LOUISIANA DEPARTMENT OF HEALTH

VISION (EYEWEAR)

Chapter Forty-Six of the Medicaid Services Manual

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State of Louisiana
Bureau of Health Services Financing

VISION (EYE WEAR) SERVICES

TABLE OF CONTENTS

SUBJECT **SECTION**

OVERVIEW

Medicaid covered eyewear services are available to Medicaid eligible beneficiaries who are under the age of 21 years. No eyewear services are available for beneficiaries aged 21 years and older unless the beneficiary receives both Medicare and Medicaid, and in such cases, Medicare covers the required eyewear. In this instance, Medicaid may pick up a calculated portion of the payment as a Medicare crossover claim.

Eyewear is limited to 3 pairs per calendar year without review. Billing for the fourth and subsequent pairs must have documentation attached justifying the need for more than 3 pairs of eyewear per year.

Providers may NOT require a payment/deposit for eyewear pending payment from Medicaid. Payment from the Medicaid must be accepted as payment in full.

NOTE: Beneficiaries are not allowed to pay any remaining difference for eyewear under any circumstance, including upgrades for cosmetic purposes.

COVERED SERVICES

Medicaid may reimburse for the visual services that are medically necessary and provided to eligible Medicaid beneficiaries. (See Section 46.2 for Beneficiary Requirements).

Only those services designated in the Louisiana Medicaid Vision (Eyewear) Fee Schedule can be reimbursed by Medicaid to an optometrist, ophthalmologist, and optician.

NOTE: Some eyewear services and materials require prior authorization (PA) before rendering. The Vision (Eyewear) Fee Schedule on www.lamedicaid.com indicates which services require PA.

Eye Exams

Medicaid covered eye exams are available to Medicaid eligible beneficiaries who are under 21 years of age and are limited to 1 per calendar year. (Refer to *Chapter 5 Professional Services* for more information).

Lenses

Lenses must be of good quality and un-tinted, conforming to the Z 80.1 hardened glass or plastic lens standards of the American National Standards Institute, Federal Food and Drug Administration regulations, and federal law.

In order to receive Medicaid reimbursement for single vision lenses, at least 1 lens must exceed +1.00 sphere, -0.50 sphere, or +/-0.50 plano cylinder. Only spheres or compounds +/- cyl series, properly transposed to find price brackets, should be prescribed.

If a complete pair of eyeglasses (frames and lenses) is delivered to a Medicaid beneficiary on the same date of service, the provider must bill for all components of the eyeglasses. Providers may not bill Medicaid for lenses only and let the patient pay for the frames. Providers may dispense replacement lenses to a complete pair of eyeglasses that a beneficiary already owns.

Bifocal/trifocal lenses will only be considered when medically necessary. Bifocal/trifocal lenses requested for convenience will not be authorized.

Polycarbonate lens add-on, per lens will only be considered when medically necessary, i.e. for a child who has seizures and may be prone to fall, a child who is blind in one eye, etc.

NOTE: If a Medicaid beneficiary for whom polycarbonate lenses are not medically necessary chooses to pay the eyewear provider out-to-pocket for an “upgrade” from CR-39 to polycarbonate,

they may be permitted to do so. The provider shall have the beneficiary or legal guardian sign an agreement stating that payment is an un-coerced choice for the upgrade and that they understand and assumes the responsibility for payment for the services.

Frames

Medicaid beneficiaries must be offered a choice between metal or plastic frames. The frames must be sturdy and nonflammable. Both the metal and non-metal frames must carry at least a 1-year manufacturer's warranty.

Providers may dispense a replacement frame to a complete pair of eyeglasses, which a beneficiary already owns. Replacement frames should not be billed to Medicaid if the frame is covered by the 1-year manufacturer's warranty.

If eyeglasses are damaged, the first line of coverage shall be to utilize the manufacturer's warranty. If the frames are outside of the manufacturer's warranty, the provider must pursue the most cost-effective method to repair the damaged glasses. If repair or replacement of the damaged parts is not feasible, the full replacement of eyeglasses will be covered. Documentation that the repair or replacement of the damaged parts is not feasible must be obtained before the full replacement of eyeglasses.

