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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:

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

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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.

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

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CMS 1500 (02/12) INSTRUCTIONS FOR DME SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "DME" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	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	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
8	RESERVED FOR NUCC USE	Optional.	
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) 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.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9с	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth, Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	

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Locator #	Description	Instructions	Alerts
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	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	Leave Blank.	
17a	Unlabeled	Leave Blank.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		

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Locator #	Description	Instructions	Alerts
20	Outside Lab?	Optional.	
	ICD Indicator	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.9ICD-9-CM 00ICD-10-CM	The most energina dia mania
	Diagnosis or Nature of Illness or Injury	Required – Enter the most current ICD diagnosis code.	The most specific diagnosis codes must be used. General codes are not acceptable.
21		NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.
			Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization (PA) Number	Required – Enter the correct 9-Digit PA number in this field.	

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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 shaded 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	Required 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

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Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.	
		More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges (Dollar Amount Charges)	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank.	
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

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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 NUCC USE	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional. The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier – Optional – If possible, 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

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SAMPLE DME CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES OF SERVICE BEFORE 10/01/15)

) 第一日 設計 EALTH INSURANCE CLAIM FORM	DME
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	PICA
. MEDICARE MEDICAID TRICARE CHAMPVA	HEALTH PLAN BLK LUNG
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member ID	(<i>ID#</i>) (<i>ID#</i>) (<i>ID#</i>) (<i>ID#</i>) 1234567890123
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Adalam, Mary	06 11 00 M FX
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) Self Spouse Child Other
ITY STATE	8. RESERVED FOR NUCC USE CITY STATE
P CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Indude Area Code)
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
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX
PL Code if applicable	YES NO M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	C. OTHER ACCIDENT? TO LEE C. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	
READ BACK OF FORM BEFORE COMPLETING	
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either to below.	release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for
SIGNED	DATE SIGNED
MM DD YY QUAL. QUA	THER DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY TO TO YY TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 71b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES NPI FROM TO TO
. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES YES NO
	vice line below (24E) ICD Ind. 9 22. RESUBMISSION CODE ORIGINAL REF. NO.
. <u>1</u> 3439 в. <u>1</u> V441 с. <u>Г</u>	D.
E F G	H. 23. PRIOR AUTHORIZATION NUMBER
Ј.[К.[_	412345678
From To PLACE OF (Expl M DD YY MM DD YY SERVICE EMG CPT/HCP	DURES, SERVICES, OR SUPPLES E. F. G. H. L. J. tain Unusual Groundtancea) DIAGNOSIS DIAGNOSIS DATE SCHARGES UNITS PROVIDER ID. # MODIFIER POINTER \$ CHARGES UNITS Prev QUAL. PROVIDER ID. #
074051807 3 02 14 03 02 14 12 B4160	D A B 450 00 200 NPI
3 02 14 03 02 14 12 A4322	2 A B 50 00 30 NPI
· · · · · · · · ·	
	NPI
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt. caims, me badk) X YES NO \$ 500 00 \$ \$
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGRESS OR CREDENTIALS (confly that the statements on the reverse apply to this bill and are made a part thereof.)	CILITY LOCATION INFORMATION 33. BLLING PROVIDER NPO & PH# (225) 555-4957 XYZ Durable Medical Services 700 Main St Any Town, LA 70000
GNED Ima Biller DATE 3/9/14 a.	b. a. 1326547895 b. 1987654

