CLAIMS FILING

Hard copy billing of waiver services (except Adult Day Health Care) are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix for completing the CMS-1500 are the same information that is required when billing claims electronically. Items to be completed are listed as **required, situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

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 a CMS 1500 claim form and samples of completed CMS-1500 claim forms;

- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms;
- Instructions for completing the UB 04; and
- Samples of UB 04 claim form.

CMS 1500 (02/12) INSTRUCTIONS FOR HOME AND COMMUNITY – BASED WAIVER SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the recipient's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is **required** in this block. The carrier code is indicated on the Medicaid 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.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER 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.	

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 Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. ICD9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD codes must be used on claims for dates of service on or after 10/1/15. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page at (www.lamedicaid.com)

Locator #	Description	Instructions	Alerts
22	Resubmission Code	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization (PA) Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational	
24A	Date(s) of Service	Required -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	

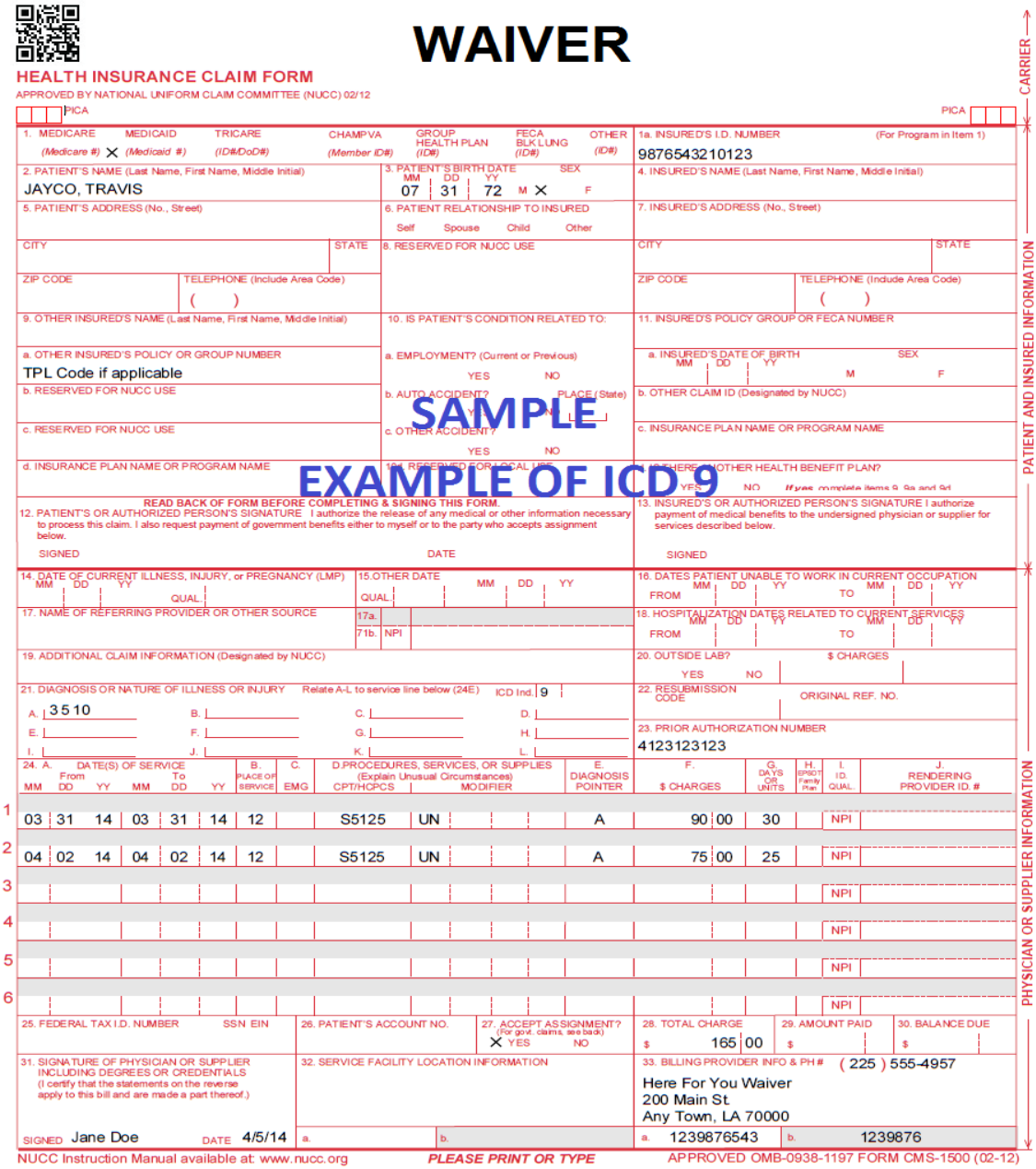
Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	

Locator #	Description	Instructions	Alerts
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	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 must 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.