If a complete pair of eyeglasses (frames and lenses) is delivered to a Medicaid beneficiary on the same date of service, the provider must bill for all the components of the eyeglasses. Providers may not bill Medicaid for frames only and let the patient pay for the lenses.

Deluxe frames require PA and will only be considered when medically necessary, i.e. child has a wide nose bridge due to a medical syndrome, or child has a small head and regular frames would not fit, etc.

Contact Lenses

Medicaid reimburses for rigid or soft contact lenses. Medicaid may reimburse for continuous wear lenses when the beneficiary cannot wear normal soft lenses. All contact lenses require PA by Medicaid. It must be clearly stated and written on the PA request form whether it is a new fitting or replacement lenses.

Contact lenses will only be considered when medically necessary and no other means can restore vision. Medicaid does not reimburse for contact lenses for cosmetic purposes.

Contact lenses may be covered when the beneficiary has 1 of the following conditions:

1. An unusual eye disease or disorder exists which is not correctable with eyeglasses;

2. Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear;

3. Irregular cornea or irregular astigmatism (does not apply if the beneficiary has had previous refractive surgery);

4. Significant, symptomatic anisometropia; and

5. Aphakia (post-surgical).

In order for the provider to be reimbursed by Medicaid for contact lenses, the provider must obtain PA from Medicaid. (See Section 46.4 for required documentation for PA requests). The PA request is then reviewed to determine if the beneficiary is being fitted with the proper type of lenses. If either soft or rigid lenses could be used, Medicaid will approve the least expensive type.

Reimbursement for "Fitting of Spectacles"

Medicaid provides separate reimbursement for the "fitting of spectacles" on the same day or subsequent day as an optometrist or ophthalmologist office visit. The most appropriate and inclusive Current Procedural Terminology (CPT) code shall be used for the "fitting of spectacles." These relevant codes are located on the Professional Services fee schedule.

Reimbursement covers delivery and final adjustment to the visual axis and anatomical topography of Medicaid covered eyewear. If final adjustments to the visual axes and anatomical topography are **NOT** performed during the beneficiary's return, the provider must **NOT** bill for the "fitting of spectacles." For example, if the beneficiary returns to the office only to pick up eyewear, billing of the procedure code for fitting of spectacles is considered inappropriate billing.

Eyewear Replacement Policy

Eyewear is limited to 3 pairs per calendar year without review. Billing for the fourth and subsequent pairs must have documentation attached justifying the need for more than 3 pairs of eyewear per year.

Acceptable documentation includes, but is not limited to, the following:

1. Documentation that shows the necessity of changing the prescription for the eyewear more than 3 times in the calendar year; or

2. Copies of the different prescriptions for eyeglasses, which were written within the calendar year.

For services that do not require PA, providers should fill the prescription, i.e., order the glasses from the manufacturer and dispense the glasses to the beneficiary, prior to filing for payment. Providers should not hold the eyewear until payment is received.

Date of delivery of eyewear is the date of service on the claim form.

Providers may not require a payment/deposit for eyewear pending payment from Medicaid. Payment from the Louisiana Medicaid Program must be for medically necessary services and must be accepted as payment in full.

Eyewear may not be upgraded for cosmetic purposes under any circumstances.

Medicaid covers medically necessary eyewear. Medicaid does not cover any eyewear, initial or replacement that is to be used as “spare” or “back-up” eyewear. The beneficiary may choose to purchase (out of pocket) duplicate eyewear that is to be used as “spare or “back-up” eyewear.

BENEFICIARY REQUIREMENTS

Medicaid covered eyewear services must be medically necessary and are available to eligible Medicaid beneficiaries who meet the following criteria:

1. Under the age of 21; and

2. Aged 21 years and older ONLY if the beneficiary receives both Medicare and Medicaid and Medicare covers the required eyewear. In this instance, Medicaid may pick up a calculated portion of the payment as a Medicare crossover claim.

Eligibility Verification

It is the responsibility of the provider to verify the beneficiary's Medicaid eligibility for each date of service. All beneficiaries enrolled in the Louisiana Medicaid program are issued plastic identification cards. These permanent identification cards contain a card control number (CCN) that can be used by the provider to verify Medicaid eligibility. Louisiana Medicaid offers several options to assist providers with verification of current eligibility.

