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

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	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. 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 (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	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	Patient Status	Optional.	

Locator #	Description	Instructions	Alerts
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	Situational – Complete if appropriate or 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	Employer's Name or School Name	Situational – Complete if appropriate or 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.	

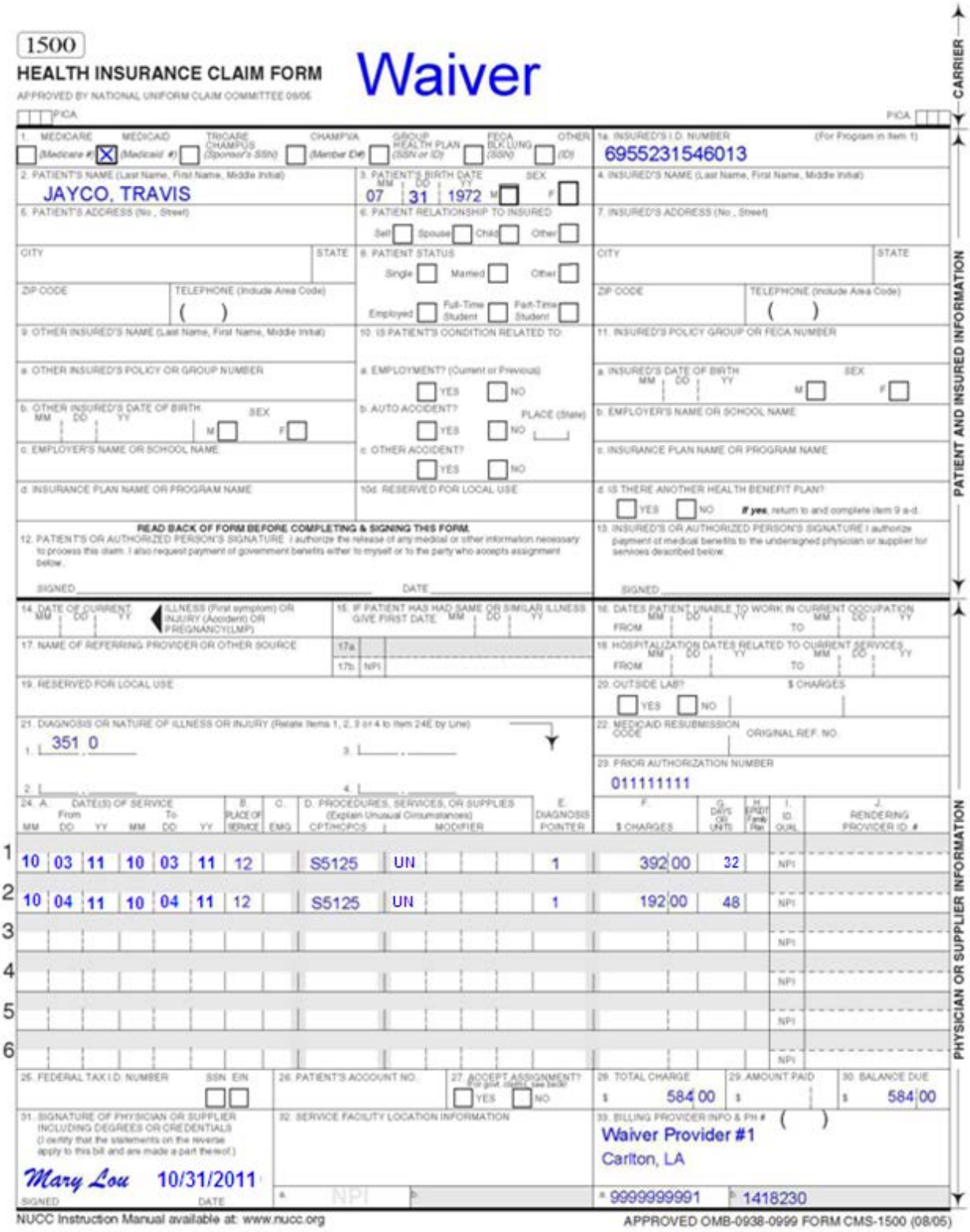
Locator #	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabelled	Situational – Complete if applicable.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required -- 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

Locator #	Description	Instructions	Alerts
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	Required – Enter the 9-digit PA number in this field.	
24	Supplemental Information	Situational	
24A	Date(s) of Service	Required -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank	
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	Required – 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	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.	

Locator #	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	Situational – If applicable, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. – Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	Situational – 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.	

