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CHAPTER 7: COMMUNITY CHOICES WAIVER

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## APPENDIX D: CLAIMS FILING

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**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](http://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;

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- 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.

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

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	<b>Required</b> – Enter the recipient's 13-digit Medicaid I.D. 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 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	RESERVED FOR NUCC USE		
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
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 commercial insurance coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	<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	OTHER CLAIM ID (Designated by NUCC)	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.	
12	Patient's or Authorized Person's Signature (Release of Records)	<b>Situational</b> – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabeled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
21	ICD Indicator  Diagnosis or Nature of Illness or Injury	<p><b>Required</b> – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p><b>Required</b> – Enter the most current ICD diagnosis code.</p> <p><b>NOTE:</b> The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p><b>ICD9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</b></p> <p><b>ICD codes must be used on claims for dates of service on or after 10/1/15.</b></p> <p><b>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 (<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>)</b></p>

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

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Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block.  More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	<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.	
24J	Rendering Provider I.D. #	<b>Situational</b> – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b> . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is <b>optional</b> .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	<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	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter ‘0’ if the third party did not pay.  If TPL does not apply to the claim, leave blank.	

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Locator #	Description	Instructions	Alerts
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Optional</b> -- The practitioner or the practitioner's authorized representative's original signature is no longer required.  <b>Required</b> -- Enter the date of the signature.	
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	
32a	NPI	<b>Optional</b> .	
32b	Unlabeled	<b>Situational</b> – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	<b>Optional</b> .	
33b	Unlabeled	<b>Required</b> – Enter the billing provider's 7-digit Medicaid ID number.  ID Qualifier - <b>Optional</b> . If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

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

**Sample forms are on the following pages.**



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

## WAIVER

## HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	2. MEDICAID (Medicaid #) <input checked="" type="checkbox"/>	3. TRICARE (TRICARE #)	4. CHAMPVA (Member ID#)
5. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		6. PATIENT'S BIRTH DATE (MM/DD/YY) 07/31/72	
7. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? (PLACE / State) c. OTHER ACCIDENT? d. INSURANCE PLAN NAME OR PROGRAM NAME	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM/DD/YY) M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME		12. INSURED'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 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		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 FROM MM/DD/YY TO MM/DD/YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. 3510 B. C. D. E. F. G. H. I. J. K. L.		22. RE submission CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER 4123123123		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. #	
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			

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

## HEALTH INSURANCE CLAIM FORM

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

## WAIVER

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9876543210123</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 DD YY) <b>07 31 72</b> SEX <b>M X F</b>		5. PATIENT'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED <b>Self Spouse Child Other</b>		7. INSURED'S ADDRESS (No., Street)	
8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>TPL Code if applicable</b>		a. EMPLOYMENT? (Current or Previous) <b>YES NO</b>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <b>YES NO</b> PLACE (State) <b>LA</b>	
c. RESERVED FOR NUCC USE		c. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <b>YES NO If yes, complete items 9, 9a and 9d.</b>	
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.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) <b>MM DD YY</b> <b>08 15 12</b> QUAL <b>G5 10</b>		15. OTHER DATE <b>MM DD YY</b> <b>09 15 12</b> QUAL <b>S5 125</b>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <b>YES NO</b> \$ CHARGES <b>90 00</b>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b>		22. RESUBMISSION CODE <b>ORIGINAL REF. NO.</b>	
A. <b>G5 10</b> B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER <b>Prior Auth #</b>	
24. A. DATE(S) OF SERVICE From <b>MM DD YY</b> To <b>MM DD YY</b> B. PLACE OF SERVICE <b>EMG</b> C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) <b>S5 125 UN</b> E. DIAGNOSIS POINTER <b>A</b> F. \$ CHARGES <b>90 00</b> G. DAYS OF UNITS <b>30</b> H. SPAN (Start/End) <b>NPI</b> I. ID. QUAL. <b>NPI</b> J. RENDERING PROVIDER ID. # <b>NPI</b>		28. TOTAL CHARGE <b>\$ 165 00</b> 29. AMOUNT PAID <b>\$</b> 30. BALANCE DUE <b>\$ 165 00</b>	
25. FEDERAL TAX I.D. NUMBER <b>SSN EIN</b>		26. PATIENT'S ACCOUNT NO. <b>1234</b>	
27. ACCEPT ASSIGNMENT? <b>X YES NO</b>		31. BILLING PROVIDER INFO & PH# <b>(225) 555-4957</b>	
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.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED <b>Ima Biller</b> DATE <b>10/15/15</b>		HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000	
a. <b>123967654</b>		b. <b>1239876</b>	