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

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

	DME		
			PICA
1. MEDICARE MEDICAID TRICARE CHAMPV	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(For Program in Itam 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member II 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	D#) (ID#) (ID#) (ID#) [3.PATIENTS BIRTH DATE SEX MM, DD, YY	1234567890123 4. INSURED'S NAME (Last Name, First N	lame Middle Initiali
ADALAM, MARY	06 11 00 M FX		,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
CITY STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	СПУ	ISTATE
ZIP CODE TELEPHONE (Indude Area Code)			HONE (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 FE) CA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
TPL Code if applicable b. RESERVED FOR NUCCUSE	YES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIMID (Designated by NUC	M F
	SAMPLE		
c. RESERVED FOR NUCC USE		G. INSURANCE PLAN NAME OR PROGR	RAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 104. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENER	FIT PLAN2
EVA		0	mplete items 9, 9a and 9d.
READ BACK OF FORM BE ONE 40 TO EN O 12. PATIENTS OR AUTHORIZED PERSONS SIGMATURE 1 authorize the to process this claim. I also request payment of government benefits either 1	A SN HC THIS ORN release of any medical or other information necessary o myself or to the party who accepts assignment	 INSUPPOSOR A THIRDED PERS payment of medical benefits to the un services described below. 	ON'S SIGNATURE I authorize dersigned physician or supplier for
below. SIGNED	DATE	SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.0	THER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORI MM DD YY FROM	
17. NAME OF RÉFERRING PROVIDER OR OTHER SOURCE 178. 71b.	NPI	18. HOSPITALIZATION DATES RELATED	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	NP		TO CHARGES
		YES NO	
	rvice line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGI	NAL REF. NO.
A. [G809 B. [Z931 C. [D.[23. PRIOR AUTHORIZATION NUMBER	
L	N	512345678	
24. A. DATE(S) OF SERVICE B. C. D.P.ROCE From To PLACEOF (Exp MM DD YY MM DD YY SERVICE EMG CPT/HCF	DURES, SERVICES, OR SUPPLIES E. Iain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	F. G. H. DAYS BROT \$ CHARGES UNTS Firms	I. J. ID. RENDERING SUAL. PROVIDER ID. #
70074051807	CS MODIFIER POINTER	S CHARGES UNITS Plen	20AL PROVIDER ID. #
10 08 15 10 08 15 12 B416	0 AB	500 00 200	NPI
10 08 15 10 08 15 12 A432	2 AB	90 00 30	NPI
			NPI
			NPI
			NPI
			NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. datmo, see back)	28. TOTAL CHARGE 29. AMOU	
1234	X YES NO	s 590 00 s	\$ 590 00
31. SIGNATURE OF PHYSICAN OR SUPPLIER 32. SERVICE F/ INCLUDING DEGREES OR CREDENTIALS (I) ontify that the statements on the reverse apply to this bill and are made a part thereof.) 31. SIGNATURE OF PHYSICAN OR SUPPLIER	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# XYZ Durable Medical Servi 700 Main St Any Town, LA 70000	(800)233-3333 ices
SIGNED Ima Biller DATE 10/10/15 a.	Þ.	a. 1326547895 b.	1987654
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE		197 FORM CMS-1500 (02-12

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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.

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Adjustments/Voids Appearing on the Remittance Advice

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

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

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

An Adjustment/Void will generate credit and debit entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Sample forms are on the following pages

