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**CHAPTER 7: COMMUNITY CHOICES WAIVER**

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**APPENDIX D: CLAIMS FILING****PAGE(S) 18**

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**CLAIMS FILING**

Community Choices Waiver services (except ADHC) must be filed by electronic claims submission 837P or on the CMS 1500 claim form.

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

This appendix includes the following:

- Instructions for completing the CMS 1500
- Sample of CMS 1500 claim form
- Instructions for completing the UB 04
- Sample of UB 04 claim form

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CMS 1500 (08/05) 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 #).	
1a	Insured's I.D. Number	<b>Required</b> – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.  <b>NOTE:</b> The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> 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 (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).  Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	Patient Status	<b>Optional.</b>	

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Locator #	Description	Instructions	Alerts
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<p><b>Situational</b> – If recipient has no other coverage, leave blank.</p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block (the carrier code list can be found at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under the <b>Forms/Files</b> link).</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	
9b	Other Insured's Date of Birth Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	<b>Situational</b> – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	<b>Situational</b> – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	<b>Situational</b> – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	<b>Optional.</b>	
15	If Patient Has Had Same or Similar Illness Give First Date	<b>Optional.</b>	
16	Dates Patient Unable to Work in Current Occupation	<b>Optional.</b>	
17	Name of Referring Provider or Other Source	<b>Situational</b> – Complete if applicable.	
17a	Unlabelled	<b>Situational</b> – Complete if applicable.	
17b	NPI	<b>Optional.</b>	
18	Hospitalization Dates Related to Current Services	<b>Optional.</b>	
19	Reserved for Local Use	Reserved for future use. Do not use.	
20	Outside Lab?	<b>Optional.</b>	
21	Diagnosis or Nature of Illness or Injury	<b>Required</b> -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	The most specific diagnosis codes must be used. General codes are not acceptable

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Locator #	Description	Instructions	Alerts
22	Medicaid Resubmission Code	<b>Optional.</b>	
23	Prior Authorization Number	<b>Required</b> – Enter the 9-digit PA number in this field.	
24	Supplemental Information	<b>Situational</b>	
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	<b>Leave Blank</b>	
24D	Procedures, Services, or Supplies	<b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block.  More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	<b>Required</b> -- 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	<b>Situational</b> – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	<b>Optional.</b> – If possible, leave blank for Louisiana Medicaid billing.	

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Locator #	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	<p><b>Situational</b> – If applicable, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b>.</p> <p>Entering the Rendering Provider's NPI in the non-shaded portion of the block is <b>optional</b>.</p>	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	<b>Optional.</b>	
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	<p><b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay.</p> <p>If TPL does not apply to the claim, leave blank.</p>	
30	Balance Due	<b>Situational</b> – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	

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Locator #	Description	Instructions	Alerts
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	Optional.	Claims will no longer be rejected back to providers for a missing original signature or missing original initials on a stamped or computer generated 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 & Ph #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	The revised form accommodates the entry of the Billing Provider's NPI.  Providers of atypical services (non-medical) are not required to obtain an NPI.
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit Medicaid ID Number MUST be entered here.

**REMINDER: MAKE SURE “WAIVER” IS WRITTEN IN BOLD, LEGIBLE LETTERS ON THE TOP OF THE CLAIM FORM**

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1500										1500									
HEALTH INSURANCE CLAIM FORM										Waiver									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/06																			
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 BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>6955231546013</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>JAYCO, TRAVIS</b>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DO YY <b>07 31 1972</b> M <input type="checkbox"/> F <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
5. PATIENT'S ADDRESS (No., Street)										8. INSURED'S STATUS Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
6. PATIENT'S STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										9. INSURED'S CITY									
7. INSURED'S CITY										10. INSURED'S STATE									
8. INSURED'S STATE										11. INSURED'S POLICY GROUP OR FECA NUMBER									
9. INSURED'S POLICY GROUP OR FECA NUMBER										12. INSURED'S DATE OF BIRTH MM DO YY M <input type="checkbox"/> F <input type="checkbox"/>									
10. INSURED'S DATE OF BIRTH MM DO YY M <input type="checkbox"/> F <input type="checkbox"/>										13. EMPLOYER'S NAME OR SCHOOL NAME									
11. EMPLOYER'S NAME OR SCHOOL NAME										14. INSURANCE PLAN NAME OR PROGRAM NAME									
12. INSURANCE PLAN NAME OR PROGRAM NAME										15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, return to and complete item 9 a-d.</b>									
13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, return to and complete item 9 a-d.</b>										16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)									
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## Instructions for Completing the UB04 for Adult Day Health Care

