#### **CHAPTER 46: VISION (EYE-WEAR) SERVICES APPENDIX C: CLAIMS FILING**

**PAGE(S) 13** 

## 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.)

# CHAPTER 46: VISION (EYE-WEAR) SERVICESAPPENDIX C: CLAIMS FILINGPA

**PAGE(S) 13** 

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

### **PAGE(S) 13**

### 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	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). 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		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Insurance Plan Name or

Is There Another Health

Patient's or Authorized Person's Signature

(Release of Records) Insured's or Authorized

Person's Signature

(Payment)

blank.

Program Name

Benefit Plan?

11c

11d

12

13

# **CHAPTER 46: VISION (EYE-WEAR) SERVICES**

APPEN	DIX C: CLAIMS	S FILING	PAGE(S) 13
		Situational – If recipient has no other coverage, leave blank.	Only the 6-digit
9a	Other Insured's Policy or Group Number	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.	code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the
		Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	field.
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.	

Situational – Complete if appropriate or leave blank.

Situational – Complete if appropriate or leave blank.

Situational – Complete if appropriate or leave blank.

Situational – Obtain signature if appropriate or leave

**ISSUED: REPLACED:** 

### CHAPTER 46: VISION (EYE-WEAR) SERVICES APPENDIX C: CLAIMS FILING

### **PAGE(S) 13**

14	Date of Current Illness / Injury / Pregnancy	Optional	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional	
17	Name of Referring Provider or Other Source	Leave Blank.	
17a	Unlabelled	Leave Blank.	
17b	NPI	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
21	ICD Ind. 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.         9       ICD-9-CM         0       ICD-10-CM         Required – Enter the most current ICD diagnosis code.         NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD- 10-CM codes will be announced at a later date.

### 05/12/14 04/21/11

#### **CHAPTER 46: VISION (EYE-WEAR) SERVICES APPENDIX C: CLAIMS FILING**

#### 22 **Resubmission Code** Effective with date Situational. If filing an adjustment or void, enter an "A" for of processing an adjustment or a "V" for a void as appropriate AND one of 5/19/14 providers the appropriate reason codes for the adjustment or void in currently using the the "Code" portion of this field. proprietary 213 Adjustment/Void Enter the internal control number from the paid claim line as forms will be it appears on the remittance advice in the "Original Ref. No." required to use the portion of this field. CMS 1500 (02/12). Appropriate reason codes follow: To adjust or void more than one Adjustments 01 = Third Party Liability Recovery claim line on a 02 = Provider Correction claim, a separate 03 = Fiscal Agent Error form is required 90 = State Office Use Only – Recovery for each claim line 99 = Othersince each line has a different Voids internal control 10 = Claim Paid for Wrong Recipient number. 11 = Claim Paid for Wrong Provider 00 = OtherSituational – Complete if appropriate or leave blank. Prior Authorization 23 Number If the services being billed must be Prior Authorized, the PA number is **required** to be entered. Supplemental 24 Leave Blank. Information Required -- Enter the date of service for each procedure. Date(s) of Service 24A Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable. Required -- Enter the appropriate place of service code for Place of Service the services rendered. 24B EMG Leave Blank. 24C

### 05/12/14 04/21/11

**ISSUED:** 

**REPLACED:** 

### CHAPTER 46: VISION (EYE-WEAR) SERVICES APPENDIX C: CLAIMS FILING

### **PAGE(S) 13**

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	\$Charges	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> 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. Optional: Enter the Rendering Provider's NPI in the non- shaded portion of the block.	
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.	

### ISSUED: REPLACED:

## CHAPTER 46: VISION (EYE-WEAR) SERVICES APPENDIX C: CLAIMS FILING

### **PAGE(S) 13**

05/12/14 04/21/11

27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of	
		Medicaid assignment.	
28	Total Charge	<b>Required</b> – 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 payments in this field.	
30	RESERVED FOR NUCC USE	Leave Blank.	
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	Unlabelled	Situational – Complete as appropriate or leave blank.	
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabelled	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> appe ar on paper claims.