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



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9876543210123

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 72 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

SAMPLE

EXAMPLE OF ICD 9

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 3510 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 4123123123

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	03 31 14	03 31 14	12		S5125	UN		A	90 00	30		NPI	
2	04 02 14	04 02 14	12		S5125	UN		A	75 00	25		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) X YES NO

28. TOTAL CHARGE $ 165 00

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Jane Doe DATE 4/5/14

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (225) 555-4957

Here For You Waiver
200 Main St
Any Town, LA 70000

a. 1239876543 b. 1239876

CARRIER

PATIENT AND INSURED INFORMATION

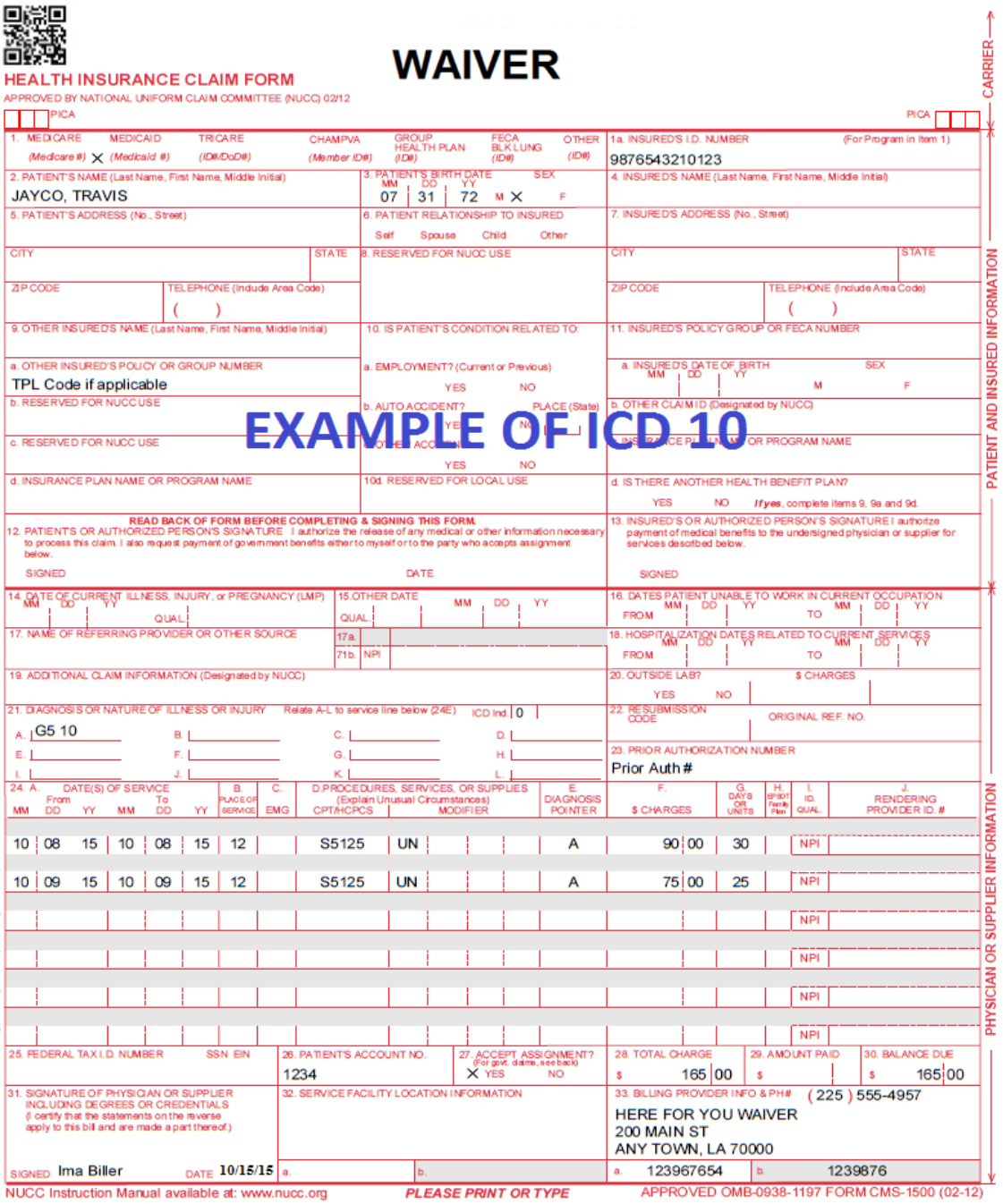
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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



WAIVER

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

CARRIER

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9876543210123

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 72 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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, complete items 9, 9a and 9d.