The following eligibility verification options are available:

1. **Medicaid Eligibility Verification System (MEVS)**, an automated eligibility verification system using a swipe card device or PC software through vendors;

2. **Recipient Eligibility Verification System (REVS)**, an automated telephonic eligibility verification system; and

3. **e-MEVS**, a web application via the Louisiana Medicaid website. (See Appendix D for website address).

These eligibility verification systems provide confirmation of the following:

1. Beneficiary eligibility;

2. Third party (insurance) resources;

3. Service limits and restrictions;

4. Lock-In; and

5. Managed Care Organization (MCO) Plan Linkage.

Before accessing the REVS, MEVS, and e-MEVS eligibility verification systems, providers should be aware of the following:

1. Providers will be required to supply 2 identifying pieces of information about the beneficiary when prompted; and

2. Specific dates of service must be requested. A date range in the date of service field on an inquiry transaction is not acceptable.

PROVIDER REQUIREMENTS

An optometrist, ophthalmologist, physician and optical supplier must enroll as a Louisiana Medicaid vision provider in order to receive reimbursement for vision services performed on eligible Medicaid beneficiaries. Individual optometrists, ophthalmologists, and opticians not enrolled in the Louisiana Medicaid program may not use the name and/or provider number of an enrolled provider in order to bill Medicaid for services rendered.

Providers must meet all Louisiana Medicaid provider enrollment requirements. Additionally, providers must be licensed by the appropriate governmental authority and licensing boards when applicable.

Optical Groups

For Louisiana Medicaid purposes, an optical group consists of 2 or more optometrists, ophthalmologists, or optical suppliers offering vision services to the Louisiana Medicaid beneficiary population. Optical groups must be enrolled in the Louisiana Medicaid program prior to rendering services to a Medicaid beneficiary.

Individual Providers

The Louisiana Medicaid Program will assign only 1 provider number per individual provider type. For this reason, an individual optical provider may have only 1 "Pay To" address regardless of the number of locations where individual services are rendered. For example, if an individual optical provider practices at multiple locations, Medicaid payments will be sent to only 1 address for all services provided.

However, if an individual optical provider practices with an enrolled group and maintains a private practice, the group must bill for services performed in the group setting and the individual optical provider must bill individual services rendered in the private practice. This is the only situation in which payment for services provided by 1 optical provider would be made to more than 1 address. Payment would be made to the group at its address and to the individual optical provider at the private address.

NOTE: All changes of address, group affiliation, contact information, etc. must be reported in writing to Provider Enrollment. (See Appendix D for Contact/Referral Information).

PRIOR AUTHORIZATION

Prior authorization (PA) for eyewear will be considered only when the item is medically necessary. If the service requires PA, the provider shall not fill the prescription or dispense the eyewear until an approval letter is obtained from Medicaid.

Completed requests with all required documentation shall be mailed to the Prior Authorization Unit (PAU). (See Appendix D for Contact/Referral Information).

Required Documentation for Prior Authorization

Request for PA shall include the following:

1. Completed Form PA-01. (See Appendix B);

2. Copy of the prescription;

3. Letter that documents medical necessity for all PA requests; and

NOTE: The letter of medical necessity **must** be obtained from the prescribing provider and must be specific to each individual beneficiary.

4. Copy of the invoice and a detailed description of the items(s) for all codes "manually priced" as noted in the eyewear fee schedule. (See Appendix A).

The Form PA-01 must include information regarding all eyewear items that will be delivered on the same date of service to the beneficiary, including those items that do not require PA.

The items, that require PA, must be listed on the first line(s) of the Form PA-01, under the "Description of Services" section and must include the following:

1. Field 11 - Procedure Code;

2. Field 11A - Modifier-when applicable;

3. Field 11B – Description;

4. Field 11C - Requested Units; and

5. Field 11D - Requested Amount.

Items that do not require PA must be listed below those that require PA on the Form PA-01. Only the "Description" (Field 11B) shall be completed for items that do not require PA.

NOTE: DO NOT ENTER A PROCEDURE CODE FOR ITEMS THAT DO NOT REQUIRE PA.

PA requests related to eyewear will be granted for a 3-month authorization period. The provider shall indicate the appropriate 3-month span in the "Dates of Service" sections on the Form PA-01. The "Begin Date of Service" (Field 7) must be the date of initial contact with the beneficiary. The "End Date of Service" must be 3 months from the begin date of service specified in Field 7.

