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**CHAPTER 46: VISION (EYEWEAR) SERVICES** 

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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:

DXC Technology 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 <a href="https://www.lamedicaid.com">www.lamedicaid.com</a>, 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; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

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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	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the beneficiary's 13 digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS, or REVS.  NOTE: The beneficiarys' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the beneficiary'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 beneficiary.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the beneficiary'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 beneficiary 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 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,

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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.	
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.	
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	Insured'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.	

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Locator #	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.  In the following circumstance, entering the name of the appropriate physician is required:  • If Services are performed at the request of an ordering provider:  Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported.  • DK Ordering Provider  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.	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-digit NPI 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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Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	<b>Situational</b> . 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.	To adjust or void more than one claim line on a claim, a separate form is required
		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.	for each claim line 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 Beneficiary 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.	
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	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 correct field.	

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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	<b>Required</b> 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.	
<b>24</b> J	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.	Situational – Enter the provider specific identifier assigned to the beneficiary. 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.	
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.	

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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	Required Enter the date of the signature.	
32	Service Facility Location 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-digit NPI Number must appear on paper claims.
33b	Other ID#	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit Medicaid Provider Number <u>must</u>
335	Caron IDII	ID Qualifier – Optional – If possible, leave blank for Louisiana Medicaid billing.	appear on paper claims.