EXAMPLE OF ICD 10

PATIENT AND INSURED INFORMATION

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. G5 10 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

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 08 15		10 08 15			12		S5125	UN	A	90 00	30		NPI	
2	10 09 15		10 09 15			12		S5125	UN	A	75 00	25		NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE $ 165 00

29. AMOUNT PAID $

30. BALANCE DUE $ 165 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.)
SIGNED Ima Biller DATE 10/15/15

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH# (225) 555-4957
HERE FOR YOU WAIVER
200 MAIN ST
ANY TOWN, LA 70000
a. 123967654 b. 1239876

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.

- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

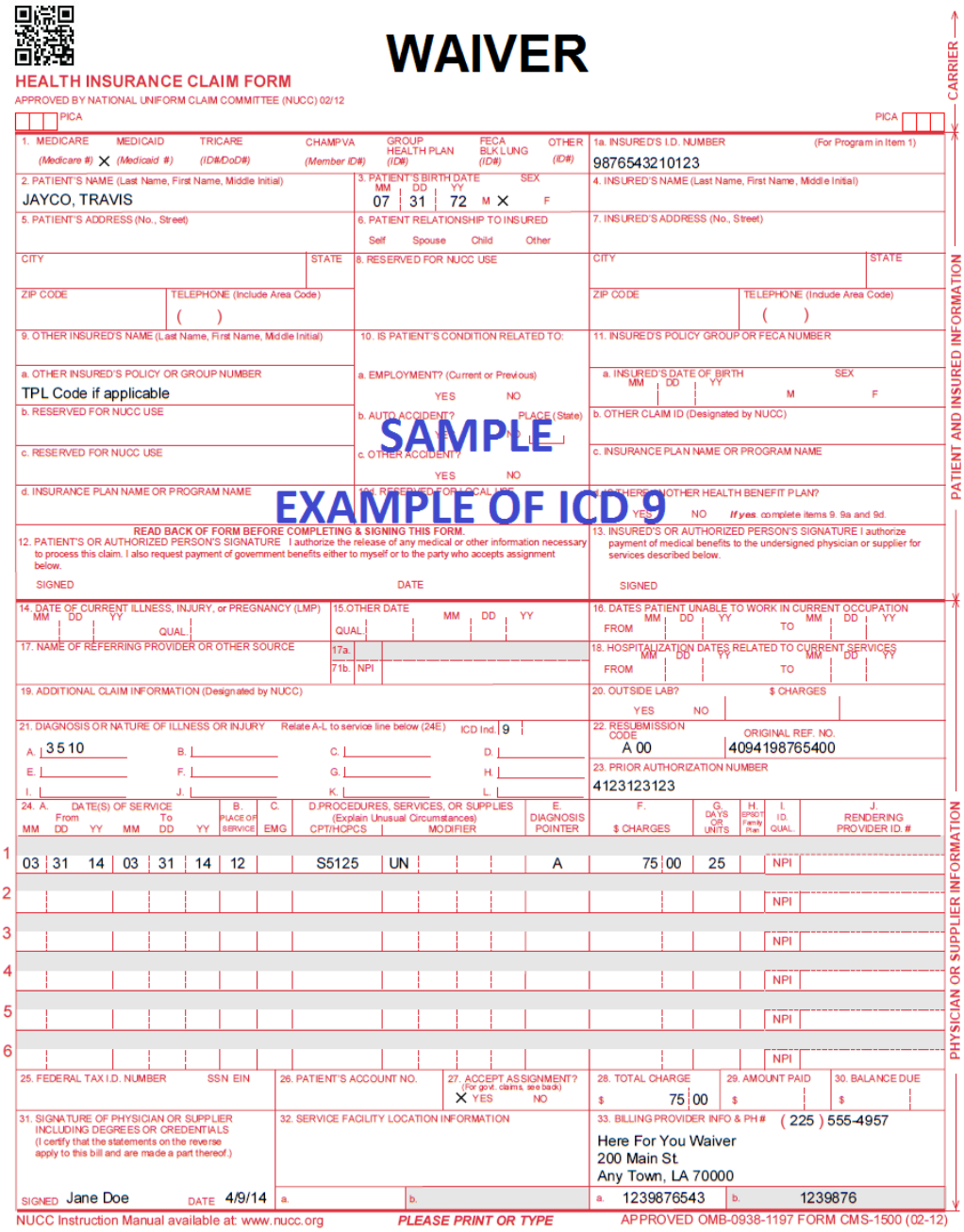
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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.