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

**CHAPTER 7: COMMUNITY CHOICES WAIVER****APPENDIX D: CLAIMS FILING****PAGE(S) 18**

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

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

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## APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p><b>Required.</b> – Enter the appropriate Value Code (listed below).</p> <p>*80 = Covered days</p> <p>*Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.</p>	
42	Revenue Code	<p><b>Required.</b> – Enter the revenue code which identifies the service provided.</p> <p><u>Revenue Code &amp; Description (Corresponding Level of Care)</u></p> <p>932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day (27 = Adult Day Health Care)</p>	
43	Revenue Description	<b>Required.</b> – Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	<b>Leave blank.</b>	
45	Service Date	<p><b>Required.</b> – Enter the day of service for each day services are provided (e.g., 01-01, 02-02, 03-03, etc) for each revenue code indicated. Enter a service line for each service day.</p> <p><b>Required.</b> – Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.</p>	The CREATION DATE replaces the Date of Provider Representative Signature
46	Units of Service	<p><b>Required.</b> – Enter the total number of units for each day of service. 1 unit = 15 minutes of service.</p> <p><b>Note:</b> ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) each prior authorized week.</p>	Reminder: 1 Unit is equal to 15 minutes of service
47	Total Charges	<b>Leave Blank.</b>	

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

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## APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
58-A,B,C	Insured's Name	<p><b>Required.</b> – Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p><b>Situational</b> – If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.</p>	
59-A,B,C	Pt's. Relationship Insured	<p><b>Situational.</b> – If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows:</p> <ul style="list-style-type: none"> <li>01 = Patient is insured</li> <li>02 = Spouse</li> <li>03 = Natural child/Insured has financial responsibility</li> <li>04 = Natural child/ Insured does not have financial responsibility</li> <li>05 = Step child</li> <li>06 = Foster child</li> <li>07 = Ward of the court</li> <li>08 = Employee</li> <li>09 = Unknown</li> <li>10 = Handicapped dependent</li> <li>11 = Organ donor</li> <li>13 = Grandchild</li> <li>14 = Niece/Nephew</li> <li>15 = Injured Plaintiff</li> <li>16 = Sponsored dependent</li> <li>17 = Minor dependent of minor dependent</li> <li>18 = Parent</li> <li>19 = Grandparent</li> </ul>	
60-A,B,C	Insured's Unique ID	<p><b>Required.</b> – Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A.</p> <p><b>Situational.</b> – If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.</p>	

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## APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
61-A,B,C	Insured's Group Name (Medicaid not Primary)	<b>Situational.</b> – If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	<b>Situational.</b> – If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	<b>Required.</b> – Enter the 9-digit prior authorization number in 63A	
64-A,B,C	Document Control Number	<p><b>Situational.</b> – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u></p> <p>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></p> <p>10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.
65-A,B,C	Employer Name	<b>Situational.</b> – If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	Leave blank.	

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## APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
67	Principal Diagnosis Codes	<b>Required.</b> – Enter the ICD-9-CM code for the principal diagnosis.	
67 A-Q	Other Diagnosis code	<b>Situational.</b> – Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. <b>Note:</b> Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.	
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	<b>Optional.</b> – Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	Leave blank.	
71	PPS Code	Leave blank.	
72- A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a – e	Other Procedure Code / Date		
75	Unlabeled	Leave blank.	
76	Attending	Leave blank.	
77	Operating	Leave blank.	
78	Other	Leave blank.	
79	Other	Leave blank.	
80	Remarks	<b>Situational.</b> – Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

Signature is not required on the UB-04.