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

		URA	NCE	CLA	IM F	ORM			DN	ΛE							
1. MEC	PICA	MEDIC	AID	TRI	COMMI CARE	TTEE (N	CHAMPVA (Member ID	#) (IC	ROUP EALTH PLAN #)	(ID#	CA (LUNG	OTHER (ID#)	1a. INSURED'S I.D. NUMBE 1234567890123	R	(Fe	or Program	PICA nin Item 1)
	ENT'S NAMI		lame, Fin	st Name	e, Middle	Initial)				TDATE YY	SEX		4. INSURED'S NAME (Last !	Name, First Nam	e, Middle	e Initial)	
	am, Mary		o., Street	0				06 6. PATIEI	11 NT RELATIO	00 M		F X	7. INSURED'S ADDRESS (N	lo., Street)			
								Self	Spouse	Child	Oti	her	CITY				STATE
СПҮ							STATE	8. RESER	VED FOR N	NUCC USE			СПҮ				STATE
ZIP CO	DE		TE		NE (Inclu	ide Area	Code)						ZIP CODE			ude Area (Code)
9. OTH	ER INSUREI) S NAM	E (Last N) irst Name	e, Middle	Initial)	10, IS P/	TIENT'S CO	ONDITION	RELATE	D TO:	11. INSURED'S POLICY GR	OUP OR FECA) NUMBEI	R	
	ER INSURED			GROUP	NUMBE	R		a. EMPL(DYMENT? (Previous)		a. INSURED'S DATE OF E MM DD Y	SIRTH Y	м	SEX	F
	ERVED FOR							b. AUTO	ACCIDENT	-		CE (State)	b. OTHER CLAIM ID (Design	nated by NUCC)			
	ERVED FOR		0.5						SA	M	PL	E	C. INSURANCE PLAN NAME	000000000000000000000000000000000000000	ANIANT		
C. RESE	ERVED FOR	NUCCI	JSE					c. OTHE		s, .	NO		C. INSURANCE PEAN NAME	C OR PROGRAM	I NAME		
d. INSU	RANCE PLA	N NAME	ORPR	OGRAN	NAME			10d. RES	ERVED FO	R LOCAL I	USE		d IS THERE ANOTHER HE	ALTH BENEFIT	PLAN?		
							EXA	IV	IPI		U	- 1	13. INSURED'S OR AUTHOR	If yes, compl	ete items	9, 9a and	9d.
12. PATI to pr below	ocess this cla	UTHORI im. I also	IZED PE	RSON'S paymen	S SIGNAT	TURE I	OMPLETING authorize the r enefits either to	elease of myself or	any medical to the party	km. I or other in who accept	nformation ts assignn	necessary tent	payment of medical bene services described below	fits to the under	signed ph	nysician or	supplier for
SIG									DATE				SIGNED				
14. DAT MM	E OF CURR DD	ENT ILLI YY	QUAL		or PREG	NANCY	(LMP) 15.01 QUA	HER DA			1 **		16. DATES PATIENT UNABI	LE TO WORK IN YY T			IPATION YY
17. NAM	NE OF REFE	RRING F			OTHER S	SOURCE	17a.						18. HOSPITALIZATION DAT	ES RELATED T	O CURR	ENT SERV	VICES
10 400	DITIONAL CL		ODMATI	ON /Do	cianated	by NUC	71b.	NPI					FROM	T 5 Cl	O HARGES		
					-	-							YES NO				
	3NOSIS OR 439	NATURE		NESS C		RY Re	slate A-L to sen	vice line b	elow (24E)	ICD Ind.			22. RESUBMISSION CODE A 99	0RIGINAL			
A. [3]	439		B F.	-	41		C. [G.]			D. H.	·		23. PRIOR AUTHORIZATIO		10070	5000	
L.		_	J.			_	к. 🗆			L.			412345678				
24. A. MM	DA TE(S) From DD YY	OF SEF	To DD	**	B. PLACE OF SERVICE	C. EMG		ain Unusu	ERVICES, (al Circumsta MOD		D	E. AGNOSIS POINTER	F. G DA \$ CHARGES UNI	S HI, I. YS EPSDT ID. R Family QUA		REND	J. DERING DER ID. #
	4051807	03	02	14			B4160					AB	450 00 20				
- T									1	1 1	1						
														NP	1		
		1	1		1	1				1 1	1			NP	1		
														NP	4		
1									1					NP	1		
25. FED	ERAL TAX I	D. NUM	BER	SS	SN EIN	26	PATIENT'S A	CCOUNT	NO. 2	27. ACCEP (For govt.	TASSIGI claims, see	MENT? back)	28. TOTAL CHARGE	29. AMOUNT	PAID		ANCE DUE
INCI (I ce	NATURE OF LUDING DEC ntify that the y to this bill a	SREES C	OR CREE	DENTIA	LS	32	SERVICE FAI	טוודץ נס		X YES	N	Ю	 \$ 450 00 33. BILLING PROVIDER IN XYZ Durable Medi 700 Main St Any Town, LA 700 	cal Service		\$ 555-49	957
SIGNED	Ima Bi	ler		DATE	3/9/1	4 a.			b.				 1326547895 	b.	198	7654	
	Instructio					w.nuc	c.org		PLEASE	PRINT	OR TY	PE	APPROVED OM				-1500 (02-

