINAL REF. NO	
A.  G5 10 B.		C		D. L				
E F.	L	G		нЦ		23. PRIOR AUTHORIZATION	NUMBER	
i J.		к. 🔄		L		Prior Auth#		
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD	B. C. PLACEOF	(Explain	Unusual Circu	ES, OR SUPPLIE Imstances)	DIAGNOSIS	F. G. DAYS		J. RENDERING
MM DD YY MM DD	YY SERVICE EMG	CPT/HCPCS		MODIFIER	POINTER	\$ CHARGES UNITS	B Plan QUAL.	PROVIDER ID. #
10 08 15 10 08	15 12	S5125	UN		Α	90 00 30	NPI	
10 09 15 10 09	15 12	S5125	UN		A	75 00 25	NPI	
							NPI	
							NPI	
1 1 1 1	1 1		1 1	1 1		1 1 1		
							NPT	
			1	1 1			NPL	
25. FEDERAL TAX I.D. NUMBER	SSN EIN 2	3. PATIENT'S ACC	OUNT NO.	27. ACCEPT	ASSIGNMENT? alma, see back)	28. TOTAL CHARGE		30. BALANCE DUE
		234		(For govt. di X YES	alma,seeback) NO	s 165 00	s	\$ 165 00
<ol> <li>SIGNATURE OF PHYSICIAN OR 5 INCLUDING DEGREES OR CRED (I certify that the statements on the apply to this bill and are made a participation.</li> </ol>	SUPPLIER 3 IENTIALS	2. SERVICE FACIL	ITY LOCATIO	IN INFORMATION	4	33. BILLING PROVIDER INFO HERE FOR YOU W 200 MAIN ST ANY TOWN, LA 700	0&PH# (225)5 /AIVER	555-4957
Ima Biller	DATE 10/15/15 a		b.			a. 123967654	b. 1239	876

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### 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 – 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 WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/01/15)

