### CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

### PAGE(S) 14

# 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:

#### DXC Technology 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 <u>www.lamedicaid.com</u>, directory link "HIPAA Information Center", sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.

This appendix includes the following:

- Instructions for completing the 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.

07/01/19 04/19/17

ISSUED: REPLACED:

### CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

PAGE(S) 14

### CMS 1500 (02/12) INSTRUCTIONS FOR DME SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "DME" at the top center of the Louisiana Medicaid claim form in LARGE letters.
		Required – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS.	
1a	Insured's ID Number	<b>NOTE:</b> The recipients' 13-digit Medicaid ID number <u>must</u> 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	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).	
	Sex	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	<b>Optional</b> – Printthe 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 NUCCUse	Leave Blank.	

07/01/19 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

Locator #	Description	Instructions	Alerts
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other 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(s) or EOBs from other insurance(s) are attached to the claim.	Only the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6- DIGIT CODE FOR TRADITIONAL MEDICARE CLAIMS.
9b	Reserved for NUCCUse	Leave Blank.	
9c	Reserved for NUCCUse	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.	

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

Locator #	Description	Instructions	Alerts
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	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	<ul> <li>Required- Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported.</li> <li>DK Ordering Provider</li> <li>Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who ordered the service(s) or supply (ies) on the claim.</li> </ul>	For LA Medicaid other source is defined as the ordering provider. The ordering provider is required.
17a	Other ID	<b>Required</b> – Enter the 7-digit Medicaid ID number of the ordering provider.	
17b	NPI#	Required - Enter the NPI number of the ordering provider.	The 10-digit NPI Number is <u>required</u> .
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	

ISSUED: REPLACED:

### 07/01/19 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

Locator #	Description	Instructions	Alerts
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. 0 ICD-10-CM Required – Enter the most current ICD diagnosis code. NOTE: ICD-10-CM "V", "W", "X", & "Y" 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. 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).

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### 07/01/19 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

Locator #	Description	Instructions	Alerts
22	Resubmission and/or Original Reference Number	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	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	<b>Required</b> – Enter the correct 9-Digit PA number in this field.	

ISSUED: REPLACED:

### 07/01/19 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

Locator #	Description	Instructions	Alerts
24	Supplemental Information	Situational - DME Providers are required to enter 11-digit NDC codes on claim detail lines for enteral feeding products only. In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 and <u>shall be entered</u> in the <u>shaded</u> section of 24A through 24g. Claims for enteral feeding products must include the NDC from the label of the product administered. A list of the procedure codes and NDCs for products that currently require NDC information can be found on <u>www.lamedicaid.com</u> under the Fee Schedules directory link.	DME providers must enter NDC information in the SHADED section of 24A through 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s). The NDC indicated on the claim must match the NDC on the Prior Authorization.
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	<b>Required</b> Enter the appropriate place of service code for the services rendered.	
24C	EMG	Situational – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the unshaded area(s). When a modifier(s) is required, enter the applicable modifier in the appropriate field.	Where modifiers are required, the modifier(s) on the claim must match the modifier(s) on the Prior Authorization.

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

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	\$Charges (Dollar Amount Charges)	<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	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	ID Qualifier	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID	Leave Blank.	
25	Federal Tax ID 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?	<b>Optional</b> . Claimfiling acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

# PAGE(S) 14

Locator #	Description	Instructions	Alerts
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. Do not report Medicare payments in this field.	
30	Reserved for NUCCUse	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	<b>Optional.</b> The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	<b>Required</b> Enter the date of form completion.	
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	
32a	NPI#	Optional.	
32b	Other ID Number	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info and Phone #	<b>Required</b> Enter the provider name, address including zip code and telephone number.	
33a	NPI#	<b>Required</b> – Enter the billing provider's 10- digit NPI number.	The 10-digit NPI Number <u>must</u> appear on paper claims.
33b	Other ID Number	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier – Optional – If possible, do not enter a qualifier for Louisiana Medicaid claims.	The 7-digit Medicaid provider number must appear on paper claims.