## A sample form is on the following page

### **PAGE(S) 13**

### SAMPLE VISION CLAIM FORM

EALTH INSURANCE		10010203									
	CLAIN COMMITTEE (NO	000/02/12									PICA
I. MEDICARE MEDICAID	TRICARE	CHAMPVA	GROUP	FECA BLK LUNG	OTHER	1a. INSURED'S I	.D. NUMBE	R		(For Pr	rogram in Item 1)
(Medicare #) 🗙 (Medicaid #)	(ID#/DoD#)	(Member ID		(ID#)	(ID#)	123456789	0123				
2. PATIENT'S NAME (Last Name, Fir	st Name, Middle Initial)		3. PATIENT'S BIRTH I MM DD Y	DATE SE Y	x	4. INSURED'S N	AME (Last I	Name, Fi	irst Name, I	Middle Init	ial)
Adalam, Mary				м 00	FΧ						
5. PATIENT'S ADDRESS (No., Stree	0		6. PATIENT RELATIO			7. INSURED'S A	DDRESS (M	lo., Stree	et)		
СПҮ		STATE	Self Spouse 8. RESERVED FOR N		ther	СПҮ					STATE
		STAIL	0. RESERVED FOR IN	JOU USE							
ZIP CODE TE	LEPHONE (Include Area	Code)				ZIP CODE		TE	LEPHONE	(Indude /	Area Code)
(	)								(	)	
9. OTHER INSURED'S NAME (Last I	Name, First Name, Middle	Initial)	10. IS PATIENT'S CO	NDITION RELATE	ED TO:	11. INSURED'S I	POLICY GR	OUPOF	R FECA NU	MBER	
a. OTHER INSURED'S POLICY OR	GROUPNUMBER		a. EMPLOYMENT? (C		)	a. INSURED'S MM	DATE OF I	BIRTH Y		SE	
TPL Code if applicable b. RESERVED FOR NUCC USE			YES			h OTHER OF 17	UD (Deel	anded by	M		F
C. TEDENTED FOR NOUT ODE			b. AUTO ACCIDENT?		CE (State)	b. OTHER CLAIN	n in (nesiĝi	nated by	NUUC)		
c. RESERVED FOR NUCC USE			C. OTHER ACCIDENT	-		c. INSURANCE F	PLAN NAME	E OR PR	OGRAM N	AME	
			YES	NO							
d. INSURANCE PLAN NAME OR PR	OGRAM NAME		10d. RESERVED FOR			d. IS THERE AN	OTHER HE	ALTH BE		AN?	
						YES	NO	Ifyes	s, complete	items 9, 9	a and 9d.
	K OF FORM BEFORE CO	OMPLETING	& SIGNING THIS FOR	M. or other information		13. INSURED'S C	OR AUTHO	RIZED P	ERSONS	SIGNATU	RE I authorize
<ol> <li>PATIENT'S OR AUTHORIZED PE to process this claim. I also request below</li> </ol>	payment of government be	autionze the enefits either to	o myself or to the party w	/ho accepts assign	ment	payment of m services desc	edical bene ribed below	nits to the	e undersigr	nea physic	tian or supplier for
below. SIGNED		C A					D				
		JP									
		(IMD) IE O			RI	16 DATES PAT		ETOW		IDDENT	
	JURY, or PREGNANCY (	(LMP) 15.0				16. DATES PATI		LE TO W			OCCUPATION DD YY
QUAI	L.			ĹĒČ	) NL	Хом ММ	DD	YY	то	MM	
QUAI	L.			ĹĔĽČ	) NL	IB. HOSPITALIZ	DD	YY	TO ATED TO C	MM	
QUAI 17. NAME OF REFERRING PROVID	ER OR OTHER SOURCE	17a. 7 1b.		LĒ Č	) NL	Хом ММ		YY	TO ATED TO C TO		
QUAI 17. NAME OF REFERRING PROVID	ER OR OTHER SOURCE	17a. 7 1b.		LE'Č	ONL	18. HOSPITALIZ/ FROM		YY	TO ATED TO C		
QUAI 17. NAME OF REFERRING PROVID 19. ADDITIONAL CLAIM INFORMAT	ER OR OTHER SOURCE	17a. 71b.			) NL	18. HOSPITALIZ/ FROM 20. OUTSIDE LA			TO ATED TO C TO		
17. NAME OF REFERRING PROVID 19. ADDITIONAL CLAIM INFORMAT 21. DIAGNOSIS OR NATURE OF ILL	ER OR OTHER SOURCE	17a. 71b.			ONL	18. HOSPITALIZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE			TO ATED TO C TO \$ CHAF RIGINAL RI		
17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. L367.1	ER OR OTHER SOURCE	17a. 71b. C)				18. HOSPITALIZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH			TO ATED TO C TO \$ CHAF RIGINAL RI		
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. [367.1           B.           I.           I.           J.	ER OR OTHER SOURCE	ate A-L to ser C G K	vice line below (24E)	D H L		Ia. HOSPITALIZ. FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889			TO ATED TO C TO \$ CHAF RIGINAL RI BER		
17. NAME OF REFERRING PROVID     19. ADDITIONAL CLAIM INFORMAT     21. DIAGNOSIS OR NATURE OF ILL     A <u>1367.1</u> B     EF     LJ     24. A. DATE(S) OF SERVICE     From	ICN (Designated by NUCC ION (Designated by NUCC NESS OR INJURY Rel I  B. C	17a.     71b.	vice line below (24E)	D H L R SUPPLIES		IB. ROSPITALIZ, FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F.	DD   ATTON DAT		TO ATED TO C TO \$ CHAF RIGINAL RI BER	RGES	
OUAI     OUAI     OUAI     OUAI     OF REFERRING PROVID     OUAI     OUAINIFORMAT	ER OR OTHER SOURCE	17.a. 7 1b. 7 1b.	vice line below (24E)	D H L R SUPPLIES	DINL DINL DIAGNOSIS POINTER	Ia. HOSPITALIZ. FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889			TO ATED TO C TO \$ CHAF RIGINAL RI BER	RGES	DD   YY SERVICES DD   J.
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. 1367 . 1           E           F           24. A. DATE(S) OF SERVICE           From           TO           MM           DD           YY           MM	ICN (Designated by NUCC ION (Designated by NUCC NESS OR INJURY Rel I  B. C	17a.     71b.	vioe line below (24E) UURES, SERVICES, O Iain Unusual Circumstar CS MODI	D H L R SUPPLIES		IB. ROSPITALIZ, FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F.			TO ATED TO C TO \$ CHAF RIGINAL RI BER	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. 1367 . 1           E           F           24. A. DATE(S) OF SERVICE           From           TO           MM           DD           YY           MM	ER OR OTHER SOURCE	17a. 71b. 71b. 71b. 71b. 71b. 71b. 71b. 71b	vioe line below (24E) UURES, SERVICES, O Iain Unusual Circumstar CS MODI	D H L R SUPPLIES	POINTER	18. HOSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES			TO ATED TO C TO \$ CHAP RIGINAL RI SER	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. 