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



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9876543210123

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 72 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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*, complete items 9, 9a and 9d.

SAMPLE

EXAMPLE OF ICD 9

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 3510 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 00 ORIGINAL REF. NO.: 4094198765400

23. PRIOR AUTHORIZATION NUMBER: 4123123123

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	03 31 14	03 31 14	12		S5125	UN	A	75 00	25		NPI
2											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) X YES NO

28. TOTAL CHARGE $ 75 00

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED Jane Doe DATE 4/9/14

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (225) 555-4957

Here For You Waiver
200 Main St
Any Town, LA 70000

a. 1239876543 b. 1239876

CARRIER

PATIENT AND INSURED INFORMATION

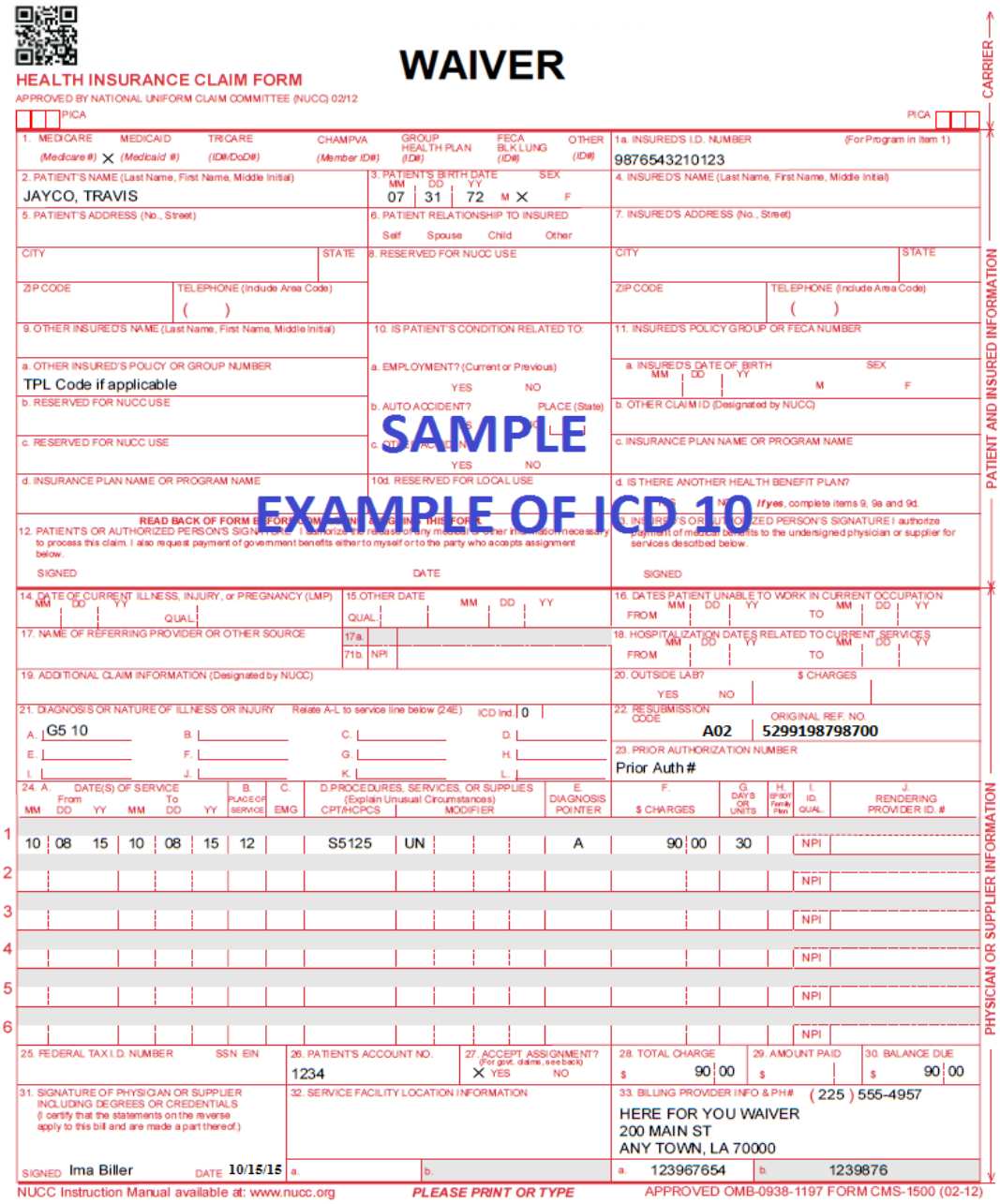
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9876543210123

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 72 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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? NO If yes, complete items 9, 9a and 9d.

