

CLAIMS FILING

Vision (eyewear) services are billed on the CMS-1500 (08/05) claim form or electronically in the 837P transaction. Items to be completed are either **required** or **situational**.

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).

Claims should be submitted to:

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

This appendix includes the following:

- Sample CMS 1500 claim form and instructions; and
- Sample 213 Adjustment/Void form and instructions.

CHAPTER 46: VISION (EYE-WEAR) SERVICES**APPENDIX C: CLAIMS FILING****PAGE(S) 14****CMS 1500 (08/05) Claim Filing Instructions**

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 <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Required – 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	Optional – 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	Optional – Complete if appropriate or leave blank.	
7	Insured's Address	Optional – Complete if appropriate or leave blank.	
8	Patient Status	Optional.	
9	Other Insured's Name	Optional – Complete if appropriate or leave blank.	

CHAPTER 46: VISION (EYE-WEAR) SERVICES**APPENDIX C: CLAIMS FILING****PAGE(S) 14**

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient has no other coverage, leave blank.</p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files link).</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	
9b	Other Insured's Date of Birth Sex	Optional – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	Optional – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	Optional – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Optional – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Optional – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Optional – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	Optional – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	Optional – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Optional – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Optional – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Optional – Obtain signature if appropriate or leave blank.	

CHAPTER 46: VISION (EYE-WEAR) SERVICES**APPENDIX C: CLAIMS FILING****PAGE(S) 14**

Locator #	Description	Instructions	Alerts
14	Date of Current Illness / Injury / Pregnancy	Leave Blank.	
15	If Patient Has Had Same or Similar Illness Give First Date	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Leave Blank.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabelled	Situational – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is required to be entered.	
17b	NPI	Situational – If the recipient is linked to a Primary Care Physician, enter the referring provider's 10-digit NPI number	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Leave Blank.	
21	Diagnosis or Nature of Illness or Injury	Required - Enter the most specific, current ICD-9 numeric diagnosis code and, if desired, narrative description.	The most specific diagnosis code must be used.
22	Medicaid Resubmission Code	Leave Blank.	
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.	

CHAPTER 46: VISION (EYE-WEAR) SERVICES**APPENDIX C: CLAIMS FILING****PAGE(S) 14**

Locator #	Description	Instructions	Alerts
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).	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, 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	Required - Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Leave Blank.	
24I	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 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.	

CHAPTER 46: VISION (EYE-WEAR) SERVICES**APPENDIX C: CLAIMS FILING****PAGE(S) 14**

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	Optional – 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	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Required - The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. Required - Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or Leave blank.	
32a	NPI	Optional.	
32b	Unlabelled	Optional.	
33	Billing Provider Info	Required - Enter the provider name,	

CHAPTER 46: VISION (EYE-WEAR) SERVICES

APPENDIX C: CLAIMS FILING**PAGE(S) 14**

Locator #	Description	Instructions	Alerts
	& Ph #	address including zip code and telephone number.	
33a	NPI	Optional. – Enter the billing provider’s NPI number.	
33b	Unlabelled	Required – Enter the billing provider’s 7-digit Medicaid ID number.	

PAGE(S) 14

Example of Vision (Eye-Wear) claim form

VOIDS AND ADJUSTMENTS

Completing the 213 Adjustment/Void Form

The 213 adjustment/void form is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Molina Medicaid Solutions by calling Provider Relations at (800) 473-2783 or at www.lamedicaid.com using the Forms/Files/User Guides link. Instructions and an example of a completed 213 adjustment form are shown on the following pages.

If a claim has been paid using the 837P claim transaction, an adjustment or void may be submitted electronically or by using the Molina 213 adjustment/void form.

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

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

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

1. A claim is approved on the remittance advice dated 07/17/2010, ICN 0266156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2010, ICN 0035126742100.
3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (0035126742100) and RA date (12/11/2010) must be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of an adjustment appears within this document.

To file a void, the provider must enter all the information from the original claim exactly as it appeared on the original claim. When the void claim is approved, it will be listed under the "void" column of the RA and a corrected claim may be submitted (if applicable).