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

PAGE(S) 17

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

EALTH INSURANCE		UCC) 02/12	DM	E		
PICA						PICA
MEDICARE MEDICAID (Medicare #) X (Medicaid #)	TRICARE (IDII/DoDIII)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (/D#)	FECA OTHER BLK LUNG (ID#) (ID#)	1a. INSURED'S LD. NUMBER 1234567890123	(For Program in Item 1)
PATIENT'S NAME (Last Name, First	t Name, Middle Initial)	3. PA		SEX	4. INSURED'S NAME (Last Nam	ne, First Name, Middle Initial)
ADALAM, MARY			06 11 00	M F X	7. INSURED'S ADDRESS (No.,	(tim at)
PATIENT S ADDRESS (ND., Street))	Se Se		hild Other	n instress resness (no.)	Sugar
ITY		STATE 8. RE	SERVED FOR NUCC	USE	СПҮ	STATE
IP CODE TEL	EPHONE (Indude Area	Code)			ZIP CODE	TELEPHONE (Include Area Code)
()					()
OTHER INSURED'S NAME (Last Na	ame, First Name, Middle	Initial) 10. I	IS PATIENT'S CONDIT	ION RELATED TO:	11. INSURED'S POLICY GROU	P OR FECA NUMBER
OTHER INSURED'S POLICY OR G	ROUP NUMBER	a. EN	PLOYMENT? (Curren	t or Previous)	a INSURED'S DATE OF BIR	TH SEX
PL Code if applicable			YES	NO		M F
RESERVED FOR NUCCUSE		b. AL	JTO ACCIDENT?	PLACE (State)	b. OTHER CLAIMID (Designate	id by NUCC)
RESERVED FOR NUCC USE				PLE	G. INSURANCE PLAN NAME OF	R PROGRAM NAME
			YES	NO		
NSURANCE PLAN NAME OR PRO	OGRAM NAME	10d.	RESERVED FOR LOC	ALUSE	d. IS THERE ANOTHER HEALT	
READ BACK			NI G THI FO ML	Θ	13. IN THE D'S OF AU. HE HIZ	If yes, complete items 9, 9a and 9d. ED PERSON'S SIGNATURE I authorize
PATIENT'S OR AUTHORIZED PER to process this claim. I also request p		authorize the releas en efits either to myse	e of any medical or oth alforto the party who a	er intermation necessar coepts assignment	y payment of medical benefits services described below.	to the undersigned physician or supplier for
signed			DATE		SIGNED	
MM COECURRENT ILLNESS, IN	JURY, or PREGNANCY	(LMP) 15.OTHER QUAL	DATE MM	DD YY	16. DATES PATIENT UNABLE T MM DD YY FROM	TO WORK IN CURRENT OCCUPATION
	R OR OTHER SOURCE	17a.			18. HOSPITALIZATION DATES	RELATED TO CURRENT SERVICES
		71b. NPI			FROM	то
1007010 0 101050000070						A 01110000
ADDITIONAL CLAIM INFORMATIC	ON (Designated by NUC)	D)			20. OUTSIDE LAB? YES NO	\$ CHARGES
DIAGNOSIS OR NATURE OF ILLN	ESS OR INJURY Re	C) late A-L to service II	ne below (24E) ICD	Ind. 0	YES NO 22. RESUBMISSION	ORIGINAL REF. NO.