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



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/05

Waiver

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 6955231546013

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JAYCO, TRAVIS

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 1972 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. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ 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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 351 0 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 011111111

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 03 11	10 03 11	12		S5125	UN	1	392 00	32		NPI
2	10 04 11	10 04 11	12		S5125	UN	1	192 00	48		NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 584 00

29. AMOUNT PAID $

30. BALANCE DUE $ 584 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Lou 10/31/2011

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Waiver Provider #1

Carlton, LA

a. 9999999991 b. 1418230

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Instructions for Completing the UB04 for Adult Day Health Care

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	Required. – Enter the name and address of the facility.	
2	Pay to Name/Address/ID	Situational. – Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	Optional. – Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	Optional. – Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	Required. – Enter the appropriate 3-digit code as follows: *1st Digit - Type of Facility* 8 = Special Facility (LOC=Adult Day Health Care) *2nd Digit - Classification* 9 = Other (Adult Day Health Care - ADHC) *3rd Digit – Frequency Definition* 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.	

Locator #	Description	Instructions	Alerts
5	Federal Tax No.	Optional.	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	Required. – Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. – 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)	Required. – 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	Required. – 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	Required. – Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	Required. – 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.	

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

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	Required. – Enter the appropriate Value Code (listed below). *80 = Covered days *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.	
42	Revenue Code	Required. – Enter the revenue code which identifies the service provided. Revenue Code & Description *(Corresponding Level of Care)* 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	
43	Revenue Description	Required. – Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	Leave blank.	
45	Service Date	Required. – 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. Required. – 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.	The CREATION DATE replaces the Date of Provider Representative Signature
46	Units of Service	Required. – Enter the total number of units for each day of service. 1 unit = 15 minutes of service. Note: ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) each prior authorized week.	Reminder: 1 Unit is equal to 15 minutes of service
47	Total Charges	Leave Blank.	

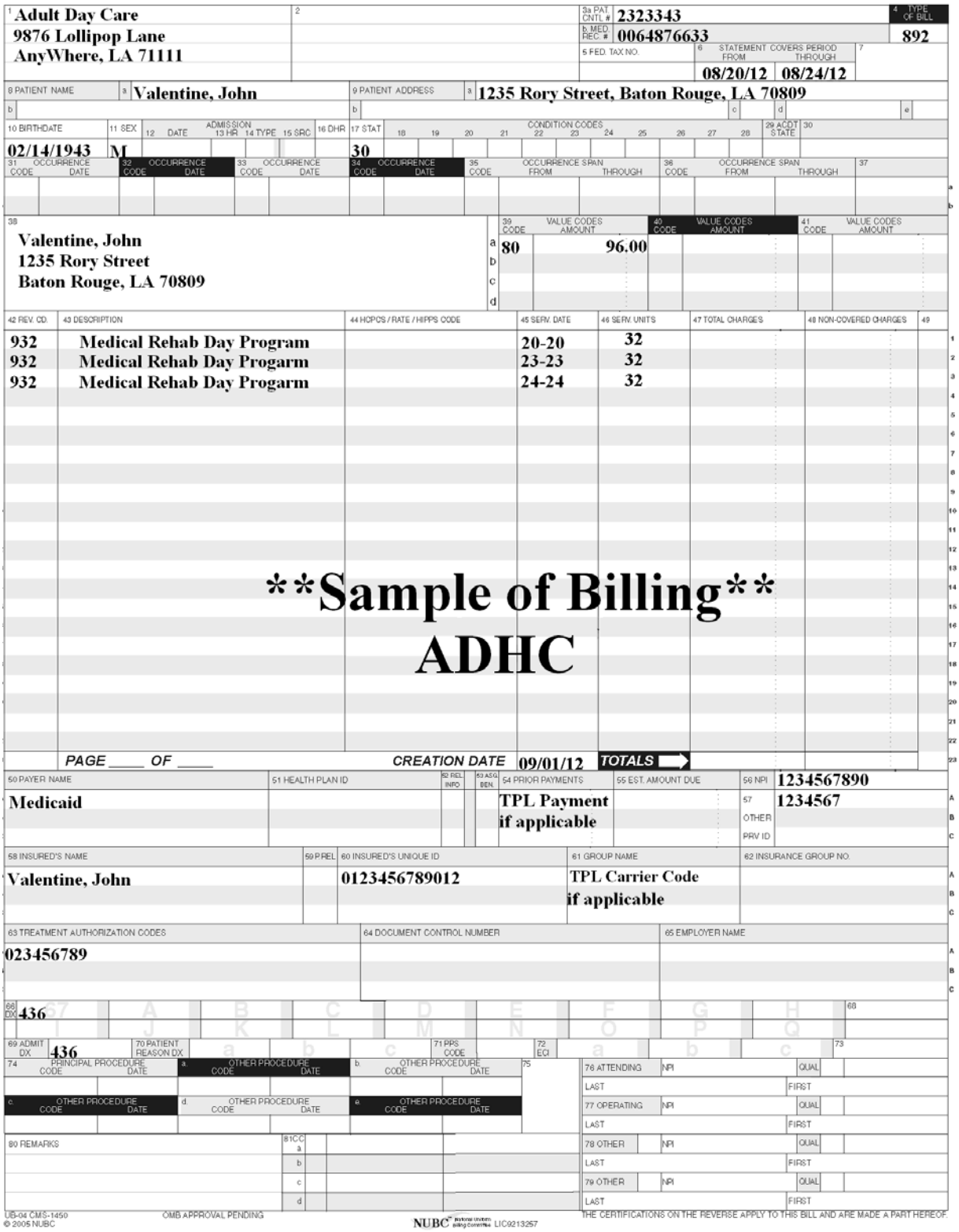
Locator #	Description	Instructions	Alerts
48	Non-Covered Charges	Leave Blank.	
49	Unlabeled Field (National)	Leave Blank.	
50-A,B,C	Payer Name	Situational. – Enter insurance plans other than Medicaid on Lines “A”, "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is required. 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.	
51-A,B,C	Health Plan ID	Situational. – Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is required.	
52-A,B,C	Release of Information	Optional.	
53-A,B,C	Assignment of Benefits Cert. Ind.	Optional.	
54-A,B,C	Prior Payments	Situational. – 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. If private insurance was available, but no private insurance payment was made, then enter ‘0’ or ‘0.00’ in this field.	
55-A,B,C	Estimated Amt. Due	Optional.	
56	NPI	Optional. – Enter the provider’s National Provider Identifier (NPI)	
57-A,B,C	Other Provider ID	Required. – Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57A.	The 7-digit Medicaid ID number MUST be entered here.