# **REMINDER:** MAKE SURE "DME" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

#### Sample forms are on the following pages

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT

**APPENDIX B – CLAIMS FILING** 

**PAGE(S) 14** 

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

CONTRACT CONTRAC		1E	Mail To: Molina P.O. Box 9 Baton Rou	ge, LA 70821
and the second	HAMPVA - REALTH PLAN - EEK		RED'S I.D. NUMBER	PICA For Program in Item 1)
(Medicare#) X (Medicaid#) (DuPDcD#) ( 2. PATIENT'S NAME (Last Name, First Name, Midde Initial)	Wember 10 #) (10 #) (10 #)	(10#) 1234	4567890123 ED S NAME (Last Name, F	First Name, Middle Initial)
LOU, JANNIE	S. PATIENT'S BETH DATE	FX		
I PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONS HIP TO I Self Spouse Child	NSURED 7. INSUR	ED'S ADDRESS (No., She	90)
лгү	STATE 8. RESERVED FOR NUCC USE	СПҮ		BTATE
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OTHER INSURED'S NAME (Last Name, First Name, Middle Initi	a) 10. IS PATIENT'S CONDITION RE	LATED TO 11 INSU	RED'S FOLICY GROUP O	( ) R FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Pri			ory.
TPL CODE IF APPLICABLE				SEX M F
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RESERVED FOR NUCCUSE			ANCE PLAN NAME OF P	ROGRAM NAME
		NO	and a state of the	
INSURANCE FLAN NAME OF PROGRAM NAME	10d. CLAIM CODES (Designated )	by NUCC) d. 15 THE		ENEFIT PLAN?
READ BACK OF FORM BEFORE COM	EXAMPLE (	JF ICD 1		res, complete items 9, 9a, and 9d PERSON'S SIGNATURE Lauthorize
		ation necessary paym assignment service	ent of medical benefits to th	ne undersigned physician or supplier for
PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE Tauth to process this claim. Takes request payment of government bene talow.	H A REFERR	ING PRC	<b>VIDER</b>	
SIGNED	DATE		NED	
A DATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LM MM   DO   YY QUAL	P) 15. OTHER DATE MM DD	YY FROM	MM   DO	TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1234567			LATED TO CURRENT SERVICES
ION JOHN DOE, MD	17h NPI 1234567890	FROM	a	то
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G809 Z931	c D	1 000		
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A DATE(S) OF SERVICE B C. D.	K L L L PROCEDURES, SERVICES, OR SUPPLIES	3 E.		H. I.
M DD YY MM DD YY SERVICE EMG	(Explain Unusual Circumstances) PT/HCPCS MODIFIER	DIAGNOGIS PONTER \$CH	F. G. DAVS EP OA VS EP OA PE UNITS P	H. J. J. May ID. RENDERING May OUAL PROVIDER ID. #
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#### 07/01/19 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

# PAGE(S) 14

#### ADJUSTING/VOIDING CLAIMS

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

<u>Only a paid claim can be adjusted or voided</u>. 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

ISSUED: REPLACED:

07/01/19 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

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

ISSUED: 07/01/19 REPLACED: 04/19/17

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT APPENDIX B – CLAIMS FILING