DIAGNOSIS OR NATURE OF ILLN	ESS OR INJURY Re	(ate A-L to service II	ne below (24E) ICD	D. [YES NO 22. RESUBMISSION CODE A 02	ORIGINAL REF. NO. 5287131589100
DIAGNOSIS OR NATURE OF ILLN	ESS OR INJURY Re	late A-L to service li	ine below (24E) ICD		YES NO 22. RESUBMISSION	ORIGINAL REF. NO. 5287131589100
DAGNOSIS OR NATURE OF ILLN . G809 B. 	ESS OR INJURY Re	G. L	ne below (24E) ICD ICD ICD ICD ICD ICD ICD ICD ICD ICD	р н	YES NO 22. RESUBMISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678	ORIGINAL REF. NO. 5287131589100
L F. A. DATE(S) OF SERVICE From M. DOT YY MM DOT Y405 1807	ESS OR INJURY Re Z931 B. C. PLAGEOF	G. L. C. C. L. C. C. L. C.	25, SERVICES, OR SU	D. L.	YES NO 22. RESUBMISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678	ORIGINAL REF. NO. 5287131589100 UMBER H. L. J. RENDERING
L F. A. DATE(S) OF SERVICE From M. DOT YY MM DOT Y405 1807	ESS OR INJURY Re 2931 B. C. PLACEOF YY SERVICE EMG	C. L G. L B. PROCEDURE (Explain Ur CPT/HCPCS	25, SERVICES, OR SU	D	YES NO 22. RESUBILISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678 F. DATE \$ CHARGES UNITS	ORIGINAL REF. NO 5287131589100 UMBER Ht. L. RENDERANG PROVIDER ID. #
L F. A. DATE(S) OF SERVICE From M. DOT YY MM DOT Y405 1807	ESS OR INJURY Re 2931 B. C. PLACEOF YY SERVICE EMG	C. L G. L B. PROCEDURE (Explain Ur CPT/HCPCS	25, SERVICES, OR SU	D	YES NO 22. RESUBILISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678 F. DATE \$ CHARGES UNITS	ORIGINAL REF. NO 5287131589100 UMBER #H. L. & J. RENDERING WWW DAL. PROMERID.#
L J A. DATE(S) OF SERVICE From M DDD YV MM DD O74051807 C	ESS OR INJURY Re 2931 B. C. PLACEOF YY SERVICE EMG	C. L G. L B. PROCEDURE (Explain Ur CPT/HCPCS	25, SERVICES, OR SU	D	YES NO 22. RESUBILISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678 F. DATE \$ CHARGES UNITS	ORIGINAL REF. NO. 5287131589100 ILMBER H. I. RENDERING PROVIDER ID. #
DAGNOSIS OR NATURE OF ILLN I 1 G8 09 B. . F. . J. . F. . DATE(S) OF SERVICE M DD	ESS OR INJURY Re 2931 B. C. PLACEOF YY SERVICE EMG	C. L G. L B. PROCEDURE (Explain Ur CPT/HCPCS	25, SERVICES, OR SU	D	YES NO 22. RESUBILISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678 F. DATE \$ CHARGES UNITS	ORIGINAL REF NO 5287131589100 UMBER H, L & C. RENDERING PROVIDER ID.#
DAGNOSIS OR NATURE OF ILLN I 1 G8 09 B. . F. . J. . F. . DATE(S) OF SERVICE M DD	ESS OR INJURY Re 2931 B. C. PLACEOF YY SERVICE EMG	C. L G. L B. PROCEDURE (Explain Ur CPT/HCPCS	25, SERVICES, OR SU	D	YES NO 22. RESUBILISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678 F. DATE \$ CHARGES UNITS	ORIGINAL REF. NO. 22827131589100 ILMBER