SAMPLE

EXAMPLE OF ICD 10

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

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. G5 10 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A02 ORIGINAL REF. NO.: 5299198798700

23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

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 08 15	10 08 15	12		S5125	UN	A	90 00	30		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE $ 90 00

29. AMOUNT PAID $

30. BALANCE DUE $ 90 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.)

SIGNED Ima Biller DATE 10/15/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH# (225) 555-4957

HERE FOR YOU WAIVER
200 MAIN ST
ANY TOWN, LA 70000

a. 123967654 b. 1239876

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

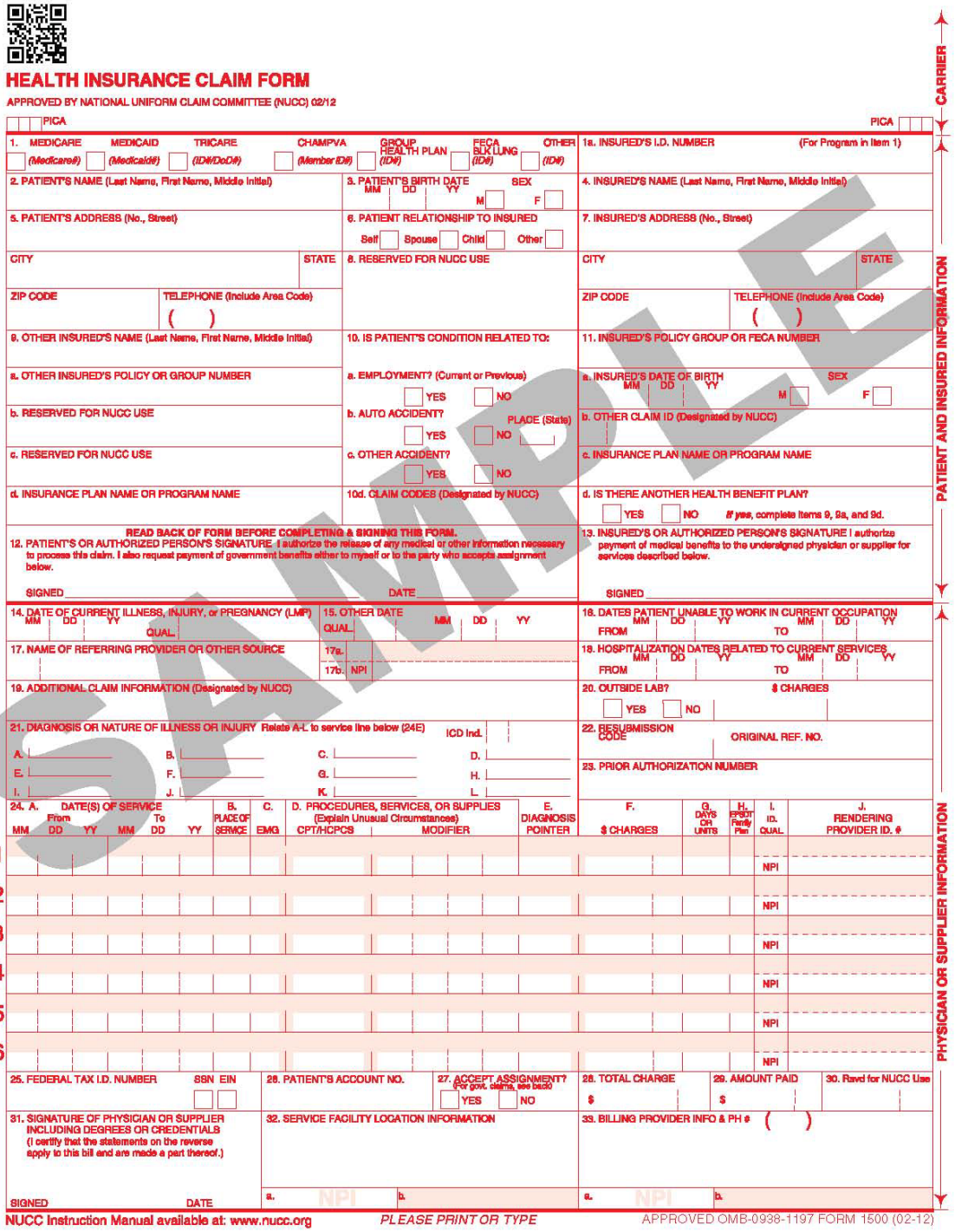
APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										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 $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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.	
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.	Enter total number of units billed on the claim, not the number of days

Locator #	Description	Instructions	Alerts
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.	Creation date must be later than the through date in Form Locator 6
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.	
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.	

