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**CHAPTER 17: END STAGE RENAL DISEASE**

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**APPENDIX B: CLAIMS FILING****PAGE(S) 18**

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### **CLAIMS FILING**

Claims for End Stage Renal Disease (ESRD) services must be filed by electronic claims submission 837I or on the UB 04 claim form.

There are limits placed on the number of line items that are allowed when filing claims. ESRD claims must include National Drug Code (NDC) information for all physician administered drugs identified with an alphanumeric Healthcare Common Procedure Coding System (HCPCS) code and billed with a revenue code. Two-page claims are acceptable for ESRD services.

#### **Epoetin Alfa (EPO)**

Payment made to providers billing the Epogen treatments individually is based on the total units of EPO as indicated in value code 40A. The total payment for EPO is indicated on the first treatment claim line for the first service date, and the remainder of the EPO treatment dates will appear on the remittance advice (RA) with zero (0 dollar) payments and edit code 978 (payment adjusted to zero, call help desk).

Special documentation is not required with the claim for Medicaid only recipients requiring 10,000 units or more of EPO per administration; however, documentation should be maintained with the recipient's records.

When claims for Epogen services are billed with HR634 or HR635, payment is indicated on the first line and all other lines are paid at zero. This does not allow providers to submit adjustments if the claims are paid incorrectly. Therefore, providers must submit a void and allow the successfully voided claim to process and appear on the remittance advice before re-submitting the corrected claim for processing. In order to void more than one claim line, a separate UB04 form is required for each claim line as each claim line as a different Internal Control Number.

Epogen must be reported using procedure code Q4081. No other HCPCS code will be accepted for Epogen.

The units of service field for EPO must be reported based on the HCPCS code dosage description as is done with all other physician administered drugs. For example: The HCPCS code description for Q4081 is Injection, EPO, 100 units (for ESRD on dialysis). If the provider administers 12,400 units of EPO on that date of service, 124 should be entered as the service units in FL 46.

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## Instructions for Completing the UB04 Form

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	<b>Required.</b> Enter the name and address of the facility.	
2	Pay to Name/Address/ Identification (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 Number	<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 Number	<b>Optional.</b> Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	<b>Required.</b> Enter the appropriate 3-digit code as follows: <u>. First digit - type facility</u> <u>7 = Clinic or hospital based renal dialysis facility</u> <u>b. Second digit-classification</u> <u>2 = Hospital based or independent renal dialysis facility</u> <u>c. Third digit-frequency</u> <u>1 = Admission through discharge</u> <u>2 = Interim-first claim</u> <u>3 = Interim-continuing</u> <u>4 = Interim-last claim</u> <u>7 = Replacement of prior claim</u> <u>8 = Void of prior claim</u>	
5	Federal Tax Number	<b>Optional.</b>	
6	Statement Covers Period (from and through dates) dates of the period covered by this bill.	<b>Required.</b> Enter the beginning and ending service dates.	
7	Unlabeled	<b>Leave blank.</b>	
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.	

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Locator #	Description	Instructions	Alerts
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 recipient's date of birth using six 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 recipient 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	<b>Leave blank.</b>	
14	Type Admission	<b>Leave blank.</b>	
15	Source of Admission	<b>Leave blank.</b>	
16	Discharge Hour	<b>Leave blank.</b>	
17	Patient Status	<b>Leave blank.</b>	
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>	

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Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p><b>Required.</b> Enter the following value codes when billing for Epogen (EPO):</p> <p>49 = Hematocrit Reading – Enter the patient's hematocrit reading to justify administering more than 10,000 units of EPO. Enter 49 in the "Code" field. Enter the hematocrit reading in the "Amount" field, right justified to the left of the dollar/cents delimiter. Enter "00" in the "Cents" portion of the "Amount" section of the field.</p> <p>68 = EPO Drug – Enter the total number of units of EPO administered and/or supplied relating to the billing period. Enter 68 in the "Code" field. Enter the total number of EPO units administered in the "Amount" field. Report amount in whole units right-justified to the left of the dollar/cents delimiter. Enter "00" in the "Cents" portion of the "Amount" section of the field.</p> <p>No other value codes are required for processing Hemodialysis claims; if optional codes are entered, they must be entered after 49 and 68, above.</p>	<p><b>When billing for EPO, providers must enter value codes 49 and 68 first in the value code fields; other value codes are optional, and if they are entered, they must be entered below 49 and 68.</b></p>
42	Revenue Code	<p><b>Required.</b> Enter the applicable revenue code(s) which identifies the service provided.</p> <p>Codes must be valid. Revenue Code 001 must be entered in Form Locator 42 line 23 with corresponding total charges entered in Form Locator 47 line 23.</p>	