DAGNOSIS OR NATURE OF ILLN IG8 09 BL I Fr J A DATE(S) OF SERVICE J From Y MM DO YV MM DO740051807	ESS OR INJURY Re 2931 B. C. PLACEOF YY SERVICE EMG	C. L G. L B. PROCEDURE (Explain Ur CPT/HCPCS	25, SERVICES, OR SU	D	YES NO 22. RESUBILISSION CODE A 02 23. PRIOR AUTHORIZATION N 512345678 F. DATE \$ CHARGES UNITS	ORIGINAL REF. NO. 2887131589100 UMBER HWW ID. RENDERING PROVIDER ID. # NPI NPI NPI
DACHOSIS OR NATURE OF ILLN 	ESS OR INJURY Re 2931 B C. YY SERVICE ENG 15 12	Add A-L to service II C G G D. PROCECURE (Expland V) CP/A/CPAC U B4 160	IS, SERVICES, OR SU MCOPIER MCOPIER		YES NO 22 RESUMMENDENT AO2 23. PRIOR AUTHORIZATION N 512345678 3 CHARGES UM19 5000 000 200	ORIGINAL REF. NO. 22827131589100 ILMBER
DACHOSIS OR NATURE OF ILLN 	ESS OR INJURY Re 2931 	ALL DESERVICE IN C C C C C C D. PROCEQUER D. PROCECURE CEDIAN UR CPT/HCPCS B4160 PATIENTS ACCOM	S. SERVICES, OR SU MODIFIER		YES NO 22 RESUMINSON COCE A 02 23. PRIOR AUTHORIZATION N 512345678 5 CHARGES 500 00 200 200 200 200 200 200 200	ORIGINAL REF. NO. S287131589100 ILMBER INPI ILMBER INPI ILMPI INPI INDUER <t< td=""></t<>
E F. J. 4. DATE(S) OF SERVICE M DD Y MM DD 0074051807 0 08 15 10 08 .	ESS OR INJURY Re 2931 	ALL IS SERVICE II C C C C C C C C C C C C C C C C C C	IS, SERVICES, OR SU MCOPIER MCOPIER	D L PPPUES E DAGNOS	YES NO 22 RESERVISION 23. PRIOR AUTHORIZATION N 512345678 5 CHARGES 500 00 200 	ORIGINAL REF NC. S287131589100 UMBER #Wr in. RENDERING PROVIDER D. # NPI NPI NPI NPI NPI NPI NPI NPI
DACNOSIS OR NATURE OF LLN , G8 0.9 ,,,,,,,,	ESS OR INJURY Re 2931 	ALL IS SERVICE II C C C C C C C C C C C C C C C C C C	IS, SERVICES, OR SU MODIFIER	D L PPPUES E DAGNOS	YES NO 22 RESERVISION A 02 23. PRIOR AUTHORIZATION N 512345678 5 CHARGES 500 00 200 	ORIGINAL REF NO. S287131589100 UNBER MARY ID. RENDERING PROVDER ID. # NPI NPI NPI NPI NPI NPI NPI NPI
DACHOSIS OR NATURE OF ELK G8 09 8 J J A DOTE(S) OF SERVICE M DD Y MM DD 074051807 0 08 15 10 08 1 	ESS OR INJURY Re 2931 	ALL IS SERVICE II C C C C C C C C C C C C C C C C C C	IS, SERVICES, OR SU MODIFIER	D L PPPUES E DAGNOS	YES NO 22 RESUBILISSION 23 PRIOR AUTHORIZATION N 512345678 Constraints 5 CHARGES 500 00 200 28 TOTAL CHARGE 2 28 TOTAL CHARGE 2 3 BLUNG PROVIDER INFO 3	ORIGINAL REF NC. S287131589100 UMBER MPI L. RENDERING PROVIDER ID. # NPI