Filing Adjustments for a Medicare/Medicaid Claim

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

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should rebill Medicare for a corrected payment. These claims may “crossover” from Medicare to Medicaid, but cannot be automatically processed by Medicaid (as the electronic crossover claim appears to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy adjustment claim (Molina Form 213) with Medicaid. These should be sent to Molina Medicaid Solutions, Attention: Crossover Adjustments, P.O. Box 91023, Baton Rouge, LA 70821, and should have a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached. In addition, the provider should write “2X7” at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

Instructions for Completing the 213 Adjustment/Void form

- 1. REQUIRED** ADJ/VOID—Check the appropriate block
- 2. REQUIRED** Patient's Name
 - a. Adjust-Print the name exactly as it appears on the original claim if not adjusting this information.
 - b. Void-Print the name exactly as it appears on the original claim
- 3. REQUIRED** Patient's Date of Birth
 - a. Adjust-Print the date exactly as it appears on the original claim if not adjusting this information.
 - b. Void-Print the name exactly as it appears on the original claim.
- 4. REQUIRED** Medicaid ID Number-Enter the 13 digit recipient ID number.
- 5. Optional** Patient's Address and Telephone Number
 - a. Adjust-Print the address exactly as it appears on the original claim
 - b. Void-Print the address exactly as it appears on the original claim.
- 6. REQUIRED** Patient's Sex
 - a. Adjust- Print this information exactly as it appears on the original claim if not adjusting this information.
 - b. Void-Print this information exactly as it appears on the original claim.
- 7. Leave Blank** Insured's Name
- 8. Leave Blank** Patient's Relationship to Insured—
- 9. Optional** Insured's Group No.
- 10. Situational** Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank.
- 11. Leave Blank** Was Condition Related to

CHAPTER 46: VISION (EYE-WEAR) SERVICES

APPENDIX C: CLAIMS FILING**PAGE(S) 14**

- 12. Leave Blank** Insured's Address
- 13. Leave Blank** Date of
- 14. Leave Blank** Date First Consulted You for This Condition
- 15. Leave Blank** Has Patient ever had same or Similar Symptoms
- 16. Leave Blank** Date Patient Able to Return to Work
- 17. Leave Blank** Dates of Total Disability-Dates of Partial Disability
- 18. Leave Blank** Name of Referring Physician or Other Source
- 18a. Situational** Referring ID Number - Enter the Community CARE authorization number if applicable or leave blank.
- 19. Leave Blank** For Services Related to Hospitalization Give Hospitalization Dates
- 20. Leave Blank** Name and Address of Facility Where Services Rendered
(if other than home or office)
- 21. Leave Blank** Was Laboratory Work Performed Outside of Office—Leave blank
- 22. REQUIRED** Diagnosis of Nature of Illness
- a. Adjust-Print the information exactly as it appears on the original claim if not adjusting the information.
- b. Void-Print the information exactly as it appears on the original claim.
- 23. Situational** Attending Number—Enter the attending number submitted on original claim, if any, or leave this space blank
- 24. Situational** Prior Authorization #—Enter the PA number if applicable or leave blank.
- 25. REQUIRED** A through F
- a. Adjust-Print the information exactly as it appears on the original claim if not adjusting the information.
- b. Void-Print the information exactly exactly as it appears on the original claim.
- 26. REQUIRED** Control Number—Print the correct Control Number as shown on the remittance advice.

CHAPTER 46: VISION (EYE-WEAR) SERVICES

APPENDIX C: CLAIMS FILING**PAGE(S) 14**

- 27. REQUIRED** Date of remittance advice that Listed Claim was paid—Enter MM DD YY from RA form.
- 28. REQUIRED** Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.
- 29. REQUIRED** Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary
- 30. REQUIRED** Signature of Physician or Supplier—All Adjustment/Void forms must be Signed.
- 31. REQUIRED** Physician's or Supplier's Name, Address, Zip Code and Telephone Number— enter the requested information appropriately plus the seven (7) digit Medicaid provider number and provider NPI number.
- 32. Optional** Patient's Account Number—Enter the patient's provider-assigned account number.

***REQUIRED** items must be completed or form will be returned.

CHAPTER 46: VISION (EYE-WEAR) SERVICES

APPENDIX C: CLAIMS FILING

PAGE(S) 14

MAIL TO:
MOLEHA
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2733
924-3345 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING CLAIM FORM
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1. ☒ ADJ. ☐ VOID

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
Adalam, Mary

3. PATIENT'S DATE OF BIRTH
06/11/05

4. MEDICAID ID NUMBER
1234567891234

5. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

6. PATIENT'S SEX
MALE ☐ FEMALE ☒

7. INSURED'S NAME

8. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

9. INSURED'S GROUP NO. (OR GROUP NAME)

10. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

11. TELEPHONE NO.
060606

12. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR IDENTIFICATION NUMBER

13. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ NO ☐
B. AN AUTO ACCIDENT
YES ☐ NO ☐

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (MFP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. DATE PATIENT ABLE TO RETURN TO WORK

17. DATES OF TOTAL DISABILITY
FROM THROUGH

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

19. REFERRING ID NUMBER

20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

21. DIAGNOSIS OR NATURE OF ILLNESS - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1-11, OR ICD CODE

22. ATTENDING NUMBER

23. PROC. AUTHORIZATION NO. **123456789**

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