Providers enrolled as a group must indicate the individual provider's Medicaid provider number on the Form PA-01 (Field 6) when requesting PA. This provider number must match the attending provider number in item 24K of the CMS-1500 when services are billed.

Prior Authorization Requests for Contact Lenses

The provider must submit the following information with the PA request for contact lenses:

1. The medical condition that makes the beneficiary eligible for contact lenses;
2. Whether the beneficiary is aphakic or not aphakic;
3. Substantiation for special fittings (e.g.; Keratoconus);
4. All appropriate procedure codes;
5. The provider's total fee, including professional fitting services (excluding initial examination), the contact lenses, the required care kits, and follow-up visits for 90 days; and
6. A statement indicating if the contact lenses are:
    a. An original fitting (or refitting) or for replacement lenses;
    b. For unilateral or bilateral lenses;
    c. Spherical or toric;
    d. Rigid (PMMA or gas permeable) or soft lenses; and
    e. Daily wear or extended wear.

NOTE: PA requests that do not include all items as listed above will be returned to the provider for more information.

Prior Authorization Decisions and Delivery of Service

A PA request that contains all of the required documentation shall not take longer than 25 days to process. Should the provider fail to receive a PA decision within a timely manner, the provider shall contact the PAU. (See Appendix D for Contact Referral Information).

Once the review process has been completed, providers are notified, via letter, of the decision to approve or deny the service. If the service is not approved, a denial reason is indicated in this letter. If approved, the letter also includes the 9-digit PA number assigned to the request, which must be used when billing. This 9-digit number must be entered in item 23 of the CMS 1500 form or the electronic Health Insurance Portability and Accountability Act (HIPAA) compliant equivalent, 837P when billing.

Upon PA approval, the provider shall deliver the services as soon as possible within the authorized period. In order for a claim to be paid, PA required services must have been approved, and the dates of service must fall between the dates listed on the PA. The actual date that the service was delivered shall be used as the date of service when filing a claim for payment.

After PA approval is received and the eyewear is delivered to the beneficiary, the provider shall bill for all of the services rendered. All eyewear services, regardless of whether PA is required, may be billed on the same claim form. (See Section 46.5 - Reimbursement for more information on claims related information).

Post Authorization

Post authorization may be obtained for a procedure that normally requires PA if a beneficiary becomes retroactively eligible for Medicaid; however, such requests must be submitted within 6 months from the date of Medicaid certification of retroactive eligibility.

REIMBURSEMENT

The fiscal intermediary (FI) accepts standardized professional 837P electronic transactions if the software vendor, billing agent, or Clearinghouse (VBC) used by the provider has been tested and approved by the FI. Providers billing hard copy claims will continue to bill on the CMS-1500. (See Appendix C for sample CMS 1500 form and instructions). All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

In order for a claim to be paid by Medicaid, services that require prior authorization (PA) must have been approved, and the dates of service must fall between the dates listed on the PA. The actual date that the service was delivered shall be used as the date of service when filing a claim for payment.

After PA approval is received and the eyewear is delivered to the beneficiary, the provider shall bill for all of the services rendered. All eyewear services, regardless of whether PA is required, may be billed on the same claim form.

Billing Information

All claims submitted must contain Louisiana Medicaid approved Healthcare Common Procedure Coding System **(**HCPCS**)** eyewear codes. Refer to the Vision (Eyewear) fee schedule located on www.lamedicaid.com.

All claims for payment shall be submitted with the procedure code(s) identified on the Vision (Eyewear) fee schedule for lens and frames and must include the appropriate number of units (quantity) for each item. Additionally, all claims must include the appropriate place of service (POS) code.

Reimbursement Fee

A flat fee has been established for each code listed in the Vision (Eyewear) fee schedule, with the exception of the "non-specific" codes listed as "manually priced".

These "non-specific" codes require PA and the reimbursement fee will be determined at the time of PA based on invoice cost. A copy of the invoice must be submitted with the PA request in order to determine the amount of reimbursement. Use of these codes shall be limited to when there is no established code available to describe the service being rendered.

