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CHAPTER 46: VISION (EYE-WEAR) SERVICES

APPENDIX C: CLAIMS FILING

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CLAIMS FILING

Hard copy billing of vision (eyewear) services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields may be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Molina Medicaid Solutions P.O. Box 91020 Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center", sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

LOUISIANA MEDICAID PROGRAM	ISSUED:	09/29/15
	REPLACED:	05/12/14

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This appendix includes the following:

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

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

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CMS 1500 (02/12) INSTRUCTIONS FOR VISION SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the 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 must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are	ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter
		attached to the claim.	dashes, hyphens,

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Locator #	Description	Instructions	Alerts
			or the word TPL in the field.
			NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE.
9b	RESERVED FOR NUCC USE	Leave Blank.	
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 FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	

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Locator #	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	Leave Blank.	
17a	Unlabeled	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	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. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.c om).

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

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24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Leave Blank.	
241	I.D. Qual.	Optional. 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.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28			
	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Total Charge Amount Paid	Required – Enter the total of all charges listed on the claim. 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.	

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31	Signature of Physician or Supplier Including Degrees or Credentials	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	Unlabeled	Situational – Complete as appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	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.

Sample forms are on the following pages

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SAMPLE VISION CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES OF SERVICE ON OR BEFORE 10/01/15)

9(常国 数 2 数							
HEALTH INSURAN	ICE CLAIM FORM	И					
PPROVED BY NATIONAL UN	FORM CLAIM COMMITTEE (NUCC) 02/12					
PICA							PICA
. MEDICARE MEDICA		CHAMPVA	HEALT	P TH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaio		(Member ID			(ID#)	(ID#)	1234567890123
. PATIENT'S NAME (Last Nar	ne, First Name, Middle Initial)		3. PATIENT'S				4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Adalam, Mary				1 0		FΧ	7. INSURED'S ADDRESS (No., Street)
PATIENT'S ADDRESS (No.,	Street)			Spouse	ISHIP TO INSU Child	Other	/. INSURED SADDRESS (No., Steet)
ΠY		STATE	8. RESERVE	FOR NU	CC USE		CITY STATE
IP CODE	TELEPHONE (Include Area	a Code)					ZIP CODE TELEPHONE (Indude Area Code)
	()						()
OTHER INSURED'S NAME	(Last Name, First Name, Midd	lle Initial)	10. IS PATIE	NT'S CON	NDITION RELA	TED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLIC	Y OR GROUP NUMBER		a. EMPLOYM	IENT? (Cu	rrent or Previo	us)	a. INSURED'S DATE OF BIRTH SEX
PL Code if applicab	le			YES	NO		MM DD YY M F
RESERVED FOR NUCC US			b. AUTO ACC	DIDENT?	P	LACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
			C/	1 s			
RESERVED FOR NUCC US	E		c. OR.AC	CODEN.	IFL		c. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME (OR PROGRAM NAME		10d. RESERV	YES VED FOR	LOCAL USE		d IS THERE ANOTHER HEALTH BENEFIT PLAN?
		·XA	MP	'LE		F IC	NO If yes, complete items 9, 9a and 9d.
PATIENT'S OR AUTHORIZ to process this claim. I also re	D BACK OF FORM BEFORE ED PERSON'S SIGNATURE equest payment of government	I authorize the r	release of any	medical o	l. r other informal ho accepts assi	ion necessary	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED			DAT	E			SIGNED
DATE OF CURRENT ILLNE	ESS, INJURY, or PREGNANC	Y (LMP) 15.01	THER DATE	ММ	, DD , Y	Υ	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY
NAME OF REFERRING PE	QUAL.	QUA E 17a.					FROM TO TO TO THE PROPERTY OF
			NPI				FROM TO TO
). ADDITIONAL CLAIM INFO	RMATION (Designated by NU	CC)					20. OUTSIDE LAB? \$ CHARGES
. DIAGNOSIS OR NATURE (OF ILLNESS OR INJURY F	Relate A-L to sen	vice line below	(24E)	ICD Ind. 9		YES NO 22. RESUBMISSION CODE ORIGINAL REF. NO.
367.1	B.	C.			D. J		CODE ORIGINAL REF. NO.
	F.	G.			н. [23. PRIOR AUTHORIZATION NUMBER
	J	К.			L		423499889
From IM DD YY MM	TO PLACE OF DD YY SERVICE EMG	(Expla	DURES, SER\ ain Unusual C CS I		ces)	E. DIAGNOSIS POINTER	F. G. H. I. J. DAYS BEDI ID. RENDERING OR Family \$ CHARGES UNITS Find QUAL PROVIDER ID. #
		V2102				А	72 00 2 NPI
3 31 14 03	31 14 11	V2102	KI	LT		A	12 00 2 14-1
3 31 14 03	31 14 11	V2020)	Ш		Α	16 00 1 NPI
							NPI
							NPI NPI
<u> </u>	1	<u> </u>		<u> </u>			
							NPI
							NPI NPI
5. FEDERAL TAX I.D. NUMBE	ER SSN EIN 2	6. PATIENT'S A	CCOUNT NO.	. 27	. ACCEPT ASS (For govt. claims,	IGNMENT? see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
				>	. ACCEPT ASS (For govt. claims, YES	IGNMENT? see back) NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 88 00 \$ \$
I. SIGNATURE OF PHYSICIA INCLUDING DEGREES OR (I certify that the statements	IN OR SUPPLIER 3: CREDENTIALS on the reverse	6. PATIENT'S A		>	X YES	IGNMENT? see back) NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
. SIGNATURE OF PHYSICIA INCLUDING DEGREES OR	IN OR SUPPLIER 3: CREDENTIALS on the reverse			>	X YES	IGNMENT? see back) NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 88 00 \$ \$ \$ \$ 33. BILLING PROVIDER INFO & PH# (888) 222-3333 SEE CLEAR OPTICAL SHOPPE 123 MAIN ST
(I certify that the statements	IN OR SUPPLIER 3: CREDENTIALS on the reverse			TION INFO	X YES	IGNMENT? see back) NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 88 00 \$ \$ \$ \$ \$ 33. BILLING PROVIDER INFO & PH# (888) 222-3333 SEE CLEAR OPTICAL SHOPPE