Sample forms are on the following page

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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 PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12				
MEDICARE MEDICAID TRICARE CHAMPVA	BEOUP PLAN BECANG OTHER	1a. INBURED'S I.D. NUMBER		(For Program in Item 1)
(Medicare#) X (Medicaid#) (ID#DcD#) (Member ID#)	(104) (104) (104)	1234567890123		NAME OF THE PARTY
PATIENT'S NAME (Last Name, First Name, Midde Initial). 8.  LOU, JANNIE	MM   DD   YY - /	4. INSURED'S NAME (Last Na	ame, First Name,	Middle Initial)
	00 11 01	7. INSURED'S ADDRESS (No	i., Street)	
	Sert Spouse Child Other			
TY: STATE 8.	RESERVED FOR NUCC USE	СПҮ		STATE
P CODE TELEPHONE (Include Avea Code)		ZIP CODE	TELEPHON	JE (Indude Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle hills) 10	IS PATIENT'S CONDITION RELATED TO:	11, INSURED'S POLICY GRO	UP OR FECA N	UMBER
OTHER INSURED'S POLICY OR GROUP NUMBER  TPL CODE IF APPLICABLE	SAMPLE	a. INSURED'S DATE OF BIRT	(H	SEX F
RESERVED FOR NUCCUSE  EXAM.	IPLES OF ICE	b. OTHER CLAIM ID (Designs	ated by NUCC)	NAME
NSURANCE FLAN INME OF PROSESS IN MAIE AND OF PROSESS IN MAIE AND OF PATIENTS OF AUTHORIZED PRESIDUES SIGNATURE I submore the reset to process this daim I discrepant payment of government sensities tiller to me.	ase of any medical or other information necessary	REVIOLE IS. INSURED'S OR AUTHOR payment of medical bening services described below.	i ves, or de ZED PERSON'S	LAN? ate illems 9, 9a, and 9d. SISIGNATURE I authorize pried physicilari or supplier for
talow:				
DATE OF CURRENT ILLNESS, INJURY, O' PRESHANCY (LMP) 15. OT MM   DO   YY	DATE	SIGNED	TO WORK INC	DUDDON'T COOL DATION
QUAL	MM DD YY			
NAME OF REFERRING PROMOER OF OTHER SOURCE  K JON DOE, MD  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	1236548 1236549875	FROM 18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO	TC SHELATED TO YY TC	CURRENT SERVICES
NAME OF REFERRING PROMOER OF OTHER SOURCE  K JON DOE, MD  17b N  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Pelate &L to service ILLNESS OR INJURY.	1236548 PI 1236549875	FROM 18. HOSPITALIZATION DATE MM DD FROM 20. OUTSIDE LAB?	TC SHELATED TO YY TC	CURRENT SERVICES MM DD YY  CHARGES
NAME OF REFERRING PROMOER OF OTHER SOURCE  K JON DOE, MD  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	1236548 FI 1236549875	FROM 18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO	S RELATED TO YY  TO SCO	CURRENT SERVICES MM DD YY  CHARGES
NAME OF REFERRING PROMOTER OF OTHER SOURCE  K JON DOE, MD  ADDITIONAL CLAIMINFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OF INJURY Pelate & L to service    H5034  B C C  F C G  K	1236548 FI 1236549875	FROM  18. HOSPITALIZATION DATE FROM  20. OUTSIDE LAR?  YES NO  22. RESUBMISSION  23. PRIOR AUTHORIZATION  PA # IF APPLI	SRELATED TO YY  \$C  CRIGINAL F  NUMBER  CABLE	CURRENT SERVICES MM DD YY  CHARGES
NAME OF REFERRING PROMOER OF OTHER SOURCE  K JON DOE, MD  ADDITIONAL CLAIMINFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Pelate & Litoservoei  H5034  E	1236548 PI 1236549875 ine below (24E)   ICD Incl.   0	FROM  18. HOSPITALIZATION DATE FROM  20. OUTSIDE LAE?  19. YES NO  22. RESUBMISSION  23. PRIOR AUTHORIZATION	SHELATED TO	CURRENT SERVICES  IMM DD YY  MARGES  REF. NO.  RENDERING PROVIDER ID. #
NAME OF REFERRING PROMIDER OR OTHER SOURCE	1236548 FI 1236549875  Ine below (24E) ICD Incl. 0   D   H   L   L   L   L   L   L   L   L   L	FROM 18. HCSPITALIZATION DATE FROM 20. OUTSIDE LAB? 21. YES NO 22. RESUBMISSION 23. PRIOR AUTHORIZATION PA # IF APPLI F. G.	SHELATED TO	CURRENT SERVICES  IMM DD YY  SHARGES  REF. NO.  RENDERING PROVIDER ID. #  1236548  1236549875
NAME OF REFERRING PROMOBER OR OTHER SOURCE    JON DOE, MD	1236548 PI 1236549875  Ine below (R4E) ICD Incl. 0   D   H   L   E   E   D   L   E   D   L   E   D   L   E   D   L   E   D   L   E   D   L   D   D   D   D   D   D   D   D	IS HOSPITALIZATION DATE IS HOSPITALIZATION DATE FROM 20 OUTSIDE LAB? 20 OUTSIDE LAB? 22 PEIGE MISSION 22 PRICE AUTHORIZATION PA # IF APPLI F. G. CHARGES UNITS	CRIGINAL F  NUMBER  CABLE  B FENT ID  FRINT GUAL	CURPIENT SERVICES  NEW DD YY  HARGES  REF. NO.  RENDERING FROWDER 10. #  1236549875  1236548  1236549875
NAME OF REFERRING PROMDER OF OTHER SOURCE   17a	1236548 PI 1236549875  Ine below (P4E) (CD Incl. 0   D   H   L   L   E   E   E   E   E   E   E   E	IS HOSPITALIZATION DATE FROM MM DO  ERROM MM DO  22. COURSIDELASP  22. RESUBMISSION 22. RESUBMISSION 23. PRIOR AUTHORIZATION PA # IF APPLI  F. COPE S CHARGES  150,00 1	ORIGINAL F  NUMBER  CABLE  B PRET ID  FRINGE ODA  NPI	CURPIENT SERVICES  LINY DD YY  HARGES  REF. NO.  RENDERING FROMDER ID. #  1236549875  1236548
NAME OF REFERRING PROMOBER OR OTHER SOURCE   17a	1236548 PI 1236549875  Ine below (24E) ICD Ind. 0   D   H   L   L   L   E   D   IAGNOSIS   POINTER  A A A	FROM   18 HOSPITALIZATION DATE   FROM   20 OUTSIDE LAR?   19 OUTSIDE LAR.   19 OUT	CABLE  H I PRINT ID. NPI	CUPRIENT SERVICES  MW DD YY  HARCES  REF. NO.  RENDERING  RENDERIN
NAME OF REFERRING PROMIDER OF OTHER SOURCE   17a	1236548 FI 1236549875  Ine below (24E)   CO Ind.   0   H	FROM  IS HOSPITALIZATION DATE FROM  20 OUTSIDE LAR?  YES NO  22 RESUBMISSION  23 PRIOR AUTHORIZATION  PA # IF APPLI  F. S. CHARGES  150,00 1  90,00 1	CABLE  H I PRINT ID. NPI	CUPPIENT SERVICES  MW DD YY  HARGES  REF. NO.  RENDERING  RECOMBER ID. #  1236548  1236548  1236548  1236548  1236548
NAME OF REFERRING PROMDER OF OTHER SOURCE   17a	1236548 PI 1236549875  Ine below (24E) ICD Ind. 0   D   H   L   L   L   E   D   IAGNOSIS   POINTER  A A A	FROM   18 HOSPITALIZATION DATE	ORIGINAL F  NUMBER  CABLE  B H L  B PROT ID  B PROT ID	REF. NO  REPROPERING PROVIDER ID. #  1236548  1236548  1236548  1236548  1236548  1236548  1236548
NAME OF REFERRING PROMOTER OF OTHER SOURCE   17a	1236548 PI 1236549875  Ine below (24E) ICD Ind. 0   D   H   L   L   L   E   D   IAGNOSIS   POINTER  A A A	FROM   18 HOSPITALIZATION DATE	CABLE  H L REPORT ID. NPI  NPI  NPI  NPI  NPI  NPI	REF. NO  REPROPERING PROVIDER ID. #  1236548  1236548  1236548  1236548  1236548  1236548  1236548
NAME OF REFERRING PROMOBER OF OTHER SOURCE   17a	1236548	FROM	CRIGINAL F NUMBER CABLE S PRIT ID. FRINT OUAL NPI NPI NPI	REF. NO  REP. NO  REP
NAME OF REFERRING PROVIDER OF OTHER SOURCE   17a	1236548	FROM	ORIGINAL F  NUMBER  CABLE  B H L  B PROT ID  B PROT ID  NPI  NPI  NPI  NPI  NPI  NPI  NPI  N	CURRIENT SERVICES  NOV. DD YY  HARCES  REF. NO.  RENDERING  RENDER