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Locator #	Description	Instructions	Alerts
43	Revenue Description	<p><b>Required for services other than physician-administered drugs.</b> Enter the narrative description of the corresponding revenue code in Form Locator 42.</p> <p><b>Required for physician-administered drugs.</b> Hemodialysis claims reporting EPO or other physician-administered drugs must contain the following:</p> <p>Report the N4 qualifier in the first two positions, left-justified.</p> <p>Immediately following the N4 qualifier, report the 11 character National Drug Code (NDC) number in the 5-4-2 format (no hyphens).</p> <p>Immediately following the last digit of the NDC (no delimiter), report the unit of measurement qualifier. The Unit of Measurement Qualifier codes are as follows:</p> <p style="padding-left: 40px;">F2 -International Unit GR-Gram ML-Milliliter UN- Unit</p> <p>Immediately following the Unit of Measurement Qualifier, report the unit quantity in <b>NDC UNITS</b> with a floating decimal for fractional units limited to three digits (to the right of the decimal).</p> <p>Any spaces unused for the quantity are to be left blank.</p> <p><b>Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible.</b></p> <p>The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.</p> <p><b>N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 . 5 6 7</b></p>	<p><b>It is necessary for hemodialysis claims to include NDC information for all physician-administered drugs identified with an alphanumeric HCPCS code and billed with Revenue Codes 634, 635, and 636.</b></p>

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Locator #	Description	Instructions	Alerts
44	HCPCS/Rates HIPPS Code  HCPCS/CPT Code (Outpatient DX Lab)	<b>Required.</b> Enter the appropriate five digit procedure code.  <b>For physician-administered drug services:</b> Claims reporting physician administered drugs identified with alphanumeric HCPCS codes must contain the following:  Enter the corresponding HCPCS Code for the NDC reported in FL 43.	<b>EPO must be reported using procedure code Q4081. No other HCPC codes will be accepted for EPO.</b>
45	Service Date	<b>Required.</b> Enter the appropriate service date (MMDDYY) for each service.  <b>Required.</b> Enter the date the claim is submitted for payment in the block just to the right of the <b>CREATION DATE</b> label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	<b>The CREATION DATE replaces the Date of Provider Representative Signature.</b>
46	Units of Service	<b>Required.</b> Enter the appropriate unit(s) for the procedure code entered on the same line in FL 44.	<b>Hemodialysis providers should no longer enter "1" in the units of service field (FL 46) for EPO.</b>  <b>The units of service for EPO (Q4081) must now be reported based on the HCPC code dosage description as is done with all other physician-administered drugs.</b>  <b>For example: The HCPC code description for Q4081 is: Injection, Epoetin Alfa, 100 units (for ESRD on dialysis). If a provider administers 12,400 units of EPO on that date of service, then 124 should be entered as the service units in FL 46.</b>

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Locator #	Description	Instructions	Alerts
47	Total Charges	<b>Required.</b> Enter the charges pertaining to the related revenue codes.	
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 required.</p> <p>If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid.</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>	
51-A,B,C	Health Plan Identification (ID)	<b>Situational.</b> Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their health plan ID numbers is required	
52-A,B,C	Release of Information	<b>Optional.</b>	
53-A,B,C	Assignment of Benefits	<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 Amount Due	<b>Optional.</b>	
56	National Provider Identifier (NPI)	<b>Required.</b> Enter the provider's NPI.	<b>The 10-digit NPI must be entered here.</b>
57	Other Provider Identification (ID)	<b>Required.</b> Enter the seven digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	

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Locator #	Description	Instructions	Alerts
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>	
59-A,B,C	Patient's Relationship to Insured	<p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter the recipient'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>	



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Locator #	Description	Instructions	Alerts
60-A,B,C	Insured's Unique Identification (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>	<p><b>ONLY the 6-digit code should be entered for commercial and Medicare HMOs in this field.</b></p> <p><b>DO NOT enter dashes, hyphens or the word TPL in the field.</b></p> <p><b>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE.</b></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 Authorization Code	<b>Leave blank.</b>	
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><b>To adjust or void more than one claim line on an outpatient claim, a separate UB-04 form is required for each claim line since each line has a different internal control number.</b></p>