APPENDIX B – CLAIMS FILING

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09/23/15 02/04/15

Sample of a Claim Form

APPROVED BY NATIONAL	UNIFORM CLAIM		02/12								
PICA										PICA	
			AMPVA G	ROUP EALTH PLAN	FECA BLK LUN (ID#)	G (IDN)	1a. INSURED'S I.D. NI	MBER		(For Program in litem 1)	
2. PATIENT'S NAME (Last	100 1 2 Color				and the second second	SEX	4. INSURED'S NAME	(Last Name, F	First Name,	Middle Initial)	
					м	F					
5. PATIENT'S ADDRESS (I	ic., Street)		6. PATIE	NT RELATION			7. INSURED'S ADDRE	88 (No., Stre	Het)	-	
CITY		S		Spouse RVED FOR NU	Child CC USE	Other	CITY		_	STATE	
									X		
ZIP CODE	TELEPHON	E (Include Area Code)					ZIP CODE	T	ELEPHON	E (Include Area Code)	
9. OTHER INSURED'S NA	AE (Last Name, Firs	st Name, Micicle Initial)	10. IS PA	TIENT'S COND	ITION RELA	TED TO:	11. INSURED'S POLIC	Y GROUP O	R FECA NU	IMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				OYMENT? (Cur	nent or Previo						
5. RESERVED FOR NUCC USE				ACCIDENT	b. OTHER CLAIM ID (i Designated by					
	-			YES	NO	LACE (State)			-	Anato and	
G. RESERVED FOR NUCC USE				G. OTHER ACCIDENT?				© INSURANCE PLAN NAME OF PROGRAM NAME			
d. INSURANCE PLAN NAM	E OR PROGRAM N	AME	10d. CLA	IM CODES (De		IUCC)	d. IS THERE ANOTHE	R HEALTH B	ENEFIT PL	ANT	
				<u> </u>	YES NO # yes, complete items 9, 9a, and 9d.						
12. PATIENT'S OR AUTHO to process this claim. I al	EAD BACK OF FO	SIGNATURE I author	ETING & SIGNIN ze the release of a	in this Form	her informatio	n necessary	13. INSURED'S OR AL payment of medical	I benefits to the	PERSON'S te undersign	SIGNATURE I authorize ned physician or supplier for	
below.	er i ardrese bækungur	S. Source in the ideal	and the set ingreet in	and the party with	- monthing and	3	CONTRACTOR CRECTORD				
SIGNED				DATE			\$IGNED				
14. DATE OF CURRENT IL	15. OTHER DA	MM	DD	YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO TO						
17. NAME OF REFERRING	178.	1			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
19. ADDITIONAL CLAIM IN	FORMATION (Deel	anated by MI ICC)	17b. NPI	b			FROM 20. OUTSIDE LAB?		TO	HARGES	
	Construction (Const	Surray of Hardey					YES	NO			
21. DIAGNOSIS OR NATU	RE OF ILLNESS OF	INJURY Relate A-L	o service line bei	ow (24E) IC	D Ind.		22. FIESUBMISSION	0	RIGINAL RI	EF. NO.	
A	B. [с		D		23. PRIOR AUTHORIZ	ATION NUM	BER		
E	F.		G		H	_					
h L		PLACEOF	ROCEDURES, S (Explain Unusual	Circumstances)	E. DIAGNOSIS	E.	G. I DAYS EP OR Fa	H. I. SOT ID. My QUAL	J. RENDERING	
I. L 24. A. DATE(S) OF SE From	To I		T/HCPCS	MODIF	ER	POINTER	\$ CHARGES	UNITS P	UNAL	PROVIDER ID. #	
I. L 24. A. DATE(S) OF SE From	To I	SERVICE EIMIG CP							1000		
I. L 24. A. DATE(S) OF SE From	To I	SERVICE EMICI CP	1						NPI		
I. L	To I	SERVICE EMG CP									
I. L 24. A. DATE(S) OF SE From	To I	SERVICE EXAG							NPI		
I. L 24. A. DATE(S) OF SE From	To I										
I. L 24. A. DATE(S) OF SE From	To I								NPI		
I. L 24. A. DATE(S) OF SE From	To I								NPI		
I. L 24. A. DATE(S) OF SE From	To I								NPI		
I. L 24. A. DATE(S) OF SE From	To I								NPI NPI NPI NPI		
I. DATE(S) OF SI MM DD YY MI				NO. [27.]			28. TOTAL CHARGE		NPI NPI NPI	D 30. Ravel for NUCC U	
I. LATTE(S) OF SE From MM DD YY MM		EIN 28. PATTE					\$	\$		D 30. Ravel for NUCC U	
I. L 24. A. DATE(S) OF SE From	ABER S9N	EIN 20. PATTE			YES		A PERSONAL MARCH	\$		D 30. Ravel for NUCC U	
A. A. DATE(S) OF SI From MM DD YY MI DU YY DU YY MI DU YY	ABER S9N	EIN 20. PATTE			YES		\$	\$		D 30. Ravel for NUCC U	

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