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#### ADJUSTING/VOIDING CLAIMS

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

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved 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 Beneficiary/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.

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

FEROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	Mail To: Molina P.O. Box 91020 Baton Rouge, LA 70821
	THER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Madicare#) X (Medicaidif) (IO#DcD#) (Member ID#) (10#) (IO#) (IO#)	1234567890123
2. PATIENT'S NAME (Last Name, First Name, Midde Initial)  2. PATIENT'S BETH DATE SEX  LOU, JANNIE  9. PATIENT'S BETH DATE SEX  06   11   07   M   F  >	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
SET   Spouse   Child   Office	CITY STATE
ZPCODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Indude Area Code)
( )	( )
OTHER INSURED'S NAME (Last Name, First Name, Middle hills)     10. IS PATIENT'S CONDITION RELATED TO:     CARADIE	11, INSURED'S POLICY GROUP OR FECA NUMBER
TPL CODE IF APPLICABLE	a. INSURED'S DATE OF BRITH SEX
b RESERVED FOR NUCC USE b AUTO ACCIDENT? PLACE	IN COLUMN DESCRIPTION
EXAMPLE OF IC	D 100 C INSURANSE PLAN NAME OF PROGRAM NAME
YES NO	STREAMWAYE LEWIN DUNIE OF LUCKENIAN BRANE
INSURANCE PLAN INVASORPRETE LINE A NI COD TOCE DITANTICE	DI DIE WOTHER HENTENED PLAN?
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	Tes C A Tes, Do date items 9, 9a, and 9d.  13. INSUREO'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorizes.
2. PAT IERT'S CRI AUTHORIZED PERSON'S SIGNATURIE. Fauthorize the release of any medical or other information necessifility of the party who accepts assignment benefits of the party who accepts assignment benefits.	payment of medical, benefits to the undersigned physician or supplier for services described below.
SIGNIED DATE	SIGNED
4. DATE OF DURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM   DD   YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY
QUAL QUAL QUAL QUAL 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17s. 1236548	FROM TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.
DK JON DOE, MD 176 NPI 1236549875	FROM TO
9 ADDITIONAL CLAIM INFORMATION (Cealgrated by NUCC)	20. OUTSIDE LAB? \$ CHARGES
M. DI AGNIOSIS OR NATURE OF ILLNESS OR INJURY. Pellate A-L to service line below (24E) ICO Incl. 0	22. RESUBMISSION CRIGINAL REF. NO
H5034	A 00 8142178901200 23. PRIOR AUTHORIZATION NUMBER
F. L G H L L L L L L L L L L L L L L L L L	PA # IF APPLICABLE
4. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. R. AGEDF (Explain Unusual directions) DIAGON MM DD YY MM DD YY SBWEE EM CPTH/CPC3   MOOIFIER POINT	IOSIS DAYS EPSOT ID RENDERING
	1236548
05 01 18 05 01 18 11 92012 A	175,00 1 NPI 1236549875
	NPI NPI
	NPI
	I I I I I I I I I I I I I I I I I I I
	NPI NPI
	NPI NPI
S. FEDERALTAX I.D. NUMBER SSN BIN 28. PATIENT'S ACCOUNT NO. 27. ADDEPT ASSIGNMENT OF THE PROPERTY OF THE PROPE	NTY 28 TOTAL CHARGE 29, AMOUNT PAID 30, Resultor NUCC Us
1234  X YES NO H SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION	\$ 175,00 \$ 33. BILLING FROMIDER INFO & FH# (800) 233-3333
INCLUDING DEGREES OF CREDENTIALS (Lipertry that the statements on the reverse	ALWAYS OPEN
apply to this bit and are made a part frenent.)  IANE DOE, MD	700 MAIN ST ANY TOWN, LA 70000
06/05/2018 DATE to DATE	a 1326547895 a 1987654
UCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-1