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Locator #	Description	Instructions	Alerts
64-A,B,C (cont'd)	Document Control Number (cont'd)	<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>	<p><b>When claims for EPO services are billed with HR634 or HR635, payment is indicated on the first line and all other lines are paid at zero.</b></p> <p><b>This does not allow providers to submit adjustments if the claims are paid incorrectly.</b></p> <p><b>Therefore, providers must submit a VOID and allow the successfully voided claim to process and appear on the remittance advice before re-submitting the corrected claim for processing.</b></p>
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	Diagnosis and Procedure Code Qualifier  DX Version Qualifier	<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>	
67  67 A-Q	Principal Diagnoses Codes  Other Diagnosis Code	<p><b>Required.</b> Enter the most current ICD diagnosis code.</p> <p><b>Situational.</b> Enter all other applicable ICD diagnoses code or codes for this claim.</p> <p><b>NOTE:</b> ICD-9-CM diagnosis codes beginning with</p>	<p><b>The most specific diagnosis codes must be used. General codes are not acceptable.</b></p> <p><b>ICD-9 diagnosis codes must be used</b></p>

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Locator #	Description	Instructions	Alerts
67	Principal Diagnoses Codes	"E" or "M" are not acceptable for any diagnosis code.	on claims for dates of service prior to 10/1/15.
67 A-Q (cont'd)	Other Diagnosis Code (cont'd)	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.	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- <a href="http://www.lamedicaid.com">www.lamedicaid.com</a>
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	Prospective Payment System (PPS) Code	Leave blank.	
72- A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a-e	Other Procedure Code/ Date		
75	Unlabeled.	Leave blank.	

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Locator #	Description	Instructions	Alerts
76	Attending	<b>Required.</b> Enter the name <u>and</u> NPI number of the attending physician.	<p><b>This field must be completed.</b></p> <p>The attending provider name and NPI cannot be the billing provider.</p> <p>The individual attending provider information must be entered in this field.</p> <p>The attending provider must be enrolled with Louisiana Medicaid.</p>
77	Operating.	<b>Leave blank.</b>	
78	Other	<p><b>Situational.</b> If applicable, enter the name and NPI Number of the referring provider or other physician.</p> <p><b>Note:</b> If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.</p>	<p><b>A referring provider is NOT required on the claim. However, if a referring provider is entered on the claim, the name and NPI number must be entered here with the Qualifier DN indicating referring provider.</b></p> <p>The referring provider cannot be the billing provider. The individual referring provider information should be entered in this field.</p> <p>If entered, the referring provider must be enrolled with Louisiana Medicaid.</p>

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Locator #	Description	Instructions	Alerts
79	Other	<b>Situational.</b> If applicable, enter the name and NPI number of any other physician.	
80	Remarks	<b>Situational.</b> Enter explanations for special handling of claims.	
81 a-d	Code-Code – QUAL / CODE / VALUE	<b>Leave blank.</b>	

**Signature is not required on the UB-04**

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**SAMPLE END STAGE RENAL DISEASE CLAIM FORM  
WITH AN ATTENDING PROVIDER ONLY  
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

DIALYSIS OF LOUISIANA 987 CORN ST. ANYWHERE, LA 71111										2										3a PAT. CNTL. # b. MED. REC. # c. FED. TAX NO. 111111111111 111111111111										4 TYPE OF BILL 723																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
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## CHAPTER 17: END STAGE RENAL DISEASE