1367.1           E           J. A. DATE(S) OF SERVICE           From           TO           MM           DD           YY           MM	ER OR OTHER SOURCE	17a. 71b. 71b. 71b. 71b. 71b. 71b. 71b. 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	18. HOSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES			TO ATED TO C TO \$ CHAP RIGINAL RI SER	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>1367.1</u> E           F.           L.           24. A. DATE(S) OF SERVICE           MM           DD           YY           03           31           14           03	IN CONTRER SOURCE	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO \$ CHAF RIGINAL RI RIGINAL RI BER LI LI LI LI LI LI LI LI LI LI LI LI LI	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>367.1</u> E           F.           J.           Z4. A. DATE(S) OF SERVICE           MM           DD           YY           D3           31           14           03	IN CONTRER SOURCE	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO \$ CHAF RIGINAL RI BER I. I. D. TD. TD. TD. TD. TD. TD. TD.	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>1367.1</u> E           F.           L.           24. A. DATE(S) OF SERVICE           MM           DD           YY           03           31           14           03	ICN (Desgnated by NUCC ICN (Desgnated by NUCC NESS OR INJURY Rel 	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO \$ CHAF RIGINAL RI SER IL IL INPI NPI NPI	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>367.1</u> E           F.           J.           Z4. A. DATE(S) OF SERVICE           MM           DD           YY           D3           31           14           03	ICN (Desgnated by NUCC ICN (Desgnated by NUCC NESS OR INJURY Rel 	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO \$ CHAF RIGINAL RI RIGINAL RI BER LI LI LI LI LI LI LI LI LI LI LI LI LI	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>367.1</u> E           74. A. DATE(S) OF SERVICE           MM           DD           YY           03           31           14           03	ICN (Desgnated by NUCC ICN (Desgnated by NUCC NESS OR INJURY Rel 	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO S CHAF RIGINAL RI BER IL I. I. I. I. I. I. I. I. I. I. I. I. I.	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>367.1</u> E           F.           J.           Z4. A. DATE(S) OF SERVICE           MM           DD           YY           D3           31           14           03	ICN (Desgnated by NUCC ICN (Desgnated by NUCC NESS OR INJURY Rel 	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO \$ CHAF RIGINAL RI SER IL IL INPI NPI NPI	RGES	
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>1367.1</u> E           F.           L.           24. A. DATE(S) OF SERVICE           MM           DD           YY           03           31           14           03	ICN (Desgnated by NUCC ICN (Desgnated by NUCC NESS OR INJURY Rel 	17a 77b 71b 71b 71b 71b 71b 71b 71b 71b 71b	vice line below (24E)	D H L R SUPPLIES	POINTER	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO S CHAF RIGINAL RI BER I I I I NPI NPI NPI	RGES	
QUAI         QUAI           17. NAME OF REFERRING PROVID         19. ADDITIONAL CLAIM INFORMAT           19. ADDITIONAL CLAIM INFORMAT         19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL         A           A         1367.1         B           E	CN (Desgnated by NUCC     ON (Desgnated by NUCC     NESS OR INJURY Rei     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D	ате А-L to ser С. <u>L</u> G. <u>L</u> С. <u>C</u> С. <u>С</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>С</u> С. <u>С</u>	DURES, SERVICES, O DURES, SERVICES, O lain Unusual Circumstar CS MODI 2 RT LT 0		A A	Com MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72			TO ATED TO C TO S CHAF RIGINAL RI BER IL I. I. I. I. I. I. I. I. I. I. I. I. I.	MM LURRENT MM LINE CONTRACT	
QUAI         QUAI           17. NAME OF REFERRING PROVID         19. ADDITIONAL CLAIM INFORMAT           19. ADDITIONAL CLAIM INFORMAT         19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL         A           A         1367.1         B           E	CN (Desgnated by NUCC     ON (Desgnated by NUCC     NESS OR INJURY Rel     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D     D	ате А-L to ser С. <u>L</u> G. <u>L</u> С. <u>C</u> С. <u>С</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>C</u> С. <u>С</u> С. <u>С</u>	Vioe line below (24E)  DURES, SERVICES, O Iain Unusual Circumstar CS MODI  2 RT LT  0	D H R. SUPPLIES UP FIER I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I _ I	A A	A MM 18. ROSPITALIZ: FROM 20. OUTSIDE LA YES 22. RESUBMISS 23. PRIOR AUTH 4234998899 F. \$ CHARGES 72   16   28. TOTAL CHARGES		YY	TO ATED TO C TO \$ CHAF RIGINAL RI BER IL IL INPI NPI NPI NPI	MM LURRENT MM LINE CONTRACT	J. SERVICES