Locator #	Description	Instructions	Alerts
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)	The 10-digit NPI must be entered here.
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.
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.	

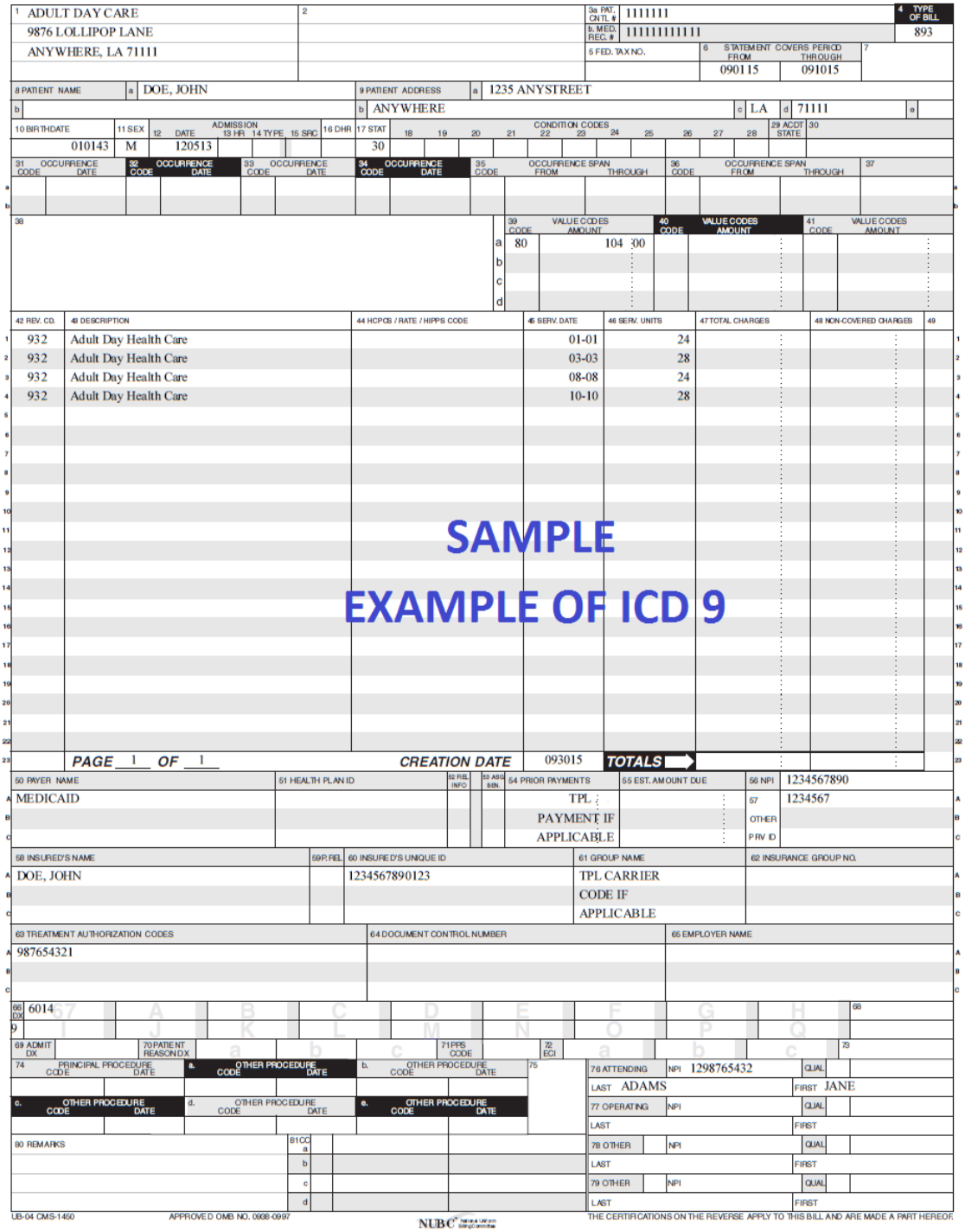
Locator #	Description	Instructions	Alerts
59-A,B,C	Patient's Relationship to Insured	Situational. – If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as 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.	
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	

Locator #	Description	Instructions	Alerts
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: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 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.	
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 3-digit Diagnosis Code is to be used only if it is not further subdivided. Where 4-digit subcategories and/or 5-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.	ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).