	ł							V	VZ		/ER	)						
EALT								•	•									
PROVED		IONAL U	NIFORM	CLAIM	СОММГ	TTEE (N	IUCC) 02/12											
MEDIC		MEDIC	AID	TRI	CARE		CHAMPVA	GRO	UP	FEC/	A OTHER	1a. INSURED	SLD. NU	MBER		0	For Progra	m in Item 1)
(Medica	are #) 🗙	(Media	aid #)	(ID4	#DoD#)		(Member ID	)#) (ID#)	UP .TH PLAN	(ID#)	(12/4)	98765432						
			ame, Fir	rst Name	e, Middle	Initial)		3. PATIENT			SEX F	4. INSURED'S	SNAME (I	ast Nam	e, First N	lame, Midd	le Initial)	
	), TRA		o., Stree	0				07 6. PATIENT		2 M X		7. INSURED'S	ADDRES	S (No., 8	Street)			
								Self	Spouse	Child	Other							
ſΓΥ							STATE	8. RESERVE	D FOR N	JCC USE		СПҮ						STATE
IP CODE			TE	LEPHO	NE (Inclu	ide Area	Code)					ZIP CODE			TELEP	HONE (Inc	dude Area	Code)
			(		)										(	)		
OTHER	INSURE	D'S NAM	E (Last M	Name, F	irst Name	e, Middle	e Initial)	10. IS PATI	ENT'S CO	NDITION	RELATED TO:	11. INSURED	S POLIC	GROU	P OR FEO	CA NUMBE	R	
OTHER	INSURE	D'S POLI	CY OR (	GROUP	NUMBER	R		a. EMPLOY	MENT? (C	urrent or P	revious)	a. INSURED	SDATE	OF BIRT	н		SEX	
	de if a								YES		NO					м		F
RESERV	VED FOF	NUCCI	JSE					b. AUTO AC	CIDENT?	ЛD	PLACE (State)	b. OTHER CL	AIM ID (D	esignated	d by NUC	ж)		
RESERV	/ED FOR	NUCC L	JSE					c. OTHER A	CCIDENT	γIΓ		c. INSURANC	E PLAN N	AME OF	RPROGR	AM NAME		
									YES		NO							
INSURA	NCE PL	AN NAME	ORPR	OGRAN	INAME	- F	XΔ	К/Л	<b>p</b> l <sub>o</sub>	LOCAL L	ĴΕ Ι(	THERE'S				IT PLAN?		
		RE	AD BAC	K OF F	ORM BE	FORE	OMPLETING	& SIGNING	THIS FOR	M.		13. INSURED	S OR AU	THORIZE	D PERS	ON'S SIGN	ATURE I	authorize
to proce below	IT'S OR /	AUTHORI aim. I also	ZED PE request	RSON'S	S SIGNAT t of gover	TURE I mment b	authorize the enefits either t	release of an o myself or to	y medical of the party w	or other inf ho accepts	ormation necessary s assignment	/ payment of services de	f medical escribed b	benefits t elow.	to the und	lersigned p	hysician o	or supplier for
SIGNE	D							DA	TE			SIGNED	)					
DATE C		ENT ILLI	NESS, IN	JURY,	or PREG	NANCY	(LMP) 15.0	THER DATE	MN	A, DD	. YY	16. DATES PA	TIENT U	NABLE T	O WORK	IN CURR	ENT OCC	UPATION
			QUAL				QUA	L.				FROM				10		
7. NAME	OF REFE	RRING	PROVID	EROR	OTHER S	SOURCE	17a. 71b.	NPI				18. HOSPITAL MN FROM		DATĘS P	RELATED	TO CURE MM	RENTSER	RVICES
9. ADDITI	ONAL C	AIM INF	ORMAT	ION (De	esign ated	by NUC						20. OUTSIDE	LAB?	1	\$	CHARGE	s	1
												YES		10				
		NATURE			or injur	RY Re	elate A-L to ser	vice line belo	w (24E)	ICD Ind.	9	22. RESUBMI CODE A 00	SSION	4		AL REF. 1		
A. <u>135</u> E. I.	10			8. <u> </u> C 1			C G			D. ] H. ]		23. PRIOR AL	THORIZA			0/004	00	
			J				ы. К. Ц		_	L L		41231231	123					
4. A. Fro	m	) OF SEF	To		B. PLACE OF	C.	(Exp	DURES, SEF lain Unusual	Circumstar	nces)	DIAGNOSIS	F.		G. DAYS	H. EPSOT Family	L ID.	REN	J. IDERING
IM DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCP	CS	MODI	FIER	POINTER	\$ CHARG	JES	UNITS	Plan C	WAL.	PROV	IDER ID. #
3 31	14	03	31	14	12		S512	5 UN			A	75	5 00	25		NPI		
		1				1		1					1 1		1 17	NPI		
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															[i	NPI		
1		1		1		1			1				1 1		1 17			
5. FEDER	AL TAX	.D. NUM	BER	S	SN EIN	26	. PATIENT'S A		D. 27	ACCEPT	ASSIGNMENT? daims, see back)	28. TOTAL C	HARGE	25	AMOUN		30. BA	LANCEDUE
										X YES	NO	\$	75 (				\$	
1. SIGNAT	ING DE	GREESC	R CREE	DENTIA	LS	32	SERVICE FA	CILITY LOCA	ATION INF	ORMATIC	N	33. BILLING				( 225 )	555-4	957
(I certify apply to	that the this bill a	statemen and are m	ts on the ade a p	e revers art there	e tof.)							Here For 200 Mair		vaiver				
												Any Tow		70000				
	Jane [	Doe		DATE	4/9/1	4 a.			b.			a. 1239	87654	3 1	<b>)</b> .	123	9876	

