
CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS RELATED INFORMATION

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CLAIMS RELATED INFORMATION

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

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

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

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

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

This appendix includes the following:

- Instructions for completing a CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

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CMS 1500 (02/12) Instructions for Waiver Services

In order to access the CMS 1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link:

https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm.

NOTE: You must write “WAIVER” at the top center of the claim form.

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; and
- 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.

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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 Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary 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.

Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website below for general information concerning topics relative to general claims filing. In order to access the General Information and Administration Provider Manual Chapter, click here:

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>.

Sample forms are on the following pages.

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT

CARRIER
PATIENT AND INSURER INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM

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

<div style="float:right;">PICA <input type="checkbox"/></div>													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (TRICARE ID#) (Member ID#) (ID#) (ID#)</small>													
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		1a. INSURED'S I.D. NUMBER 9876543210123 <small>(For Program in Item 1)</small>							
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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
7. ZIP CODE TELEPHONE (Include Area Code) ()				8. RESERVED FOR NUCC USE		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:		11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if Applicable				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		a. INSURED'S DATE OF BIRTH MM DD YY M _ F _							
c. RESERVED FOR NUCC USE				d. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)							
d. INSURANCE PLAN NAME OR PROGRAM NAME				e. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME							
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 entity who accepts assignment below. SIGNED _____ DATE _____ SIGNED _____													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (M/P) 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		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LATE? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A Z7689 E _____ C _____ D _____ F _____ G _____ H _____ I _____ J _____ K _____ L _____				ICD Ind. _____		22. SUBMISSION CODE A 02 ORIGINAL REF. NO. 8347198798700							
24. A. DATE(S) OF SERVICE To From B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, or SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. Days of Units H. Report Ref. I. ID Qual J. RENDERING PROVIDER ID.#						23. PRIOR AUTHORIZATION NUMBER Pror Auth #							
11 06 18 11 06 18 12 S5125 UN A 84.00 28 NPI													
2 3 4 5 6													
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO. 1234		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 84.00		29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof). Billar 12/17/18 DATE				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000 a. 1234509876 b. 1123456							

NUCC Instruction Manual available at: www.nucc.org

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SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										PICA <input type="checkbox"/>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY										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										CITY										STATE									
ZIP CODE										TELEPHONE (Include Area Code)										ZIP CODE									
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME									
c. RESERVED FOR NUCC USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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.										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										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										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. SUBMISSION 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										E. DIAGNOSIS POINTER										F. \$ CHARGES									
G. DAYS OR UNITS										H. ICD-9-CM										I. ID. QUAL.									
J. RENDERING PROVIDER ID. #																													
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Reserved 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. NPI									

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