Locator #	Description	Instructions	Alerts
58-A,B,C	Insured's Name	Required. – Enter the recipient's name as it appears on the Medicaid ID card in 58A. Situational – 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.	
59-A,B,C	Pt's. Relationship Insured	Situational. – 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: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	Required. – Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. Situational. – 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.	

Locator #	Description	Instructions	Alerts
61-A,B,C	Insured's Group Name (Medicaid not Primary)	Situational. – 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)	Situational. – 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	Required. – Enter the 9-digit prior authorization number in 63A	
64-A,B,C	Document Control Number	Situational. – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	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	Situational. – 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.	

Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	Required. – Enter the ICD-9-CM code for the principal diagnosis. Situational. – Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. Note: 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	Optional. – 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 74 a – e	Principal Procedure Code / Date Other Procedure Code / Date	Leave blank.	
75	Unlabeled	Leave blank.	
76	Attending	Leave blank.	
77	Operating	Leave blank.	
78	Other	Leave blank.	
79	Other	Leave blank.	
80	Remarks	Situational. – 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.



1 Adult Day Care
9876 Lollipop Lane
AnyWhere, LA 71111

3a PAT. CNTL # 2323343
b. MED REC. # 0064876633
4 TYPE OF BILL 892
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/20/12 THROUGH 08/24/12

8 PATIENT NAME a. Valentine, John
9 PATIENT ADDRESS a. 1235 Rory Street, Baton Rouge, LA 70809
10 BIRTHDATE 02/14/1943
11 SEX M
17 STAT 30

38
Valentine, John
1235 Rory Street
Baton Rouge, LA 70809

39 VALUE CODES AMOUNT a. 80 96.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
932	Medical Rehab Day Program		20-20	32		
932	Medical Rehab Day Progarm		23-23	32		
932	Medical Rehab Day Progarm		24-24	32		