QUAI         QUAI           17. NAME OF REFERRING PROVID         19. ADDITIONAL CLAIM INFORMAT           19. ADDITIONAL CLAIM INFORMAT         21. DIAGNOSIS OR NATURE OF LL           21. DIAGNOSIS OR NATURE OF LL         F           21. DIAGNOSIS OR NATURE OF LL         F           21. DIAGNOSIS OR NATURE OF LL         F           21. A. DATE(S) OF SERVICE         F           22. A. DATE(S) OF SERVICE         TO           03         31         14         03         31           03         31         14         03         31           23. FORERAL TAX LD. NUMBER         SI. SIGNATURE OF PHYSICIAN OR         SI. SIGNATURE OF PHYSICIAN OR	CR OR OTHER SOURCE      CON (Designated by NUCC      NESS OR INJURY Rel      L      B. C.      YY service EMG      14 11      14 11      14 12      SSN EIN 28.      SUPPLIER 32.	ратієнт з а	Vioe line below (24E)  DURES, SERVICES, O Iain Unusual Circumstar CS MODI  2 RT LT  0		A A A	Te. ROSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72 16		YY     F§REL     OF     O	TO ATED TO C TO S CHAF RIGINAL RI SER I NPI NPI NPI NPI NPI	MM LURRENT MMM L RGES EF. NO.	DD YY SERVICES RENDERING ROVIDER ID. #
QUAI           17. NAME OF REFERRING PROVID           19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF ILL           A. <u>367.1</u> E           F.           J.           Z4. A. DATE(S) OF SERVICE           FOM           D0           YY           MM           D0           VY           MM           D3           31           14           03           31           14           03           31           14           19.           103           103           14           03           14           14           14           15.           16.           17.           18.           19.           19.           19.           19.           19.           103           14           14           14           14           14           14. </td <td>CON (Desgnated by NUCC)     NESS OR INJURY Rel     L     L     B. C.     YY SERVICE EMG     14 11     14 11     SSN EIN 20.     SSN EIN 20.     SUPPLIES 32.</td> <td>ратієнт з а</td> <td>Vioe line below (24E)  DURES, SERVICES, O Iain Unusual Circumstar CS MODI 2 RT LT</td> <td></td> <td>A A A</td> <td>A MM Te. ROSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72 16 28. TOTAL CHA \$ 33. BILLING PR</td> <td></td> <td>YY     F§ REL     OF     OF</td> <td>TO ATED TOC TO S CHAF RIGINAL RI SER ID NPI NPI NPI NPI NPI NPI NPI</td> <td>MM                                    </td> <td>J. SERVICES</td>	CON (Desgnated by NUCC)     NESS OR INJURY Rel     L     L     B. C.     YY SERVICE EMG     14 11     14 11     SSN EIN 20.     SSN EIN 20.     SUPPLIES 32.	ратієнт з а	Vioe line below (24E)  DURES, SERVICES, O Iain Unusual Circumstar CS MODI 2 RT LT		A A A	A MM Te. ROSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72 16 28. TOTAL CHA \$ 33. BILLING PR		YY     F§ REL     OF	TO ATED TOC TO S CHAF RIGINAL RI SER ID NPI NPI NPI NPI NPI NPI NPI	MM	J. SERVICES
0UAI         0UAI           17. NAME OF REFERRING PROVID         19. ADDITIONAL CLAIM INFORMAT           19. ADDITIONAL CLAIM INFORMAT         19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF LL         A           21. DIAGNOSIS OR NATURE OF LL         F           21. DIAGNOSIS OR NATURE OF LL         F           21. DIAGNOSIS OR NATURE OF LL         F           22. A         DATE(S) OF SERVICE           03         31         14         03         31           03         31         14         03         31           03         31         14         03         31           25. FEDERAL TAX I.D. NUMBER         31. SIGNATURE OF PHYSICIAN OR         SI         SIGNATURE OF PHYSICIAN OR	CR OR OTHER SOURCE     CR OR OTHER SOURCE     CN (Desgnated by NUCC     NESS OR INJURY Rel     L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L	ратієнт з а	Vioe line below (24E)  DURES, SERVICES, O Iain Unusual Circumstar CS MODI 2 RT LT		A A A	A MM Te. ROSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH 423499889 F. \$ CHARGES 72 16 28. TOTAL CHA \$		YY     F§ REL     OF	TO ATED TOC TO S CHAF RIGINAL RI SER ID NPI NPI NPI NPI NPI NPI NPI	MM	DD YY SERVICES RENDERING ROVIDER ID. #
QUAI         QUAI           17. NAME OF REFERRING PROVID         19. ADDITIONAL CLAIM INFORMAT           19. ADDITIONAL CLAIM INFORMAT         19. ADDITIONAL CLAIM INFORMAT           21. DIAGNOSIS OR NATURE OF LL         A           21. DIAGNOSIS OR NATURE OF LL         F           21. DIAGNOSIS OR NATURE OF LL         B           21. DIAGNOSIS OR NATURE OF LL         F           22. A. DATE(S) OF SERVICE         F           M DD         Y         MM           03         31         14         03         31           03         31         14         03         31           25. FEDERAL TAX LD. NUMBER         A         ADATURE OF PHYSICIAN OR INCLUDING DE GREES OR CREES         INCLUDING DE GREES OR CREES           31. SIGNATURE OF PHYSICIAN OR INCLUDING DE GREES OR CREES         INCLUDING DE GREES OR CREES         INCLUDING DE GREES OR CREES	CR OR OTHER SOURCE     CR OR OTHER SOURCE     CN (Desgnated by NUCC     NESS OR INJURY Rel     L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L      L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L     L	ратієнт з а	Vioe line below (24E)  DURES, SERVICES, O Iain Unusual Circumstar CS MODI 2 RT LT		A A A	A MM 16. ROSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS 23. PRIOR AUTH 423499889 F. \$ CHARGES 72   16   28. TOTAL CHA \$ 33. BILLING PR SEE CLEA		YY E§REL Of N NUMB N NUMB N NUMB 2 2 2 2 2 2 2 2 2 2 2 2 2	TO ATED TOC TO S CHAF RIGINAL RI SER ID NPI NPI NPI NPI NPI NPI NPI	MM	DD YY SERVICES RENDERING ROVIDER ID. #