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

PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA PICA
RECORD BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA
MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN BLIK LING (IDB) (IDB
Medicard # X Medicard # (IDMDOD#) Member ID# HEALTH PIAN BLK LING (ID#) 1234567890123
ATTENT'S NAME (Last Name, First Name, Middle Initial) DALAM, MARY 0.2 14 85 M F X 0. PATIENT'S ADDRESS (No., Street) 0. PATIENT'S ADDRESS (No., Street) 0. PATIENT RELATIONSHIP TO INSURED Set Spouse Child Other V STATE 0. PATIENT RELATIONSHIP TO INSURED S. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO. 11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S POLICY GROUP OR FECA NUMBER 13. RESERVED FOR NUCC USE 14. INSURED'S NAME (Last Name, First Name, Middle Initial) 15. TATE 27. INSURED'S ADDRESS (No., Street) 27. INSURED'S POLICY GROUP OR FECA NUMBER 28. CONTINUE INSURED'S POLICY GROUP OR FECA NUMBER 29. AUTO ACCIDENT? PLACE (State) D. OTHER CLAIM ID (Designated by NUCC) 29. OTHER INSURED'S POLICY GROUP NAME OR PROGRAM NAME 10. INSURED'S POLICY GROUP OR FECA NUMBER 20. AUTO ACCIDENT? PLACE (State) D. OTHER CLAIM ID (Designated by NUCC) 20. INSURANCE PLAN NAME OR PROGRAM NAME
DALAM, MARY 02 14 85 M F X ATIENT'S ADDRESS (No., Street) 0. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other Y STATE 0. RESERVED FOR NUCC USE CITY STATE 0. RESERVED FOR NUCC USE CITY STATE 0. INSURED'S ADDRESS (No., Street) CITY STATE CODE TELEPHONE (Include Area Code) () TELEPHONE (Include Area Code
ATTENT'S ADDRESS (No., Street) 6. PATTENT RELATIONSHIP TO INSURED Self Spouse Child Other Y STATE 8. RESERVED FOR NUCC USE CITY STATE 2IP CODE TELEPHONE (Include Area Code) () OTHER INSURED'S POLICY OR GROUP NUMBER PLESERVED FOR NUCC USE 10. IS PATTENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S POLICY GROUP OR FECA NUMBER 13. INSURED'S POLICY GROUP OR FECA NUMBER 14. INSURED'S POLICY GROUP OR FECA NUMBER 15. AUTO ACCIDENT? 16. AUTO ACCIDENT? 17. INSURED'S ADDRESS (No., Street) TELEPHONE (Include Area Code) () 17. INSURED'S ADDRESS (No., Street) TELEPHONE (Include Area Code) () 18. INSURED'S POLICY GROUP OR FECA NUMBER 19. INSURED'S DATE OF BIRTH SEX MM DO YES MM DO YES NO 19. OTHER CLAIMID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME
Self Spouse Child Other Y STATE S. RESERVED FOR NUCC USE CITY STATE S. RESERVED FOR NUCC USE CITY STATE CODE TELEPHONE (Include Area Code) () TELEPHONE (Include A
STATE 8. RESERVED FOR NUCCUSE CITY ZIP CODE TELEPHONE (Indiude Area Code) OTHER INSURED'S NAME (Last Name, First Name, Middle initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER OTHER INSURED'S POLICY OR GROUP NUMBER 2. EMPLOYMENT? (Current or Previous) YES NO 1. AUTO ACCIDENT? PLACE (State) D. AUTO ACCIDENT? C. CSACTIVIPLE Q. INSURANCE PLAN NAME OR PROGRAM NAME
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 DOTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) YES NO 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DO W M F D. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIMID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
DITHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? C. CSACTIVE PLE a. INSURED'S DATE OF BIRTH SEX MM DO W M F D. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
DITHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? C. SACTIVE PLE A. INSURED'S DATE OF BIRTH SEX MM DO MM F D. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
PLOCE of if applicable YES NO D. AUTO ACCIDENT? PLACE (State) D. AUTO ACCIDENT? PLACE (State) D. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
PLOCE of if applicable YES NO D. AUTO ACCIDENT? PLACE (State) D. AUTO ACCIDENT? PLACE (State) D. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