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<b>Adult Day Care</b> <b>9876 Lollipop Lane</b> <b>AnyWhere, LA 71111</b>										<b>3a PAT. CNTL # 2323343</b> <b>b MED. REC. # 0064876633</b> <b>5 FID. TAX NO.</b> <b>6 STATEMENT COVERS PERIOD FROM 08/20/12 THROUGH 08/24/12</b> <b>7</b> <b>4 TYPE OF BILL 892</b>									
<b>8 PATIENT NAME a Valentine, John</b>										<b>9 PATIENT ADDRESS a 1235 Rory Street, Baton Rouge, LA 70809</b>									
<b>10 BIRTHDATE 02/14/1943</b> <b>11 SEX M</b> <b>12 DATE</b> <b>13 ADMISSION HR</b> <b>14 TYPE</b> <b>15 SRC</b> <b>16 DHR</b> <b>17 STAT</b> <b>18</b> <b>19</b> <b>20</b> <b>21</b> <b>22</b> <b>23</b> <b>24</b> <b>25</b> <b>26</b> <b>27</b> <b>28</b> <b>29 ACDT STATE</b> <b>30</b>										<b>31 OCCURRENCE DATE</b> <b>32 OCCURRENCE DATE</b> <b>33 OCCURRENCE DATE</b> <b>34 OCCURRENCE DATE</b> <b>35 CODE</b> <b>36 OCCURRENCE SPAN FROM THROUGH</b> <b>37</b> <b>38 CODE</b> <b>39 OCCURRENCE SPAN FROM THROUGH</b> <b>40</b> <b>41 CODE</b> <b>42</b> <b>43</b> <b>44</b> <b>45</b> <b>46</b> <b>47</b> <b>48</b> <b>49</b> <b>50</b> <b>51</b> <b>52</b> <b>53</b> <b>54</b> <b>55</b> <b>56</b> <b>57</b> <b>58</b> <b>59</b> <b>60</b> <b>61</b> <b>62</b> <b>63</b> <b>64</b> <b>65</b> <b>66</b> <b>67</b> <b>68</b> <b>69</b> <b>70</b> <b>71</b> <b>72</b> <b>73</b> <b>74</b> <b>75</b> <b>76</b> <b>77</b> <b>78</b> <b>79</b> <b>80</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>96</b> <b>97</b> <b>98</b> <b>99</b>									
<b>Valentine, John</b> <b>1235 Rory Street</b> <b>Baton Rouge, LA 70809</b>										<b>39 CODE 80</b> <b>40 CODE 96.00</b> <b>41 CODE</b> <b>42</b> <b>43</b> <b>44</b> <b>45</b> <b>46</b> <b>47</b> <b>48</b> <b>49</b> <b>50</b> <b>51</b> <b>52</b> <b>53</b> <b>54</b> <b>55</b> <b>56</b> <b>57</b> <b>58</b> <b>59</b> <b>60</b> <b>61</b> <b>62</b> <b>63</b> <b>64</b> <b>65</b> <b>66</b> <b>67</b> <b>68</b> <b>69</b> <b>70</b> <b>71</b> <b>72</b> <b>73</b> <b>74</b> <b>75</b> <b>76</b> <b>77</b> <b>78</b> <b>79</b> <b>80</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>96</b> <b>97</b> <b>98</b> <b>99</b>									
<b>42 REV. CD. 932</b> <b>43 DESCRIPTION Medical Rehab Day Program</b> <b>44 HOPPS / RATE / HPPS CODE</b> <b>45 SERV. DATE 20-20</b> <b>46 SERV. UNITS 32</b> <b>47 TOTAL CHARGES</b> <b>48 NON-COVERED CHARGES</b> <b>49</b>										<b>50</b> <b>51</b> <b>52</b> <b>53</b> <b>54</b> <b>55</b> <b>56</b> <b>57</b> <b>58</b> <b>59</b> <b>60</b> <b>61</b> <b>62</b> <b>63</b> <b>64</b> <b>65</b> <b>66</b> <b>67</b> <b>68</b> <b>69</b> <b>70</b> <b>71</b> <b>72</b> <b>73</b> <b>74</b> <b>75</b> <b>76</b> <b>77</b> <b>78</b> <b>79</b> <b>80</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>96</b> <b>97</b> <b>98</b> <b>99</b>									
<b>PAGE 1 OF 1</b> <b>CREATION DATE 09/01/12</b> <b>TOTALS</b>										<b>50 PAYER NAME Medicaid</b> <b>51 HEALTH PLAN ID</b> <b>52 REL. INFO</b> <b>53 ASG. BEN.</b> <b>54 PRIOR PAYMENTS TPL Payment if applicable</b> <b>55 EST. AMOUNT DUE</b> <b>56 NPI 1234567890</b> <b>57 OTHER PRV ID 1234567</b> <b>58 INSURED'S NAME Valentine, John</b> <b>59 PREL</b> <b>60 INSURED'S UNIQUE ID 0123456789012</b> <b>61 GROUP NAME TPL Carrier Code if applicable</b> <b>62 INSURANCE GROUP NO.</b> <b>63 TREATMENT AUTHORIZATION CODES 023456789</b> <b>64 DOCUMENT CONTROL NUMBER</b> <b>65 EMPLOYER NAME</b> <b>66</b> <b>67</b> <b>68</b> <b>69</b> <b>70</b> <b>71</b> <b>72</b> <b>73</b> <b>74</b> <b>75</b> <b>76</b> <b>77</b> <b>78</b> <b>79</b> <b>80</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>96</b> <b>97</b> <b>98</b> <b>99</b>									
<b>66 DX 436</b> <b>67</b> <b>68</b> <b>69</b> <b>70</b> <b>71</b> <b>72</b> <b>73</b> <b>74</b> <b>75</b> <b>76</b> <b>77</b> <b>78</b> <b>79</b> <b>80</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>96</b> <b>97</b> <b>98</b> <b>99</b>										<b>76 ATTENDING NPI</b> <b>77 OPERATING NPI</b> <b>78 OTHER NPI</b> <b>79 OTHER NPI</b> <b>80</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>96</b> <b>97</b> <b>98</b> <b>99</b>									
<b>80 REMARKS</b> <b>81</b> <b>82</b> <b>83</b> <b>84</b> <b>85</b> <b>86</b> <b>87</b> <b>88</b> <b>89</b> <b>90</b> <b>91</b> <b>92</b> <b>93</b> <b>94</b> <b>95</b> <b>9</b>																			

## CHAPTER 7: COMMUNITY CHOICES WAIVER

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1 Adult Day Care 9876 Lollipop Lane AnyWhere, LA 71111		2		3a FOL CMTL # 2323343 b MED REC # 0064876633 5 FED TAX NO.		4 TYPE OF BILL 897	
8 PATIENT NAME a Valentine, John		9 PATIENT ADDRESS a 1235 Rory Street, Baton Rouge, LA 70809		6 STATEMENT COVERS PERIOD FROM 08/20/12 THROUGH 08/20/12		7	
10 BIRTH-DATE 02/14/1943		11 SEX M		12 DATE		13 HPI	
14 TYPE		15 SRC		16 DHR		17 STAT	
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