#### **PAGE(S) 13**

#### 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.

#### CHAPTER 46: VISION (EYE-WEAR) SERVICES APPENDIX C: CLAIMS FILING

#### **PAGE(S) 13**

#### 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.

#### A sample form is on the following page

05/12/14 04/21/11

### **PAGE(S) 13**

### SAMPLE VISION CLAIM FORM ADJUSTMENT FORM

	UCC) 02/12					
PICA						PICA
MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP FEC	OTHER	1a. INSURED'S I.D. NUMBER	(For Prog	ram in Item 1)
(Medicare #) 🗙 (Medicaid #) (ID#/DoD#)	(Member IC	HEALTH PLAN BLK (ID#) (ID#) (ID#)		1234567890123		
PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Na	me, First Name, Middle Initial	)
dalam, Mary		06 11 00 M	FΧ			
PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO	INSURED	7. INSURED'S ADDRESS (No.	, Street)	
		Self Spouse Child	Other			
ſΥ	STATE	8. RESERVED FOR NUCC USE		СПҮ		STATE
P CODE TELEPHONE (Include Area	Code)			ZIP CODE	TELEPHONE (Include Ar	ea Code)
( )	,				()	
OTHER INSURED'S NAME (Last Name, First Name, Middle	e Initial)	10. IS PATIENT'S CONDITION	RELATED TO:	11. INSURED'S POLICY GROU	JP OR FECA NUMBER	
	,					
OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or F	trevious)	a. INSURED'S DATE OF BIP MM DD YY	TH SEX	
PL Code if applicable		YES	NO		м	F
RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (Designat	ed by NUCC)	
		YES	NO			
RESERVED FOR NUCC USE		c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME (	R PROGRAM NAME	
		YES	NO			
INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL U	SE	d. IS THERE ANOTHER HEAL		
READ BACK OF FORM BEFORE C				YES NO 13. INSURED'S OR AUTHORIZ	If yes, complete items 9, 9a	
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I to process this claim. I also request payment of government b below.	authorize the	release of any medical or other inf	ormation necessary s assignment		to the undersigned physicial	
SIGNED	<u>S</u> A	MPLEF	ORN	I FOR		
4. DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY MM DD QUAL	HÌ		ŎNL	16. DATES PATIENT UNABLE MM DD YY	10	
7. NAME OF RÉFERRING PROVIDER OR OTHER SOURCE		NPI		18. HOSPITALIZATION DATES FROM	RELATED TO CURRENT S MM DI TO	ERVICES
ADDITIONAL CLAIM INFORMATION (Designated by NUC)	C)			20. OUTSIDE LAB? YES NO	\$ CHARGES	
				TES NU		
I. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Re	elate A-L to ser	vice line below (24E) ICD Ind.	9		ORIGINAL REF. NO.	
I. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Re A. 1 367 . 1 B. 1	elate A-L to ser C. L	vice line below (24E) ICD Ind.	9	22. RESUBMISSION CODE	ORIGINAL REF. NO. 4090145678600	
а. <mark>ј. 367.1</mark> в. ј.			9	22. RESUBMISSION CODE A 99 23. PRIOR AUTHORIZATION	4090145678600	
A.   <mark>367 . 1</mark> B.   E.   F.   I.   J.	С.  _ G.  _ К.  _	D. j H. j		22. RESUBMISSION CODE A 99 23. PRIOR AUTHORIZATION 423499889	4090145678600 NUMBER	
L <u>367.1</u> B EF L. DATE(S) OF SERVICE B. C From Funce of	C.   G.   K.   D.PROCE	DURES, SERVICES, OR SUPE ain Unusual Circumstances)		22. RESUBMISSION CODE A 99 23. PRIOR AUTHORIZATION	4090145678600 NUMBER	J. ENDERING SVIDER ID. #
L         367.1         B.           I         F.           J.         J.           I.         J.           From         To           To         YY           M. DD         YY           MM         DD           YY         Service	C G K D.PROCEI (Expl	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS	22. RESUBMISSION CODE A 99 23. PRIOR AUTHORIZATION I 423499889 F. Question	4090145678600 NUMBER	ENDERING
1         1         B.	C. L G. L K. L D.PROCEI (Expl CPT/HCP	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS POINTER	22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES UNTS	4090145678600 NUMBER H. I. Factor ID. Factor ID. Factor PRC	ENDERING
L         367.1         B.           I         F.           J.         J.           I.         J.           From         To           To         YY           M. DD         YY           MM         DD           YY         Service	C. L G. L K. L D.PROCEI (Expl CPT/HCP	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS POINTER	22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES UNTS	4090145678600 NUMBER H. I. RE Frent D. RE Frent C.M. PRC	ENDERING