## APPENDIX B: CLAIMS FILING

PAGE(S) 18

**SAMPLE END STAGE RENAL DISEASE CLAIM FORM  
WITH AN ATTENDING PROVIDER ONLY  
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 DIALYSIS OF LOUISIANA 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CIVIL # 11111111111111111111		4 TYPE OF BILL 723	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 100915 TO 101415	
10 BIRTH DATE 010143		11 SEX M		12 DATE 120513		13 ADMISSION 13 HPI 14 TYPE 15 SPC 16 DHR	
17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE	
38		39 VALUE CODES a 49 30 300		40 VALUE CODES b 68 37200 300		41 VALUE CODES c	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIRPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	635	N412345678901 UN 1234.56	Q4081	100915	124	124; 00	
2	635	N412345678901 UN 1234.56	Q0481	101215	124	124; 00	
3	635	N412345678901 UN 1234.56	Q0481	101415	124	124; 00	
4	636	N454321432121 UN 4.56	J1760	101415	1	50; 00	
5	821	HEMODIALYSIS COMPOIST	90935	100915	1	130; 00	
6	821	HEMODIALYSIS COMPOIST	90935	101215	1	130; 00	
7	821	HEMODIALYSIS COMPOIST	90935	101415	1	130; 00	
<p><b>SAMPLE</b></p> <p>EXAMPLE OF ICD 10 WITH AN ATTENDING PROVIDER ONLY</p>							
PAGE 1 OF 1		CREATION DATE		103015		TOTALS 812; 00	
50 PAYER NAME MEDICAID		51 HEALTH PLAN ID		52 PRIOR PAYMENTS		53 EST. AMOUNT DUE	
54 TPL : PAYMENT IF APPLICABLE		55 NP1 1234567890		56 NP1 1234567		57 OTHER PRV ID	
58 INSURED'S NAME DOE, JOHN		59 PRIOR 1234567890123		60 GROUP NAME TPL CARRIER CODE IF APPLICABLE		61 INSURANCE GROUP NO.	
62 TREATMENT AUTHORIZATION CODES		63 DOCUMENT CONTROL NUMBER		64 EMPLOYER NAME			
65		66		67		68	
69 ADMIT DATE		70 PATIENT REASON DX		71 ICD-10 CODE		72 ECI	
73		74		75		76	
77		78		79		80	
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LB-04 CMS-1460

APPROVED OMB NO. 0980-0997

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THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

## CHAPTER 17: END STAGE RENAL DISEASE

## APPENDIX B: CLAIMS FILING

PAGE(S) 18

SAMPLE END STAGE RENAL DISEASE CLAIM FORM  
WITH A REFERRING PROVIDER  
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)

1 DIALYSIS OF LOUISIANA 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CNTL # b. MED. REC. # c. FED. TAX NO.		d. STATEMENT COVERS PERIOD FROM 100915 THROUGH 101415		4 TYPE OF BILL 723	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET		b. ANYWHERE		c. LA		d. 71111	
10 BIRTHDATE 010143		11 SEX M		12 DATE 120513		13 HR		14 TYPE	
15 SPC		16 DHR		17 STAT		18		19	
20		21		22		23		24	
25		26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
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835		836 OCCURRENCE DATE		837 CODE		838 OCCURRENCE DATE		839 CODE	
840		841 OCCURRENCE DATE		842 CODE		843 OCCURRENCE DATE		844 CODE	
845		846 OCCURRENCE DATE		847 CODE		848 OCCURRENCE DATE		849 CODE	
850		851							



## CHAPTER 17: END STAGE RENAL DISEASE

## APPENDIX B: CLAIMS FILING

PAGE(S) 18

**SAMPLE END STAGE RENAL DISEASE CLAIM ADJUSTMENT  
WITH AN ATTENDING PROVIDER ONLY  
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

1 DIALYSIS OF LOUISIANA 987 CORN ST. ANYWHERE, LA 71111		2		3a PAY. CMTL # 3b MED. REC. # 5 FED. TAX NO.		4 TYPE OF BILL 727	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS b ANYWHERE		c LA d 71111		e	
10 BIRTH DATE 010143		11 SEX M		12 DATE 120513		13 HR. 14 TYPE 15 SPC 16 DHR	
17 STAT		18		19		20	
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25		26		27		28	
29 ACCT STATE		30		31		32	
33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE	
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## CHAPTER 17: END STAGE RENAL DISEASE

## APPENDIX B: CLAIMS FILING

PAGE(S) 18

**SAMPLE END STAGE RENAL DISEASE CLAIM ADJUSTMENT  
WITH AN ATTENDING PROVIDER ONLY  
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 DIALYSIS OF LOUISIANA 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. ONTLE # 11111111111111111111 3b MED. REC. # 11111111111111111111 5 FED. TAX NO. 101415		4 TYPE OF BILL 727	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA d 71111		e	
10 BIRTH DATE 010143		11 SEX M		12 DATE 120513		13 HR 14 TYPE 15 SFC 16 DHR 17 STAT	
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