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## APPENDIX D: CLAIMS FILING

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**ADJUSTING/VOIDING CLAIMS**

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

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

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

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

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

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

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

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

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

**Adjustments/Voids Appearing on the Remittance Advice**

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

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

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

**Sample forms are on the following pages.**

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT 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

PICA

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		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	
JAYCO, TRAVIS		07 31 72 M X F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
CITY STATE		Self Spouse Child Other	
ZIP CODE TELEPHONE (Include Area Code)		7. INSURED'S ADDRESS (No., Street)	
( ) ( )		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
TPL Code if applicable		YES NO	
b. RESERVED FOR NUCC USE		b. AUTO-ACCIDENT? (Place (State))	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? (Place (State))	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME	
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.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED DATE		SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. 3510 B. C. D. E. F. G. H. I. J. K. L.		A 00 4094198765400	
24. A. DATE(S) OF SERVICE From To 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. ICD-9 CM I. ID. QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
03 31 14 03 31 14 12 S5125 UN A 75 00 25 NPI		4123123123	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO		28. TOTAL CHARGE 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.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED Jane Doe DATE 4/9/14		33. BILLING PROVIDER INFO & PH# (225) 555-4957	
a. 1239876543 b. 1239876		Here For You Waiver 200 Main St Any Town, LA 70000	

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## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

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

# HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		TRICARE (ID#DoD#) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (ID#) <input type="checkbox"/>		FECA BLK/LUNG (ID#) <input type="checkbox"/>		OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9876543210123</b>																																																																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>JAYCO, TRAVIS</b>								3. PATIENT'S BIRTH DATE MM   DD   YY <b>07   31   72</b>				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																																																			
5. PATIENT'S ADDRESS (No., Street)  CITY  STATE								6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)  CITY  STATE																																																																																																			
2f. ZIP CODE ( )				TELEPHONE (Include Area Code) ( )				2g. 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 <b>TPL Code if applicable</b>								a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				a. INSURED'S DATE OF BIRTH MM   DD   YY M   Y																																																																																																			
b. RESERVED FOR NUCC USE								b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				b. OTHER CLAIM ID (Designated by NUCC)																																																																																																			
c. RESERVED FOR NUCC USE								c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				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?																																																																																																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize or request any medical provider 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. INSURER'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																15. OTHER DATE MM   DD   YY																16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE QUAL: _____ 17a. _____ 17b. NPI _____																18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY																20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																																																																															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. <b>G5 10</b> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																22. RE submission CODE <b>A02</b> ORIGINAL REF. NO. <b>5299198798700</b>																																																																															
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY																B. PLACE OF SERVICE EMG <input type="checkbox"/> CPT/HCPCS <input type="checkbox"/> MODIFIER <input type="checkbox"/>																E. DIAGNOSIS POINTER \$ CHARGES _____																																																																															
10   08   15   10   08   15   12																S5125 UN																A 90   00 30 NPI																																																																															
2																																NPI																																																																															
3																																NPI																																																																															
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5																																NPI																																																																															
6																																NPI																																																																															
25. FEDERAL TAX I.D. NUMBER																SSN EIN																26. PATIENT'S ACCOUNT NO. <b>1234</b>																27. ACCEPT ASSIGNMENT? (For govt. claim, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																28. TOTAL CHARGE \$ <b>90   00</b>																29. AMOUNT PAID \$ <b>90   00</b>																30. BALANCE DUE \$ <b>90   00</b>															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <b>Ima Biller</b>																32. SERVICE FACILITY LOCATION INFORMATION																33. BILLING PROVIDER INFO & PH# <b>(225) 555-4957</b> <b>HERE FOR YOU WAIVER</b> <b>200 MAIN ST</b> <b>ANY TOWN, LA 70000</b>																a. <b>123967654</b>																b. <b>1239876</b>																																															

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## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

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## SAMPLE CLAIM FORM



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

PICA ☐ ☐

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK (LNG) <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)							
CITY					STATE					CITY					STATE				
ZIP CODE					TELEPHONE (Include Area Code) ( )					ZIP CODE					TELEPHONE (Include Area Code) ( )				
8. 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 <input type="checkbox"/> NO <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) ( )		b. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____ DATE _____										SIGNED _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17b. NPI _____		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
A. _____ B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____									
E. _____ F. _____ G. _____ H. _____																			
I. _____ J. _____ K. _____ L. _____																			
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 ON UNITS		H. PRIOR Party Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? For gov. claims, are based YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Paid 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.)										32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )							
SIGNED _____ DATE _____										a. NPI		b. _____		a. NPI		b. _____			

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## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

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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) 27**

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.	

## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

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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>            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</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>	
39-41	Value Codes and Amounts	<p><b>Required.</b> – Enter the appropriate Value Code (listed below).</p> <p>*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.</p>	Enter total number of units billed on the claim, not the number of days

## CHAPTER 7: COMMUNITY CHOICES WAIVER

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Locator #	Description	Instructions	Alerts
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	HCPSC/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>	Creation date must be later than the through date in Form Locator 6
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>	
48	Non-Covered Charges	<b>Leave Blank.</b>	
49	Unlabeled Field (National)	<b>Leave Blank.</b>	
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>	

**CHAPTER 7: COMMUNITY CHOICES WAIVER****APPENDIX D: CLAIMS FILING****PAGE(S) 27**

Locator #	Description	Instructions	Alerts
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)	The 10-digit NPI must be entered here.
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.	The 7-digit Medicaid ID number <b>MUST</b> be entered here.
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>	

## CHAPTER 7: COMMUNITY CHOICES WAIVER

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Locator #	Description	Instructions	Alerts
59-A,B,C	Patient's Relationship to 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.</p> <p>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>	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	<p><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.</p>	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	<p><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.</p>	
63-A,B,C	Treatment Auth. Code	<p><b>Required.</b> – Enter the 9-digit prior authorization number in 63A</p>	

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Locator #	Description	Instructions	Alerts
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.	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	<p><b>Required.</b> – Enter the ICD-9-CM code for the principal diagnosis.</p> <p><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 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.</p>	<p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>).</p>

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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.

## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

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

1 ADULT DAY CARE		2		3a PAT. CNTL. #		3b MED. REC. #		4 TYPE OF BILL	
9876 LOLLIPOP LANE				1111111		11111111111		893	
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT FROM		7 COVERS PERIOD THROUGH	
						090115		091015	
8 PATIENT NAME		a DOE, JOHN		9 PATIENT ADDRESS		a 1235 ANYSTREET			
b ANYWHERE				c LA		d 71111		e	
10 BIRTH DATE		11 SEX		12 DATE		ADMISSION 13 HR		14 TYPE	
010143		M		120513				15 SPC	
16 DHR		17 STAT		18		19		20	
30									
21		22		23		24		25	
26		27		28		29 ACCT STATE		30	
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE		35 OCCURRENCE DATE	
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## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

PAGE(S) 27

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

1 ADULT DAY CARE		2		3a PAT. CMT. # 111111		4 TYPE OF BILL 893	
9876 LOLLIPOP LANE				5 MED. REC. # 111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 101315 THROUGH 103015	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA		d 71111	
10 BIRTHDATE 010143		11 SEX M		12 DATE 120513		13 HR 14 TYPE 15 SFC 16 DHR 17 STAT 30	
18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE		30		31 OCCURRENCE DATE		32 CODE	
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## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

PAGE(S) 27

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

1 ADULT DAY CARE		2		3a PAT. CONT. # 1111111		4 TYPE OF BILL 897	
9876 LOLLIPOP LANE				5 MED. REC. # 111111111111			
ANYWHERE, LA 71111				6 FED. TAX NO.		7 STATEMENT COVERS PERIOD FROM 090115 THROUGH 090115	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA		d 71111	
10 BIRTHDATE 010143		11 SEX M		12 DATE OF ADMISSION 120513		13 TYPE 14 SFC 15	
16 DHR 30		17 STAT 18		19 20 21		22 CONDITION CODES 23 24 25 26 27 28	
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## CHAPTER 7: COMMUNITY CHOICES WAIVER

## APPENDIX D: CLAIMS FILING

PAGE(S) 27

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

1 ADULT DAY CARE 9876 LOLLIPOP LANE ANYWHERE, LA 71111		2		3a PAT. CNTL. # 11111111		4 TYPE OF BILL 897	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 102815 THROUGH 102815	
b ANYWHERE		c LA		d 71111		e	
10 BIRTHDATE 010143		11 SEX M		12 DATE 120513		13 ADMISSION 13 HR 14 TYPE 15 SPC	
16 DHR 30		17 STAT 30		18 19 20 21		22 23 24 25 26 27 28	
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