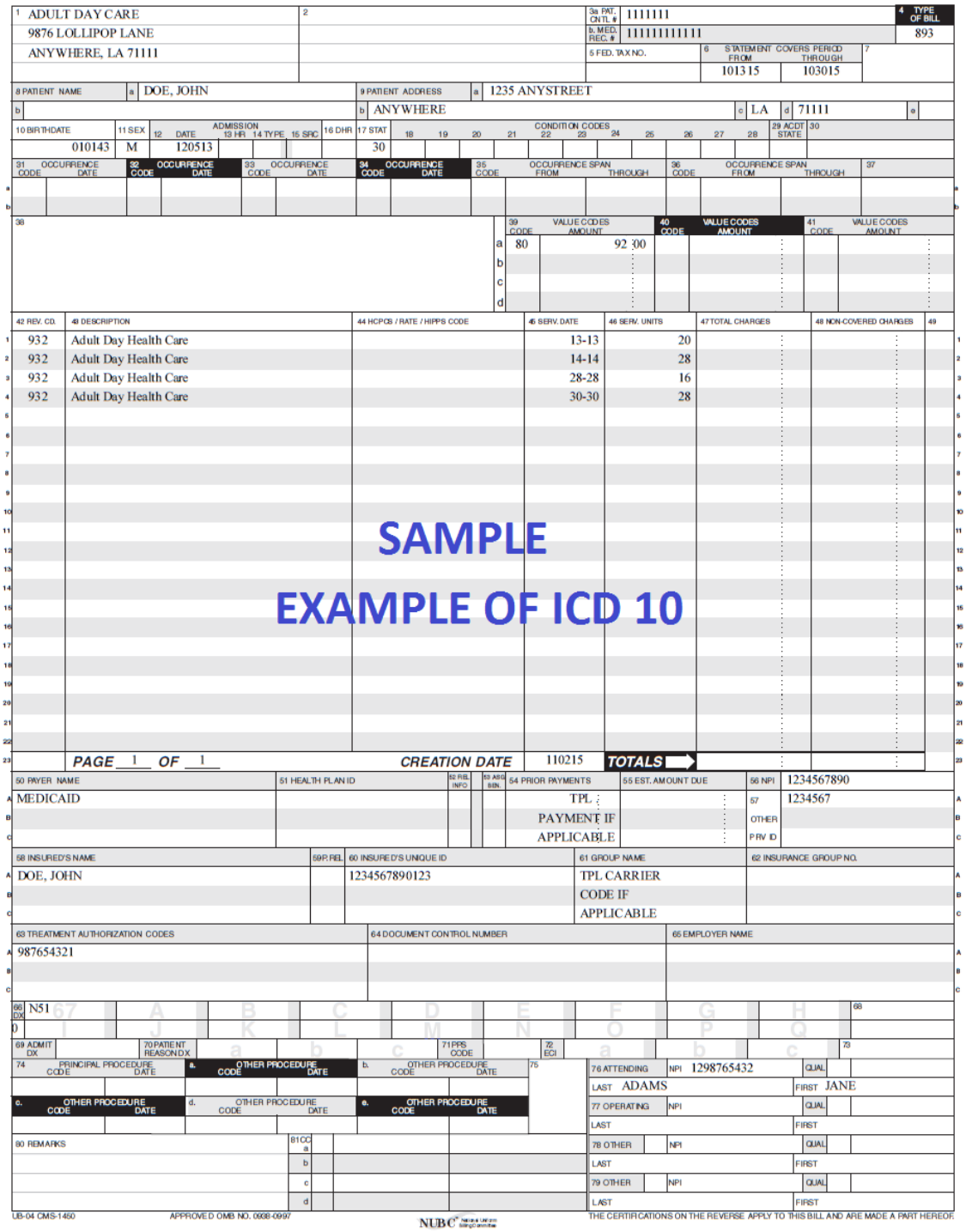
Locator #	Description	Instructions	Alerts
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. – Enter the admitting Diagnosis Code.	Refer to field locator 67.
70	Patient Reason for Visit	Leave blank.	
71	PPS Code	Leave blank.	
72- A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74 74 a – e	Principal Procedure Code / Date Other Procedure Code / Date	Leave blank.	
75	Unlabeled	Leave blank.	
76	Attending	Leave blank.	This field must be completed.
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.