PL Code if applicable YES NO D. AUTO ACCIDENT? PLACE (State) D. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
ESERVED FOR NUCC USE a. SATIPLE a. INSURANCE PLAN NAME OR PROGRAM NAME YES NO
YES NO
YES NO
YES NO NSURANCE PLAN NAME OR PROGRAM NAME 104 RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
NSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BE ORE OUT STATE IN NO GIFTIS DRIVE OF TOWNS SEP S OR A DEVELOP END FOR SIGNATURE I authorize
READ BACK OF FORM BE ORE OFF on CALL MILEGIBLE BAND. PATIENTS OR AUTHORIZED PERSONS SIGNATURE: I authorize the release of any medican or other information recessary to process the claim. I also require payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE SIGNED
DATE OF CURRENT ILLNESS, INJURY, OF PREGNANCY (LMP) 15.0THER DATE MM DD YY 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 18. HOSPITAL CATION DATES RELATED TO CURRENT SERVICES 17b NPI FROM TO F
. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES
YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 22. RESUBMISSION CODE ORIGINAL REF. NO.
. H5203 B. C. C. D. C. C. D. C.
F G H 23. PRIOR AUTHORIZATION NUMBER Prior Auth # if applicable
V. 10
A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES From To PLACEOF (Explain Unusual Croumstance) M. DD YY MM DD YY SERVICE EMG CPTA/CPCS MODIFIER POINTER \$ CHARGES UNTS FINE OWAL PROVIDER ID.
0 08 15 10 08 15 11 V2020 A 75 00 1 NPI
0 08 15 10 08 15 11 V2207 LT A 70 00 1 NPI
0 08 15 10 08 15 11 V2208 RT A 70 00 1 NPI
0 08 15 10 08 15 11
NPI NPI
NPI NPI
FEDERAL TAX LD. NUMBER SSN EIN 29. PATIENT'S ACCOUNT NO. 27. ACCEPT. ASSIGNMENT? (50 pyr. diam, seebaxl) 29. AMOUNT PAID 30. BALANCE D \$ 275 00 s \$ 275
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (888) 222-3333
INCLUDING DEGRESS OR CREDENTIALS (oratify that the satements on the tweste apply to this bill and are made a part thereof.) SEE CLEAR OPTIAL SHIPPE apply to this bill and are made a part thereof.)
ANY TOWN, LA 70000
ONED Ima Biller DATE 10/15/15 a. b. a. 1326547895 b. 1234567
JCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500

ISSUED:

REPLACED:

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ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

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

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

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Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

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

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Sample forms are on the following pages.

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SAMPLE VISION CLAIM FORM ADJUSTMENT FORM WITH ICD-9 DIAGNOSIS CODE (DATES OF SERVICE ON OR BEFORE 10/01/15)

] (常画 第2章		
EALTH INSURANCE CLAIM FORM		
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA
. MEDICARE MEDICAID TRICARE CHAMPV. (Medicare #) X (Medicaid #) (ID#DoD#) (Member I	HEALTH PLAN BLK LUNG	
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member I	D#) (ID#) (ID#) (ID#) 3. PATIENT'S BIRTH DATE SEX MM DD YY	1234567890123 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Adalam, Mary	06 11 00 M FX	,
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
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UCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02-12

ISSUED: 09/29/15 REPLACED: 05/12/14

CHAPTER 46: VISION (EYE-WEAR) SERVICES

APPENDIX C: CLAIMS FILING PAGE(S) 15

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

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3000A								
HEALTH INSURANCE CLAIM FORM								
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CHAPTER 46: VISION (EYE-WEAR) SERVICES

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