
CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

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CLAIMS FILING

Hard copy billing of DME 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 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:

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:

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

CMS 1500 (02/12) INSTRUCTIONS FOR DME SERVICES

Please click the following link to access “CMS 1500 (02/12) Instructions for DME Services”:
https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500_DME.pdf.

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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:

1. 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
2. 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 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

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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

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

HEALTH INSURANCE CLAIM FORM

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

DME

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

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA/ELIGIBLE <input type="checkbox"/> OTHER												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
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CHARGES 30												295. JL. CHARGES 90.00												296. JM. CHARGES 30												297. JN. CHARGES 90.00												298. JO. CHARGES 30												299. JP. CHARGES 90.00												300. JQ. CHARGES 30												301. JR. CHARGES 90.00												302. JS. CHARGES 30												303. JT. CHARGES 90.00												304. JU. CHARGES 30												305. JV. CHARGES 90.00												306. JW. CHARGES 30												307. JX. CHARGES 90.00												308. JY. CHARGES 30												309. JZ. CHARGES 90.00												310. KA. CHARGES 30												311. KB. CHARGES 90.00												312. KC. CHARGES 30												313. KD. CHARGES 90.00												314. KE. CHARGES 30												315. KF. CHARGES 90.00												316. KG. CHARGES 30												317. KH. CHARGES 90.00												318. KI. CHARGES 30												319. KJ. CHARGES 90.00												320. KK. CHARGES 30												321. KL. CHARGES 90.00												322. KM. CHARGES 30												323. KN. CHARGES 90.00												324. KO. 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CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

PAGE(S) 6

Sample of a Claim Form



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA												<input type="checkbox"/> PICA																																																											
1. MEDICARE (Medicare#) <input 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)																																																											
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												CITY STATE																																															
ZIP CODE TELEPHONE (Include Area Code) ()												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: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>												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. OTHER CLAIM ID (Designated by NUCC)																																															
b. RESERVED FOR NUCC USE												c. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																																															
c. RESERVED FOR NUCC USE												10d. CLAIM CODES (Designated by NUCC)												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.												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												SIGNED																																															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.												15. OTHER DATE MM DD YY QUAL.												18. 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												19. 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.												23. PRIOR AUTHORIZATION NUMBER																																															
A. B. C. D. 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 CH UNITS H. EPST/Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																																											
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25. FEDERAL TAX I.D. NUMBER SBN EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For gov. claims, see back) 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.												a. NPI b.																																															

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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