L         367.1         B.           E         F.	C. L G. L K. L D.PROCEI (Expl CPT/HCP	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS POINTER	22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES UNTS	4090145678600 NUMBER H. T. B. RE Perform OLAL PRO NPI	ENDERING
1         1         B.	C. L G. L K. L D.PROCEI (Expl CPT/HCP	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS POINTER	22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES UNTS	4090145678600 NUMBER H. I. Prest ID. Prest QUAL PRC NPI	ENDERING
1         1         B.	C. L G. L K. L D.PROCEI (Expl CPT/HCP	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS POINTER	22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES UNTS	4090145678600 NUMBER H. T. B. RE Perform OLAL PRO NPI	ENDERING
L         367.1         B.           I         F.           J.         J.           I.         J.           From         To           To         YY           M. DD         YY           MM         DD           YY         Service	C. L G. L K. L D.PROCEI (Expl CPT/HCP	DURES, SERVICES, OR SUPPLI ain Unusual Circumstances) CS MODIFIER	ES E. DIAGNOSIS POINTER	22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES UNTS	4090145678600 NUMBER Prest L. Prest Cull. PRC NPI	ENDERING
A. j 367.1     B. j	с. <u> </u> G. <u> </u> К. <u> </u> D. PROCE (Есри) (СРТ/НСР/ V2102     	D.     D.     H.     L     DURES, SERVICES, OR SUPPLI ain Unusual Circumstances      S     MODIFIER      RT   LT       I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I     I	ES E. DIAGNOSIS POINTER A	22. RESUBILISSION CODE 23. REIOR AUTHORIZATION I 423499889 F. DAYS \$ CHARGES 80  00 2	4090145678600 NUMBER H. T. D. RE PROT D. PRO NPI NPI NPI NPI NPI	INDERING VIDER ID. #
A <u>1</u> 367.1 B. <u></u> E. <u></u> F. <u></u> 4. A. DATE(S) OF SERVICE From DD YY MM DD YY SERVICE EMG 33 31 14 03 31 14 11 1	C. L G. L K. L D.PROCEI (Expl CPT/HCP	CCOUNT NO.     D.     D.     D.     D.     C.     D.     D.     C.     D.     D.     D.     C.     D.     D.     D.     C.     D.     D.	ES E DIAGNOSIS POINTER A	22. RESUBILISSION A 99 23. RFIOR AUTHORIZATION I 423499889 F. DAYS 80 00 2 80 00 2 28. TOTAL CHARGE :	4090145678600 NUMBER H. T. D. RE PROT D. PRO NPI NPI NPI NPI NPI	ENDERING
A. 367.1     B	C. L G. L K. L (PPROCE (Epp) (PT/HCP) V2102	D. [	ES E DIAGNOSIS POINTER A I I I I I I I I I I I I I I I I I I	22. RESUBILISSION CODE CODE 23. RFIOR AUTHORIZATION I 423499889 F. SAYS S CHARGES 80  00 2 28. TOTAL CHARGE S 80 00	4090145678600 NUMBER H. T. D. RE Perform QUAL PRO NPI NPI NPI NPI NPI NPI NPI 29. AMOUNT PAID 30. E \$ \$ \$ \$	
A <u>1367 . 1</u> B. <u></u> E. <u></u> F. <u></u> 4. A. DATE(S) OF SERVICE From DD YY MM DD YY SERVICE EMG 33 31 14 03 31 14 11 33 31 14 03 31 14 11 5. FEDERAL TAX I.D. NUMBER SSN EIN 26. 5. SIGNATURE OF PHYSICIAN OR SUPPLIER 32.	C. L G. L K. L (PPROCE (Epp) (PT/HCP) V2102	CCOUNT NO.     D.     D.     D.     D.     C.     D.     D.     C.     D.     D.     D.     C.     D.     D.     D.     C.     D.     D.	ES E DIAGNOSIS POINTER A I I I I I I I I I I I I I I I I I I	22. RESUBILISSION A 99 23. RFIOR AUTHORIZATION I 423499889 F. DAYS S CHARGES 80  00 2 20. TOTAL CHARGE S 80 00 33. BILLING PROVIDER INFO	4090145678600 NUMBER H. I. R. Prest D. R.	
A. 1367.1     B	C. L G. L K. L (PPROCE (Epp) (PT/HCP) V2102	D. [	ES E DIAGNOSIS POINTER A I I I I I I I I I I I I I I I I I I	22. RESUBILISSION A 99 23. RFIOR AUTHORIZATION I 423499889 F. BAYS 80  00 2 80  00 2 80  00 2 80  00 2 80  00 3 80  00 3 80	4090145678600 NUMBER H. I. R. Prest D. R.	
A <u>367 . 1</u> E <u>5. FEDERAL TAX LD. NUMBER</u> S. IGNATURE OF PHYSICIAN OR SUPPLIER <b>1.</b> <u>1.</u> <u>1.</u> <u>1.</u> <u>1.</u> <u>1.</u> <u>1.</u> <u>1.</u> <u>1.</u>	C. L G. L K. L (PPROCE (Epp) (PT/HCP) V2102	D. [	ES E DIAGNOSIS POINTER A I I I I I I I I I I I I I I I I I I	22. RESUBILISSION A 99 23. RFIOR AUTHORIZATION I 423499889 F. DAYS S CHARGES 80  00 2 20. TOTAL CHARGE S 80 00 33. BILLING PROVIDER INFO	4090145678600 NUMBER H. T. D. RE PROT D	