Modifiers Required

The following modifiers are only used when the procedure code lens is over 12.00 D spheres and shall be used for PA and claims submissions in conjunction with applicable procedure codes listed on the Vision (Eyewear) fee schedule that require a modifier.:

1. RT-indicates right eye; and

2. LT-indicates left eye.

NOTE: These modifiers shall not be used when billing procedure code when the lens is plus or minus 7.12 to plus or minus 12.00D sphere or with any other procedure code.

The attending provider number in item 24J of the CMS-1500 must match the provider number previously included on the PA-01 Form (field 6) of the PA form.

When billing for an approved service, the 9-digit PA number must be entered in item 23 of the CMS 1500 form or in the appropriate field of the electronic 837P.

Electronic Claims Status Inquiry

Providers shall use the electronic claims status inquiry (e-CSI) application to check the status of claims submitted to Louisiana Medicaid. Once enrolled on the Medicaid website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application. Refer to Chapter 1: General Information and Administration of the *Medicaid Services Manual* or to the Louisiana Medicaid website for more information on e-CSI.

Adjustment/Void Claims

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form. Refer to Appendix C for a sample adjustment and void form and instructions related to vision services.

Adjustments for a Medicare/Medicaid Claims

When a provider has filed a claim with Medicare, and Medicare pays, then the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible or co-payment.

If it is determined, at a later date, that Medicare has overpaid or underpaid, the provider shall rebill Medicare for a corrected payment. These claims may “crossover” from Medicare to Medicaid, but

cannot be automatically processed by Medicaid (as the claim will appear to be a duplicate claim, and therefore must be denied by Medicaid).

In order to receive an adjustment, the provider must file a hard-copy claim using the CMS 1500. (See Appendix C for adjustment/void form and instructions). A copy of both the most recent Medicare Explanation of Benefits (EOB) and the original EOB must be attached to the adjustment form and mailed to the FI.

The provider shall write "2X7" at the top of the CMS 1500 to indicate the adjustment is for a Medicare/Medicaid claim.

RECORD KEEPING

Providers are required to maintain records of all appointments and procedures performed on those appointments. For services provided to beneficiaries under the Vision (Eyewear) Services Program, records must be maintained for at least 6 years. Failure to produce these records, on demand, by the Medicaid program or its authorized designee, will result in sanctions against the provider.

Records must include:

1. Detailed accounts of each beneficiary's visit indicating what services were provided;

2. Copies of all claim forms submitted for prior authorization (PA) including any attachments;

3. All PA letters;

4. All prescriptions; and

5. Any additional supporting documentation.

NOTE: A list of codes and services billed is insufficient documentation.

The claim form or copies of the claim forms submitted for reimbursement are not sufficient to document the delivery of services; however, these items must be maintained in the beneficiary's record.

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on record keeping.

EYEWEAR FEE SCHEDULE

The current vision (eyewear) services fee schedule may be obtained from the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/fee_schedules/EYEWEAR.pdf.

Obsoleted fee schedules are available under the "Previous Fee Schedule" by accessing link: http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.

PRIOR AUTHORIZATION FORM

Information on completing the Prior Authorization Form (PA-01) is available at:
http://www.lamedicaid.com/provweb1/Forms/PA-01.pdf.

CLAIMS FILING

Hard copy billing of Vision (Eye-wear) 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 are submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or

2. 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 Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center", sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

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 Identification (ID) Number	**Required** – Enter the beneficiary's 13 digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibility Verification System (MEVS), eMEVS, or Recipient Eligibility System (REVS). **NOTE:** The beneficiary's' 13-digit Medicaid ID number must be used to bill claims. The card control number (CCN) 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 (MI).	
3	Patient's Date of Birth (DOB) Sex	**Situational** – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	**Situational** – 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 NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE	**Leave Blank.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
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 Third Party Liability (TPL) carrier code is **required** in this block. The carrier code is indicated on the MEVS response as the Network Provider ID Number. Make sure the explanation of benefits (EOBs) or EOBs from other insurance(s) are attached to the claim.	**ONLY the 6-digit code should be entered for commercial and Medicare Health Management Organization's (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.**	
9c	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 Federal Employees Compensation Act (FECA) Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's DOB 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.	