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352	
EALTH INSURANCE CLAIM FORM	
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) : TIPICA	PICA TO
MEDICARE MEDICARD TRICARE CH	IPVA GROUP FECA OTHER 1a, INSURED'S LD, NUMBER (For Program in Item 1)
(Medicarell) (Medicaldil) (IDI/DeDil) (Me PATIENT'S NAME (Last Name, First Name, Middle Initial)	ar (De) ((De) ((De) ((De) (De) ((De) (De)
PARENTS WAS CAR NAME, PROCESSIO, WAS PROSE	M DD W
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)
TY S	Self Spouse Child Other  TE & RESERVED FOR NUCC USE CITY STATE
P CODE TELEPHONE (Indude Area Code)	
P CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include 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 POUCY OR GROUP NUMBER	e_EMPLOYMENT? (Current or Previous)
	YES NO MM DD YY M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT?  PLADE (State)  B. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	e. OTHER ACCIDENT?  E. INSURANCE PLAN NAME OF PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	104, CLAM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
The state of the s	YES NO If yee, complete items 9, 9a, and 9t.
READ BACK OF FORM BEFORE COMPL PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I SUINCE	the release of any medical or other information necessary sourcent of medical benefits to the understoned physician or supplier for
to process this claim. I also request payment of government benefits below.	her to myself or to the party who access assignment services described below.
SIGNED	DATESIGNED
DATE OF CURRENT ILLNESS, MURRY, & PREGNANCY (LMP)	16, DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION OF TO TO TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES NM DO YY
ACCITIONAL CLAIM INFORMATION (Designated by NUCC)	176L NPI FROM TO 20, OUTSIDE LAB? \$ CHARGES
	YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate Act	CODE ORIGINAL REF. NO.
8. F.	23, PRIOR AUTHORIZATION NUMBER
A. DATE(S) OF SERVICE B. C. D. P.	
From To PLACE OF	DEBOURES SERVICES, OR SUPPLIES F. F. G. H. I. J. RENDERING PROBLEM CORG SERVICES, OR SUPPLIES F. G. G. H. I. J. RENDERING CORG S. G.
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FEDERAL TAX LD, NUMBER SSN EIN 26, PATIE	"S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 25. AMOUNT PAID 30. Royd for NUCC Up
	YES NO \$ \$
INCLUDING DEGREES OR CREDENTIALS	FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ( )
If cervity trial the statements on the reverse	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	