EALTH INSURANCE CLAIM FOR	RM								
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NU	JCC) 02/12								
PICA									PICA
MEDICARE MEDICAID TRICARE	CHAMPV	A GROL			ER 1a. INSURED'S	I.D. NUMBER		(Fo	or Program in lilem 1)
(Medicare#) (Medicald#) (ID#/DoD#)	(Member 8	D#) (ID#)	(HL	X8) (IDN)	12				
PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S		SEX	4. INSURED'S N	IAME (Last Na	me, Aral	Name, Middl	le initiel)
PATIENT'S ADDRESS (No., Street)			RELATIONSHIP T		7. INSURED'S A		Otreat)	_	
TAILET SADALLIS (I, Steel)			Bpouse Chik		r. Indoneb o A	10011200 (110.)	, or doly		
TY	STATE		D FOR NUCC US		CITY		<		STATE
							1		
P CODE TELEPHONE (Include Area C	Code)				ZIP CODE		TEL	EPHONE (Inc	dude Area Code)
( )									
OTHER INSURED'S NAME (Last Name, First Name, Middle I	nitial)	10. IS PATIEN	IT'S CONDITION	RELATED TO:	11. INSURED'S	POLICY GROU	JP OR F	ECA NUMBE	R
OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYM	ENT? (Current or	Previous)	A. INSURED'S D	ATE OF BIRT	-		SEX
			YES	NO	MM	DD YY		M	F
RESERVED FOR NUCC USE		b. AUTO ACC		PLACE (Stat	a) b. OTHER CLAI	M ID (Designat	ed by N	UCC)	
			YES	NO			2	- and the second	
RESERVED FOR NUCC USE		G. OTHER AC	- tool		C. INSURANCE	PLAN NAME C	R PROC	BRAM NAME	
INSURANCE PLAN NAME OR PROGRAM NAME		101 CLAIN C	YES ODES (Designation	4	d. IS THERE AN	OTHER HEAL	TH BEN	FEIT PLAN?	
			1		YES	NO			ms 9, 9a, and 9d.
READ BACK OF FORM BEFORE CO	MPLETING	A SIGNING T	HIS FORM.		13. INSURED'S		ED PEP	SON'S SIGN	ATURE I authorize
to process this claim. I also request payment of government be	uthorize the nailte alther	to myself or to t	he party who acce	ormation necessary pla assignment	payment of n services deal	redical benefits cribed below.	to the u	nderalgned p	hyaiclan or supplier for
below.		11							
SIGNED	1 3	DAT	E	and the second s	SIGNED				
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (	MP) 15.9	OTHER DATE		107	16 DATES PAT	IENT UNABLE	TO WO	RK IN CURRE	
	1 ou	AL	MM	y yy	MM	1 DO 1			
QUAL	QU			, , , , , , , , , , , , , , , , , , ,	FROM			то	
QUAL	178			, .w	FROM			то	
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a 17b	•			18. HOSPITALIZ			то	RENT SERVICES
. NAME OF REFERRING PROVIDER OF OTHER SOURCE	(QQ) 17a 17b	ı. NPI			FROM 18. HOSPITALIZ MM FROM 20. OUTSIDE L/ YES	ATION DATES		TO ED TO CURP MM TO	RENT SERVICES
. NAME OF REFERRING PROVIDER OR OTHER SOURCE	(QQ) 17a 17b	i. NPI			18. HOSPITALIZ MM FROM 20. OUTSIDE L/	ATION DATES	YY	TO ED TO CURP MM TO	
. NAME OF REFERRING PROVIDER OF OTHER SOURCE	(QQ) 17a 17b	i. NPI			FROM 13. HOSPITALIZ MM FROM 20. OUTBIDE L/ VEB 22. RESUBMISS CODE	AB7  BD NO  SKON		TO ED TO CURP MM TO & CHARG	
DAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate	CLU 178 17b	i. NPI	24E) ICD Ind.		FROM 18. HOSPITALIZ MM FROM 20. OUTSIDE L/ YES	AB7  BD NO  SKON		TO ED TO CURP MM TO & CHARG	
	CLU 17a 17b A-L to serving C. L G. L K. L D. PROCE	tice line below (	24E) ICD Ind. — D. — H. — L. ICES, OR SUPPI		20. OUTSIDE L/ 20. OUTSIDE L/ 20. OUTSIDE L/ 22. FIESUBMISS 23. PRIOR AUTI		ORIG	TO ED TO CURP MM TO & CHARG	J.
A DATE(S) OF SERVICE A. DATE(S) OF SERVICE A. DATE(S) OF SERVICE C. PROMOLECULAR CONTRACTION (Designated by NUCC) CONSISTENT OF CONTRACTOR (CONTRACTOR OF CONTRACTOR O	CLU 17a 17b A-L to serving C. L G. L K. L D. PROCE	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICES, OR SUPPI		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURP MM TO & CHARG	2ENT SERVICES   DD   YY 3ES     DD   YY   DD   IV   DD   IV   DD   IV   DD   IV   DD   IV   DD   IV   DD