Locator #	Description	Instructions	Alerts
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.**	
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:** **1. 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.** **1. DK Ordering Provider** **Enter the name (First Name, MI, 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 ID Number	**Situational – Complete if applicable.** **If 17 is completed, 17A is required.**	Enter the 7-digit Medicaid ID Number here.
17b	National Provider Identifier (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	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
	(Designated by NUCC)		
20	Outside Lab?	**Optional.**	
21	International Classification of Diseases (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.
22	Resubmission Code and/or Original Reference Number	**Situational**. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number (ICN) 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: Adjustments 01 = TPL 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	**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 ICN.**
23	Prior Authorization (PA) 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 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (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.	
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	Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) Family Plan	**Leave Blank.**	
24I	ID Qual.	**Optional.** If possible, leave blank for Louisiana Medicaid billing**.**	
24J	Rendering Provider ID Number	**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 Number	**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.**	
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.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	
32b	Other ID Number	**Situational** – Complete as appropriate or leave blank.	
33	Billing Provider Info and Phone Number	**Required** -- 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 Number	**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 must appear on paper claims.**

Sample forms are on the following page

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail To:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU, JANNIE

3. PATIENT'S BIRTH DATE: 06 11 07 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE | ZIP CODE | TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

9. 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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

SAMPLE
EXAMPLE OF ICD 10
WITH AN ORDERING PROVIDER

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JON DOE, MD

17a. 1236548

17b. NPI 1236549875

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. H5034 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: PA # IF APPLICABLE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05	01	18	05	01	18	11		92012		A	150.00	1		1236548 NPI 1236549875
2	05	01	18	05	01	18	11		92060		A	90.00	1		1236548 NPI 1236549875
3	05	15	18	05	15	18	11		V2020		A	45.00	1		1236548 NPI 1236549875
4	05	15	18	05	15	18	11		V2103	RT LT	A	90.00	2		1236548 NPI 1236549875
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 375.00

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JANE DOE, MD 05/21/2018 SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # (800) 233-3333
ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

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 RA, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved ICN can be adjusted or voided; thus:

1. 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; and

2. 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.**

Adjustments/Voids Appearing on the RA

When an Adjustment/Void Form has been processed, it will appear on the RA 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.

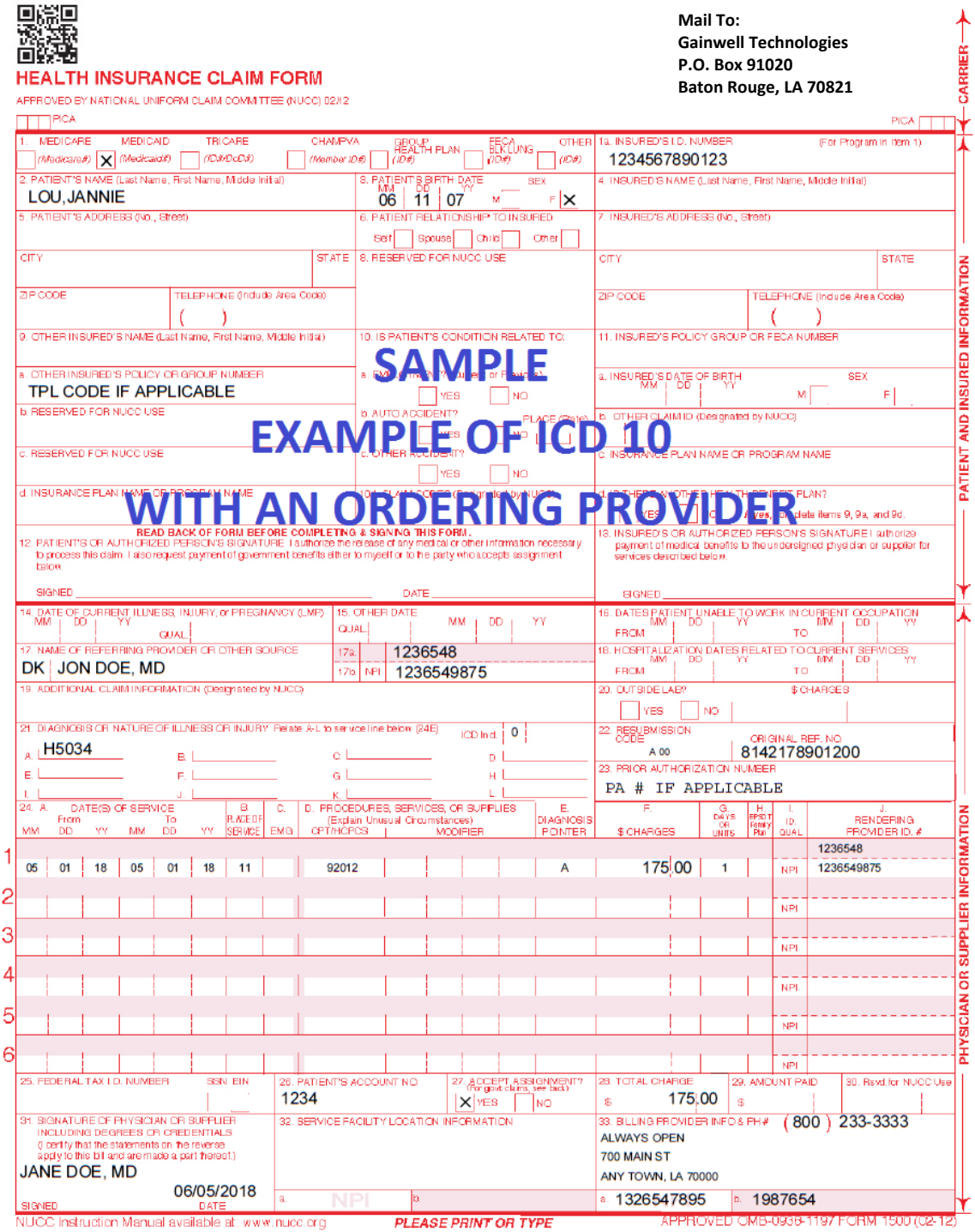
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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 RA.