****Sample of Billing****
ADHC

PAGE ____ OF ____ CREATION DATE 09/01/12 TOTALS

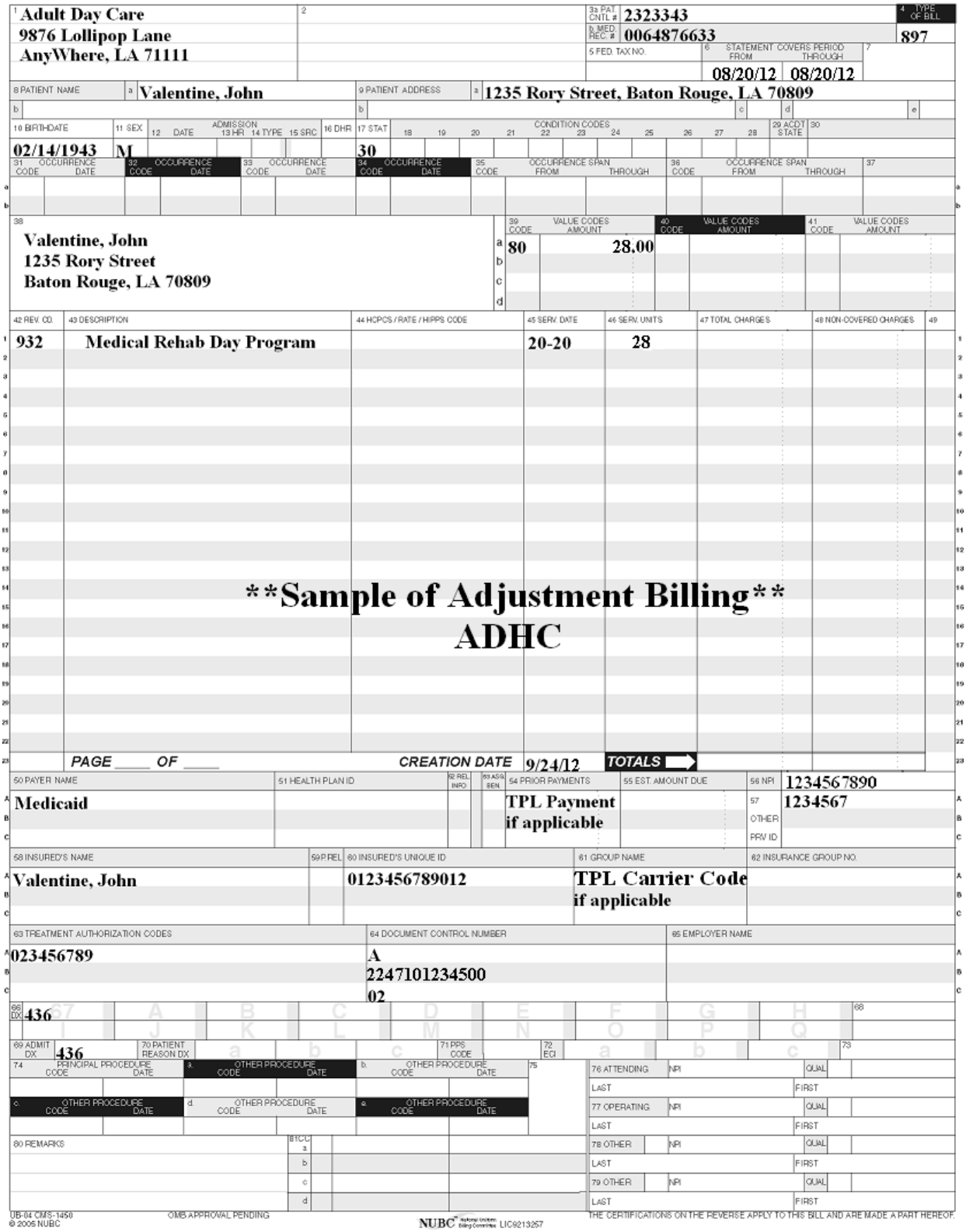
50 PAYER NAME: Medicaid
54 PRIOR PAYMENTS: TPL Payment if applicable
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME: Valentine, John
60 INSURED'S UNIQUE ID: 0123456789012
61 GROUP NAME: TPL Carrier Code if applicable

63 TREATMENT AUTHORIZATION CODES: 023456789

66 DX 436
69 ADMIT DX 436

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



1 Adult Day Care
9876 Lollipop Lane
AnyWhere, LA 71111

3a PAT. CNTL # 2323343
b MED. REC. # 0064876633
4 TYPE OF BILL 897
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 08/20/12 THROUGH 08/20/12

8 PATIENT NAME a Valentine, John
9 PATIENT ADDRESS a 1235 Rory Street, Baton Rouge, LA 70809
10 BIRTHDATE 02/14/1943
11 SEX M
17 STAT 30

38 Valentine, John
1235 Rory Street
Baton Rouge, LA 70809

39 VALUE CODES a 80 AMOUNT 28.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
932	Medical Rehab Day Program		20-20	28		

****Sample of Adjustment Billing****
ADHC

PAGE ____ OF ____ CREATION DATE 9/24/12 TOTALS

50 PAYER NAME Medicaid
51 HEALTH PLAN ID
54 PRIOR PAYMENTS TPL Payment if applicable
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME Valentine, John
60 INSURED'S UNIQUE ID 0123456789012
61 GROUP NAME TPL Carrier Code if applicable

63 TREATMENT AUTHORIZATION CODES 023456789
64 DOCUMENT CONTROL NUMBER A2247101234500 02

66 DX 436
69 ADMIT DX 436

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.