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURP TO \$ CHARG	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURP TO \$ CHARG	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate B. F. J. A. DATE(S) OF SERVICE B. C. From To PLACEOF	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURE TO MM TO & CHARC INAL REF. N R IL CUAL NPI	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURE TO TO & CHARC INAL REF. N }	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURE TO MM TO & CHARC INAL REF. N R IL CUAL NPI	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CUPE ITO ITO ITO ITO ITO ITO ITO ITO	J. RENDERING
A DATE(S) OF SERVICE A. DATE(S) OF SERVICE A. DATE(S) OF SERVICE C. PROMOLECULAR CONTRACTION (Designated by NUCC) CONSISTENT OF CONTRACTOR (CONTRACTOR OF CONTRACTOR O	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CUPE ITO ITO ITO ITO ITO ITO ITO ITO	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO TO TO A CHARG MM TO A CHARG INAL REF. N R IL ID QUAL NPI NPI NPI	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	ID TO CURE ED TO CURE MM TO MINAL REF. N IL IL CUAL NPI NPI	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	C. L A-L to servi C. L G. L D. PROCE (Expla	rice line below ( EDURES, SERV	24E) ICD Ind. — D. — H. — L. ICE8, OR BUIPS IMINETANCES)		FROM 18. HOSPITALIZ FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI 515		ORIG	TO ED TO CURE DTO MMM TO MAL REF. N R ID CUAL NPI NPI NPI	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC ADDITIONAL CLAIM INFORMATION (Designated by NUCC DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate B	CLL 17a 17b 0 AL to serv C. L G. L K. L D. PROCE (Equation of the service of the servic	rice line below ( EDURES, SERV	24E) ICD Ind.		FROM FROM FROM FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI F. SIS R \$ CHARGES			TO TO TO A CHARG MM TO A CHARG INAL REF. N R IL ID QUAL NPI NPI NPI	J. RENDERING
ADDITIONAL CLAIM INFORMATION (Designated by NUCC ADDITIONAL CLAIM INFORMATION (Designated by NUCC DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate B	CLL 17a 17b 0 AL to serv C. L G. L K. L D. PROCE (Equation of the service of the servic	tice line below ()	24E) ICD Ind.		FROM FROM FROM FROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI F. SIS R \$ CHARGES			NPI NPI NPI NPI	
CUAL     OUAL	ALL to serving the serving of the se	COUNT NO.	24E) ICD Ind.		FROM 18. HOSPITALIZ 18. HOSPITALIZ PROM 20. OUTSIDE L/ YES 22. RESUBMISS 23. PRIOR AUTI F. SIS CODE SIS CHARGES CHARGES 24. TOTAL CHA		RELAT	NPI NPI NPI NPI	
GUAL     GUAL     ADDITIONAL CLAIM INFORMATION (Designated by NUCC     ADDITIONAL CLAIM INFORMATION (Designated by NUCC     DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate     B     Fr.     J.     A. DATE(S) OF SERVICE     B     C.     FROM     DD YY MM DD YY SERVICE     BC     FROM     DD YY MM DD YY SERVICE     BC     J.     J.     SIGNATURE OF PHYSICIAN OR SEN LIN     SIGNATURE OF PHYSICIAN OR GREDENTIAL	ALL to serving the serving of the se	COUNT NO.	24E) ICD Ind. — D. — H. LCES, OR SUPPI IMODIFIER MODIFIER 27. ACCE 27. ACCE YES		FROM           18. HOSPITALIZ           PROM           20. OUTSIDE L/           YEB           22. RESUBMISS           23. PRIOR AUTI           F.           SIS           \$ CHARGES           21. OUTAL CHARGES		RELAT	NPI NPI NPI NPI	
GUAL	ALL to serving the serving of the se	COUNT NO.	24E) ICD Ind. — D. — H. LCES, OR SUPPI IMODIFIER MODIFIER 27. ACCE 27. ACCE YES		FROM           18. HOSPITALIZ           PROM           20. OUTSIDE L/           YEB           22. RESUBMISS           23. PRIOR AUTI           F.           SIS           \$ CHARGES           21. OUTAL CHARGES		RELAT	NPI NPI NPI NPI	