Sample forms are on the following pages.

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail To:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [X] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
1a. INSURED'S I.D. NUMBER: 1234567890123
2. PATIENT'S NAME: LOU, JANNIE
3. PATIENT'S BIRTH DATE: 06 11 07 SEX: M [ ] F [X]
4. INSURED'S NAME
5. PATIENT'S ADDRESS
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS
CITY / STATE / ZIP CODE / TELEPHONE
8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE
a. INSURED'S DATE OF BIRTH / SEX
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. OTHER CLAIM ID
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

SAMPLE
EXAMPLE OF ICD 10
WITH AN ORDERING PROVIDER

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE MM DD YY QUAL
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JON DOE, MD
17a. 1236548
17b. NPI 1236549875
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. H5034 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE: A 00 ORIGINAL REF. NO. 8142178901200
23. PRIOR AUTHORIZATION NUMBER: PA # IF APPLICABLE

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05	01	18	05	01	18	11		92012		A	175.00	1			1236548
														NPI	1236549875
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO. 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE $ 175.00
29. AMOUNT PAID $
30. Rsvd. for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JANE DOE, MD
SIGNED 06/05/2018 DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH# (800) 233-3333
ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (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 FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CONTACT/REFERRAL INFORMATION

Gainwell Technologies

The Medicaid Program's fiscal intermediary (FI), Gainwell Technologies, can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technologies(877) 598-8753 (Toll Free) (225) 216-6303
Electronic Media Interchange (EDI) Electronic Claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Pre-Certification Unit (Hospital) Pre-certification issues and forms	P.O. 14849 Baton Rouge, LA 70809-4849 Phone: (800) 877-0666 Fax: (800) 717-4329
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) **After hours, please call REVS*
Prior Authorization Unit (PAU)	Gainwell Technologies– Prior Authorization P.O. Box 14919 Baton Rouge, LA 70898-4919 (800) 488-6334
Provider Enrollment Unit (PEU)	Gainwell Technologies-Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit (PR)	Gainwell Technologies– Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

Louisiana Department of Health (LDH)

TYPE OF ASSISTANCE	CONTACT INFORMATION
Durable Medical Equipment (DME)	628 N. Fourth Street Phone: (225) 342-7513 Fax: (225) 376-4672 http://www.lamedicaid.com/provweb1/dme/dmeindex.htm
General Medicaid Information	Medicaid Hotline (888) 342-6207 (Toll Free) www.lamedicaid.com
Recovery and Premium Assistance Third Party Liability (TPL) Recovery, Trauma	P.O. Box 3588 Baton Rouge, LA 70821 Phone: (225) 342-1376 Fax: (225) 342-5292