PAGE(S) 14

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

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PATIENT'S NAME (Last Name, First Name, Midde Initial)	S. PATIENT'S BIRTH DATE BEX	4. INSURED S NAME (Last Name, First Name, Middle Initial)	
PATIBUT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
лтү <mark>s</mark> тл	Self Spouse Child Other TE 8. RESERVED FOR NUCC USE	CITY STATE	
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CTHER INSURED'S NAME (Last Name, First Name, Midble Initial)	10. IS PATIENT'S CONDITION RELATED TO	( ) 11. INSURED'S POLICY GROUP OR FECA NUMBER	
	TU ISPAILENT'S CONDITION RELATED TO	11 INSUREPS FOLICY GROUP OR FECA NUMBER	
OTHER INSURED S POLICY OR GROUP NUMBER TPL CODE IF APPLICABLE RESERVED FOR NUCC USE		a. INSURED S DATE OF BIRTH SEX	
RESERVED FOR NUCCUSE			
	YES NO		
INSURANCE FLAN NAME OF PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BBNEFIT PLAN?	
PATIENT'S OF AUTHORIZED PERSON'S SIGNATURE LAUthorize b process this datin. I also request payment of generative to be one being SIGNED	A REFERRING	PROVIDER	
I DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	QUAL   MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURPENT COCUPATION PROM TO TO	
2. NAME OF RÉFERRING PROVIDER OF OTHER SOURCE	17a         1234567           17b         NPI         1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
ADDITIONAL CLAIM INFORMATION (Designated by NJCC)		20 OUTSIDELABY \$CHARGES	
	service line below (24E) ICD ind. 0	22. RESUBMISSION CODE CODE CRIGINAL REF. NO	
	ср gн	A 02 6259012345600 23. PRIOR AUTHORIZATION NUMBER	
		612345678	
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SIGNATURE OF PHYSICIAN OF SUPPLIER     SIGNATURE OF OFFICE     SIGNATURE     SIGN	E FACILITY LOCATION INFORMATION	33 BLLING FRONDER INFO& FH# (800) 233-3333 XYZ DURABLE MEDICAL SERVCES 700 MAIN ST ANY TOWN, LA 70000	
9/12/16	NPI	1326547895     1987654	
BIGNED DATE " UCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0936-1197 FORM 1500 (	02-1

# CHAPTER 18: DURABLE MEDICAL EQUIPMENT

# **APPENDIX B – CLAIMS FILING**

# PAGE(S) 14

#### Sample of a Claim Form

PROVED BY NATIONAL UNIFORM CL	AIM COMMITTEE (N	000,0212								
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				Spouse Child	Other	August 10		4	<u> </u>	
TY		STATE 6	8. RESERVE	D FOR NUCC USE		CITY				STATE
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PATIENT'S OR AUTHORIZED PERSO to process this cluby. I also request pay	ON'S SIGNATURE	uthorize the rel	longe of any m	and the second se	nation necessary					hyaician or supplier fo
to process this claim. I also request pay	ment of government be	mente ether to	myself or to th	he party who accepts	assignment	services describe	ad below.		and the second	
below.	ment of government by	enalite either to			assignment	services describe	ad below.			
SIGNED			DAT	=		services describe	ad below.			
SIGNED DATE OF CURRENT ILLNESS, INJUI MM DD QUAL	RY, or PREGNANCY	(LMP) 15. OT QUAL	DAT		Asselgnment YY	SIGNED SIGNED 18. DATES PATIEN MM FROM	T UNABLE 1	O WORK		
SIGNED DATE OF CURRENT ILLNESS, INJUI MM DD QUAL	RY, or PREGNANCY	(LMP) 15. 01	DAT	=		SIGNED 8IGNED 18. DATES PATIEN	T UNABLE 1	O WORK		
Below. SIGNED DATE OF CURRENT ILLNESS, INJUI DD QUAL NAME OF REFERRING PROVIDER C	RY, or PREGNANCY (	(LMP) 15. OT QUAL 17a. 17b.	DAT	=		SIGNED SIGNED 16. DATES PATIEN MM FROM 18. HOSPITALIZATI MM	Ad below.	O WORK	TO CUR	
Below. SIGNED DATE OF CURRENT ILLNESS, INJUI MM DD QUAL NAME OF REFERRING PROVIDER C ADDITIONAL CLAIM INFORMATION	RY, or PREGNANCY ( DR OTHER SOURCE (Designated by NUCC	(LMP) 15. OT QUAL 178. 175.	DAT THER DATE	E DD		SIGNED SIGNED 18. DATES PATIEN MM FROM 18. HOSPITALIZATI MM PROM 20. OUTBIDE LAB? YES		Y WORK	IN CURR M TO TO CUR M TO \$ CHAR	RENT OCCUPATION M DD YY RENT SERVICES M DD YY GES
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