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## **CLAIMS FILING**

Hard copy billing of vision (eyewear) services is 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 may 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.)

This appendix includes the following:

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

## CHAPTER 46: VISION (EYEWEAR) SERVICES APPENDIX C: CLAIMS FILING

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

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID 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	<b>Situational</b> – 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.	
8	RESERVED FOR NUCC USE	Leave Blank.	
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 <b>required</b> 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 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,

Locator #	Description	Instructions	Alerts
			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.	
	Insured's Date of Birth	<b>Cituational</b> Complete if appropriate or leave blank	
11a	Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID	Leave Blank.	
	(Designated by NUCC) Insurance Plan Name or		
11c	ProgramName	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	Situational – Complete if appropriate or leave blank.	
	(Release of Records)		
13	Insured's or Authorized Person's Signature	Situational – Obtain signature if appropriate or leave blank.	
	(Payment)		
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	

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## CHAPTER 46: VISION (EYEWEAR) SERVICES APPENDIX C: CLAIMS FILING

Locator #	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	<ul> <li>Situational - Complete if applicable.</li> <li>In the following circumstance, entering the name of the appropriate physician is required: <ul> <li>If Services are performed at the request of an ordering provider:</li> </ul> </li> <li>Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported. <ul> <li>DK Ordering Provider</li> </ul> </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. Referring provider is not required.
17a	Other Identification Number (ID#)	Situational – Complete if applicable. If 17 is completed, 17A is required.	Enter the 7-digit Medicaid ID Number here.
17b	NPI	Situational – Complete if applicable. If 17 is completed, 17B is required.	The 10-digitNPI Number is required when 17 or 17A is complete.
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
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.

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## CHAPTER 46: VISION (EYEWEAR) SERVICES APPENDIX C: CLAIMS FILING

Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	Situational. Iffiling 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	To adjust or void more than one claim line on a claim, a separate form is required for each claim line
		it appears on the remittance advice in the "Original Ref. No." portion of this field.	since each line has a different internal control
		Appropriate reason codes follow:	number.
		Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other	
		Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	
23	Prior Authorization Number	Situational – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is required to be entered.	
24	Supplemental Information	Leave Blank.	
		Required Enter the date of service for each procedure.	
24A	Date(s) of Service	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	Leave Blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). When a modifier(s) is required, enter the appropriate modifier in the correctfield.	

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	Amount Charged	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	Leave Blank.	
241	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is Required if the shaded portion is complete.	Both the 7-digit Medicaid provider number and the 10-digit NPI numbers are required when entering a rendering provider. Rendering =Attending
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	<b>Situational</b> – 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> . Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
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 or Medicare Replacement plan payments in this field.
30	RESERVED FOR NUCC USE	Leave Blank.	

## CHAPTER 46: VISION (EYEWEAR) SERVICES APPENDIX C: CLAIMS FILING

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31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional. The practitioner or the practitioner's authorized representative's original signature is no longer required. Required Enter the date of the signature.	
	Service Facility Location		
32	Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Other ID#	Situational – Complete as 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	Required – Enter the billing provider's 10-digit NPI number.	The 10-digitNPI Number must appear on paper claims.
33b	Other ID#	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier – Optional – If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

#### Sample forms are on the following pages

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#### CHAPTER 46: VISION (EYEWEAR) SERVICES APPENDIX C: CLAIMS FILING

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

EALTH INSURANCE CLAIM FORM		Mail To: Molina P.O. Box Baton R	
	HEALTH PLAN BLK LUNG	THER 1a. INBURED'S LD. NUMBER	PICA [] (For Program in 19m 1)
(Medicare#) X (Medicaid#) (10#/0cD#) (16# PATIENT'S NAME (Last Name, First Name, Midde Initial)	SET SET SET SET SEX	1234567890123 4. INSURED'S NAME (Last Name)	First Name, Middle Initial)
LOU, JANNIE	06 11 07 M F		
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Set Spouse Child Other	7. INSURED'S ADDRESS (No., SM	eet)
τy. s	TATE 8. RESERVED FOR NUCC USE	спу.	STATE
PCODE TELEPHONE (Indude Area Code)	0	ZIP CODE	TELEPHONE (Include Area Code)
UTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP C	DR FECA NUMBER
		a. INSURED'S DATE OF BIRTH MM DD YY	M F
RESERVED FOR NUCC USE	n AUTO ACCIDENT?	b. OTHER CLAIMID (Designated )	
EXA	MPLE OF IC	D 10	
RESERVED FOR NUCCUSE		G INSURANCE PLAN NAME OF F	PROGRAM NAME
		I POCHERO WOTHER HEALTH	PENERS PLAN?
WITH AN	UKDEKING	<b>LKAAID</b>	ves, on deteillems 9, 9a, and 9d.
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SIGNED DATE OF CURRENT ILLNE SB, INJURY, OF PREGNANCY (LMP) MM + DO + YY	DATE 15. OTHER DATE	IG DATES PATIENT UNABLE TO	
MM I DO I YV	MM I DD I YY		
GUAL	QUAL	FROM DD YY	TO DD YY
QUAL	17a 1236548	FROM DD YY FROM 18. HOSPITALIZATION DATES RE	TO
QUAL NAME OF REFERRING PROVIDER OF OTHER SOURCE K JON DOE, MD	QUAL	FROM 18. HOSPITALIZATION DATES RE MM DD YY FROM	
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## CHAPTER 46: VISION (EYEWEAR) SERVICES APPENDIX C: CLAIMS FILING

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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 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.

06/20/18 09/29/15

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

ICON ICON ICON EALTH INSURANCE CLAIM FORM PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/8:	Mail To: Molina P.O. Box 91020 Baton Rouge, LA 70821
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( )	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
OTHER INSURED'S POLICY OF GROUP NUMBER	
	M F
RESERVED FOR NUCCUSE	C. DINER ACCIDENT?
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to process this daim. Laks request payment of government benefits althe talow.	
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ALTH INSURANCE CLAIM FORM				
ROVED BY NATIONAL UNFORM CLAIM COMMITTEE (NUCC) 02/	2			
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(Medicare#) (Medicaid#) (/D#/DeD#) (Merrbi	HEALTH PLAN BLKLUNG			
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	Self Spouse Child Other		1	
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( )			(	)
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THER INSURED'S POLICY OR GROUP NUMBER	4. EMPLOYMENT? (Current or Previous)	NSURED'S DATE OF BRTH		SEX
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