05/11/16 09/28/15

# CHAPTER 7: COMMUNITY CHOICES WAIVER

# APPENDIX D: CLAIMS FILING

PAGE(S) 14

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

	WAIVER		
HEALTH INSURANCE CLAIM FORM			
1. MEDICARE MEDICAID TRICARE CHAMP	VA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For	Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DcD#) (Member	rID#) (ID#) (ID#) (ID#)	9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle	initial)
JAYCO, TRAVIS	07 31 72 M × F		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
CITY STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	CITY	STATE
or a local difference of the l	6. RESERVED FOR NUCC USE		SIGIE
Z P CODE TELEPHONE (Indude Area Code)	-	ZIP CODE TELEPHONE (Induc	te 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	
			- Andrew -
DOTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY M	SEX F
RESERVED FOR NUCCUSE	VES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	r -
		a. OTHER CEARING (Designated by ROCC)	
. RESERVED FOR NUCC USE		C. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES NO		
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
EVA		If yes, complete items 9	), 9a and 9d.
READ BACK OF FORM E FORM & MM N 2. PATIENTS OR AUTHORIZED PERSONS SIGN CREET annotized to process this claim. I also request payment of government benefits either below.	I A GUINT THIS FOR L To recase of any mousel to other the mesion necessar arto myself or to the party who accepts assignment	<ol> <li>IN IRP /S OR UT O ZED PERSON'S SIGNA' payment of metacar benefits to the undersigned phy services described below.</li> </ol>	TURE I authorize sician or supplier for
SIGNED	DATE	SIGNED	
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15	5.OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURREN MM DD YY MM	IT OCCUPATION
	NAL MM DD YY	FROM DD YY TO MM	DD YY
	'a	18. HOSPITALIZATION DATES RELATED TO CURREN	NTSERVICES
71	Ib. NPI	FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	1
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to	and the balance (2.47)	YES NO 22. RESUBMISSION	
05.40	service line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO A02 52991987987(	
		23. PRIOR AUTHORIZATION NUMBER	
E F G.		Prior Auth#	
	CEDURES, SERVICES, OR SUPPLIES E.	F. G. H. L DAYS BRADT ID.	
	Explain Unusual Circumstances) DIA GNOSIS		J.
4. A. DATE(S) OF SERVICE B. C. D.P.ROV From To PLACEOF (E	CPCS MODIFIER POINTER	S CHARGES UNITS PER QUAL	J. RENDERING PROVIDER ID. #
14. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER		J. RENDERING PROVIDER ID. #
14. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	S CHARGES UNITS Frem OUL 90:00 30 NPI	J. RENDERING PROVIDER ID. #
4. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90 00 30 NPI	J. RENDERING PROVIDER ID. #
14. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER		J. RENDERING PROVIDER ID. #
14. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90¦00   30   <u>NPI</u>	J. RENDERING PROVIDER ID. #
14. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90 00 30 NPI	J. RENDERING PROVIDER ID. #
24. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90¦00   30   <u>NPI</u>	J. RENDERING PROVIDER ID. #
14. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90¦00   30   NPI	RENDERING PROVIDER ID. #
4. A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90¦00   30   NPI	RENDERING PROVIDER ID. #
14 A. DATE(S) OF SERVICE B. C. D.PROC From To Publicof (E MM DD YY MM DD YY SERVICE EMG CPT/HC	CPCS MODIFIER POINTER	90,00 30 NPI	RENDERING PROVIDER ID. #
24 A         DATE(S) OF SERVICE         B. O         C.         D. D         D	CPCS         MODIFIER         POINTER           25         UN         A           1         I         A           1         I         I           1         I         I           1         I         I	90 00 30 NPI	PROVIDER ID. #
24 A. DATE(S) OF SERVICE         B. B. O.         D. DATE(S) OF SERVICE         B. B. O.         D. DATE(S) OF SERVICE           MM         DD         YY         MSKNOR         EMG         C.         D. PRO           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         10         10         10         10         15         12         S51           10         10         10         10         10         15         12         S51           10         10         10         10         10         10         10         10           10         10         10         10         10         10         10         10           10         10         10         10         10         10         10         10           10         10         10         10         10         10         10         10           10         10         10	CRCS         MODIFIER         POINTER           25         UN         A           26         UN         A           27         A           28         A           29         A           20         A           20         A           21         A           22         ACCOUNT NO.           27         ACCOUNT NO.	90,00 30 NPI NPI NPI NPI 28. TOTAL OHARGE 29. AMOUNT PAID	PROVIDER ID. #