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



SAMPLE ADHC CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)



1 ADULT DAY CARE
9876 LOLLIPOP LANE
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 893
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 101315 THROUGH 103015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
010143	M	120513					30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	92 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	932	Adult Day Health Care		13-13	20			1
2	932	Adult Day Health Care		14-14	28			2
3	932	Adult Day Health Care		28-28	16			3
4	932	Adult Day Health Care		30-30	28			4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE 1 OF 1	CREATION DATE	110215	TOTALS			23

SAMPLE

EXAMPLE OF ICD 10

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890	
A	MEDICAID				TPL PAYMENT IF APPLICABLE		57 OTHER PRV ID	1234567	A
B									B
C									C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	DOE, JOHN		1234567890123	TPL CARRIER CODE IF APPLICABLE		A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A	987654321			A
B				B
C				C

66 DX 0 N51 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

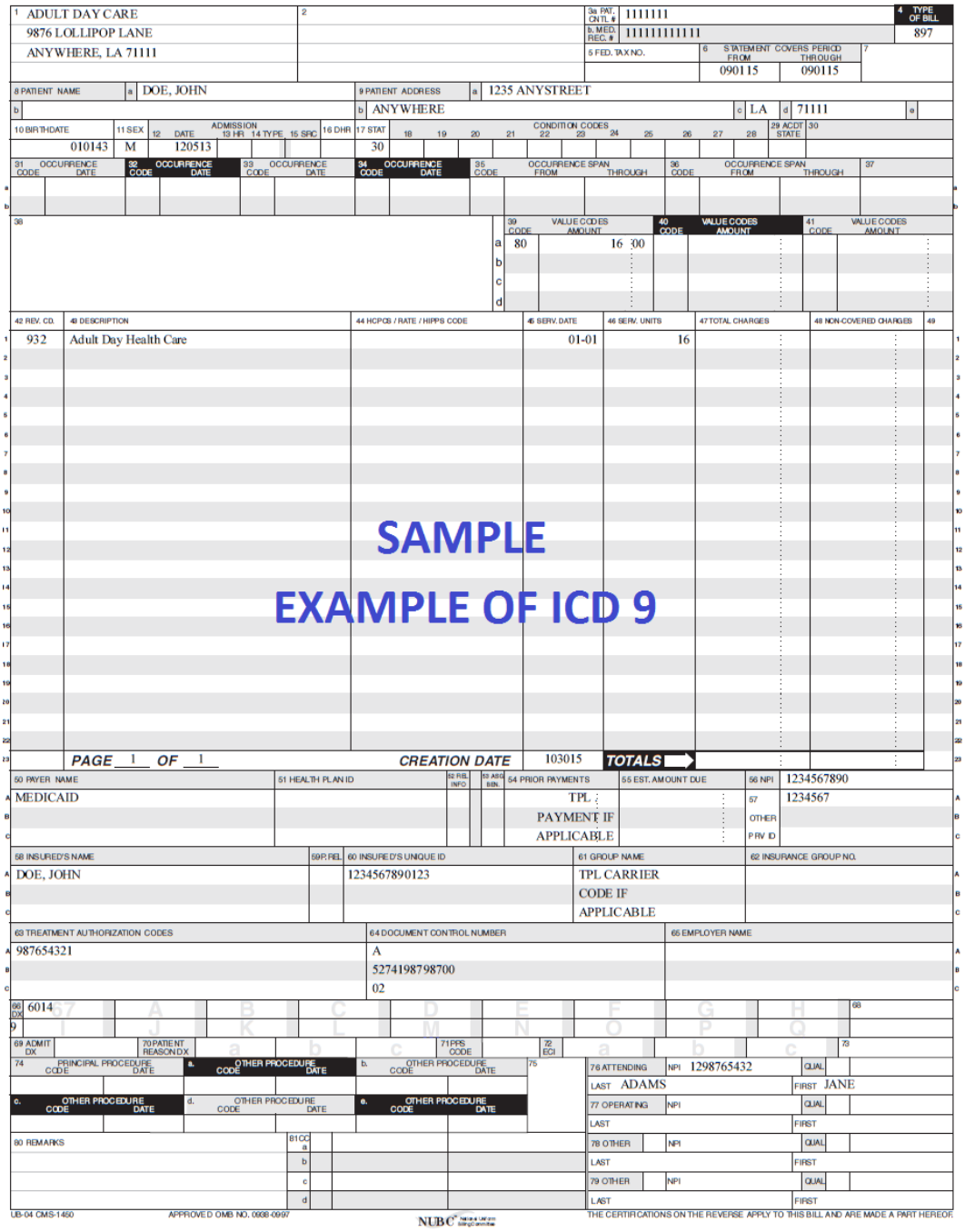
76 ATTENDING	NPI 1298765432	QUAL	
LAST ADAMS		FIRST JANE	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC			
a			
b			
c			
d			

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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



SAMPLE ADHC CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)