24. A. DATE(S) OF SERVICE         B. C. D. DPRO.           MM         DD         YY         Mas of C. D. PRO.           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         10         10         10         10         10           1234         12         12         1234         12	CRCS         MODIFIER         POINTER           25         UN         I         A           I         I         I         A           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I         I           S ACCOUNT ND.         27. ACCEPT ASSIGNMENT?         NO           X YES         NO         I         I	90,00 30 NPI NPI NPI NPI NPI 28. TOTAL CHARGE S 90,00 S	90. BALANCE DUE \$ 90 00
24. A. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         D. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         D. DATE(S) OF SERVICE         EMG C PT/HC           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           26. FEDERAL TAX I. D. NUMBER         SSN EN         20. PATENTS         1234           11. SIGNATURE OF PHYSICIAN OR SUPPLIER         SSN/DEL         22. SERVICE         23. SERVICE	CRCS         MODIFIER         POINTER           25         UN         A           26         UN         A           27         A           28         A           29         A           20         A           20         A           21         A           22         ACCOUNT NO.           27         ACCOUNT NO.	90,00 30 NPI NPI NPI 28. TOTAL CHARGE 5 90,00 29. AMOUNT PAID 5 90,00 5 33. BILLING PROVIDER INFO & PH# (225) 5	PROVIDER ID. #
24 A. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         D. POR           MM         DD         YY         VIEWSCE         EMG         C. PARC           10         0.8         15         10         0.8         15         12         S51           10         0.8         15         12         S51         S51           10         0.8         15         12         S51           10         26         FEDERAL TAX LD NUMBER         SSN EIN         20. PATIENTS           25         FEDERAL TAX LD NUMBER         SSN EIN         23. FATIENTS         24. SERVICE           11. SIGNATURE OF PHYSIGAN OR SUPPLIER         22. SERVICE         22. SERVICE         24. SERVICE	CRCS         MODIFIER         POINTER           25         UN         I         A           I         I         I         A           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I         I           S ACCOUNT ND.         27. ACCEPT ASSIGNMENT?         NO           X YES         NO         I         I	90,00 30 NPI NPI 28. TOTAL CHARGE 29. AMOUNT PAID 5 90,00 5 33. BILUNG RECVIDEN INO & PH# (225) 5 HERE FOR YOU WAIVER	90. BALANCE DUE \$ 90 00
24 A. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         D. PRO           MM         DD         YY         MARKON         EMG         C. PARKON           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         10         08         15         12         S51         S51           10         10         08         15         12         S51         S51           11         SCRAL TAX LD NUMBER         SIN EIN         20         PATIENTS           11.         SCRALTURE OF PHYSICIAN OR SUPPLIER         SERVICE         SERVICE         SERVICE           10         OFGRAL TAX LD NUMBER OF CREDENTALS         22. SERVICE         SERVICE         SERVICE	CRCS         MODIFIER         POINTER           25         UN         I         A           I         I         I         A           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I         I           S ACCOUNT ND.         27. ACCEPT ASSIGNMENT?         NO           X YES         NO         I         I	90,00 30 NPI NPI 28. TOTAL CHARGE 29. ANDUNT PAID 5 90,00 5 33. BILING PROVIDER INFO & PH# (225) 5 HERE FOR YOU WAIVER 200 MAIN ST	90. BALANCE DUE \$ 90 00
24 A. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         B. B. C. DATE(S) OF SERVICE         D. PRO           MM         DD         YY         MARKON         EMG         C. PARKON           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         08         15         10         08         15         12         S51           10         10         08         15         12         S51         S51           10         10         08         15         12         S51         S51           11         SCRAL TAX LD NUMBER         SIN EIN         20         PATIENTS           11.         SCRALTURE OF PHYSICIAN OR SUPPLIER         SERVICE         SERVICE         SERVICE           10         OFGRAL TAX LD NUMBER OF CREDENTALS         22. SERVICE         SERVICE         SERVICE	CRCS         MODIFIER         POINTER           25         UN         I         A           I         I         I         A           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I           I         I         I         I         I           S ACCOUNT ND.         27. ACCEPT ASSIGNMENT?         NO           X YES         NO         I         I	90,00 30 NPI NPI 28. TOTAL CHARGE 29. AMOUNT PAID 5 90,00 5 33. BILUNG RECVIDEN INO & PH# (225) 5 HERE FOR YOU WAIVER	30. BALANCE DUE \$ 90 00 555-4957

# **APPENDIX D: CLAIMS FILING**

### **PAGE(S) 14**

05/11/16 09/28/15

### SAMPLE CLAIM FORM

tedicare#) (Medicaid#) (UD#DoD#) (Mer TIENT'S NAME (Lest Neme, First Neme, Middle Initial) TIENT'S ADDRESS (No., Street) ST DDE TELEPHONE (Include Area Code) ( )	APVA         CROUPT IPLAN         EECLING         OTHER           (D0)         (D0)         (D0)         (D0)         (D0)         (D0)           3. PATENT B BIRTH DATE         BEX         M         F         (D0)         (D0)	1a. INSURED'S I.D. NUMBER 4. INSURED'S NAME (Last N 7. INSURED'S ADDRESS (No	ame, Finst Name, Mid	For Program in litern 1)
TIENT'S NAME (Leet Name, First Name, Middle Initial) TIENT'S ADDRESS (No., Street) ST DDE TELEPHONE (Include Area Code) ()	S. PATIENT'S BIRTH DATE     SEX     M     F      G. PATIENT RELATIONSHIP TO INSURED     Set     Spouse     Child     Other			cle initial)
DDE TELEPHONE (Include Area Code)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No	o., Street)	
DDE TELEPHONE (Include Area Code)				
DDE TELEPHONE (Include Area Code)	TE 8. RESERVED FOR NUCC USE			
( )		CITY		STATE
( )		ZIP CODE	TELEPHONE (In	nclude Area Code)
HER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GRO	OUP OR FECA NUMB	R
HER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	A. INSURED'S DATE OF BIR	<del>и</del>	SEX
SERVED FOR NUCC USE	YES NO     b. AUTO ACCIDENT?     DI ACE (State)	b. OTHER CLAIM ID (Designa	M	F
	YES NO			201
SERVED FOR NUCC USE	G. OTHER ACCIDENT?	© INSURANCE PLAN NAME	OR PROGRAM NAM	E
URANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEA	LTH BENEFIT PLAN	1
BEAD BACK OF FORM REFORE COMIN	TING & SKINING THIS FORM	YES NO 13. INSURED'S OR AUTHOR	If yes, complete its	
READ BACK OF FORM BEFORE COMPL TRENT'S OR AUTHORIZED PERSON'S SIGNATURE I authoriz process this claim. I also request payment of government banelles low.	the release of any medical or other information necessary ther to myself or to the party who accepts assignment	payment of medical benefit services described below.	ta to the undersigned	physiclen or supplier for
GNED	DATE	SIGNED		
TE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLI MM DD FROM	E TO WORK IN CURI YY TO	
ME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATE MM DD FROM	S RELATED TO CUP	RENT SERVICES
DITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$ CHAF	IGES
AGNOSIS OF NATURE OF ILLNESS OF INJURY Relate A-L to	service line below (24E)	YES NO	223. THERE IN A 44.474	
B	CD Ind.	22. FIESUBMISSION	ORIGINAL REF.	NO.
F.	вн	23. PRIOR AUTHORIZATION	NUMBER	
J. J. DATE(S) OF SERVICE B. C. D. PF	C L L XCEDURES, SERVICES, OR SUPPLIES E.	F9.	H. L	J.
From To PLACEOF	biplain Unusual Circumstances) DIAGNOSIS ICPCS MODIFIER POINTER	F. G. DAW S CHARGES UNT	S EPSOT ID. Family ID. S Plan QUAL	RENDERING PROVIDER ID. #
			NPI	
			NPI	
	*8 ACCOUNT NO. 27. ACCEPT.ASSIGNMENT?	28. TOTAL CHARGE		20 Desite Miles I
EDERAL TAX I.D. NUMBER S8N EIN 28. PATTEN	"8 ACCOUNT NO. 27. ACCEPT ASSIGNMENT? For govt. claims, see bacto	20. TOTAL GRANGE	29. AMOUNT PAID	30. Ravel for NUCC L