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.

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 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 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.	

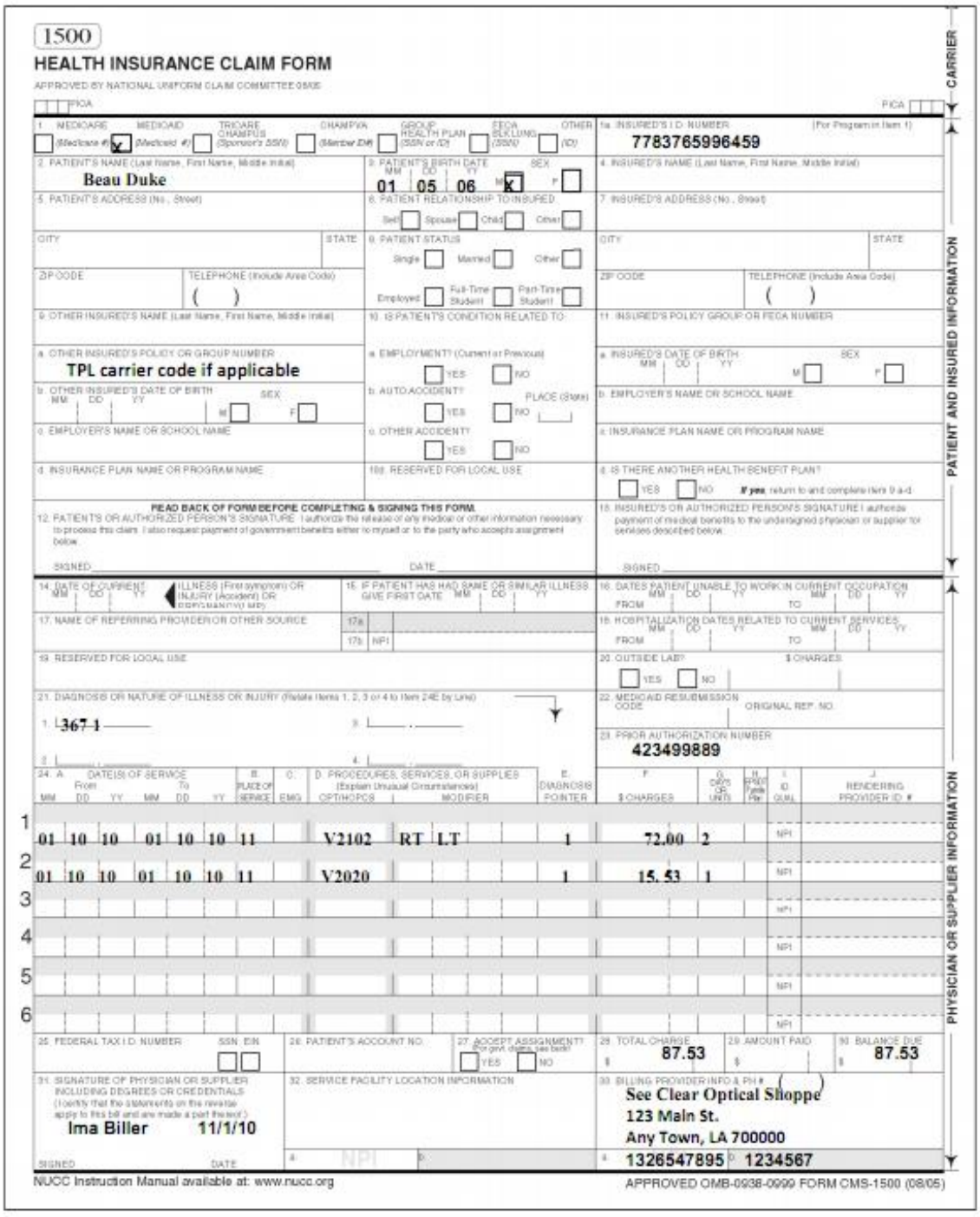
Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
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.	

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.**	

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.**	

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,	

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.	



1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 7783765996459
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beau Duke
3. PATIENT'S BIRTH DATE: 01 05 06 SEX: M [X] F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY / STATE
9. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL carrier code if applicable
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX
b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

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

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a
17b NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 367.1
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 423499889

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 10 10	01 10 10	11		V2102	RT LT	1	72.00	2		NPI	
2 01 10 10	01 10 10	11		V2020		1	15.53	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 87.53
29. AMOUNT PAID $
30. BALANCE DUE $ 87.53
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Ima Biller 11/1/10
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH #
See Clear Optical Shoppe
123 Main St.
Any Town, LA 700000
a. 1326547895 b. 1234567

NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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

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.

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.

MAIL TO:
MOLINA
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5340 (IN BATON ROUGE)

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

FOR OFFICE USE ONLY

1. ADJ. X 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 NUMBER: 1234567891234
5. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6. PATIENT'S SEX: MALE / X FEMALE
7. INSURED'S NAME
8. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
9. INSURED'S GROUP NO. (OR GROUP NAME)
10. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAID/SSN/HIC NUMBER: 060606
11. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES / NO
B. AN AUTO ACCIDENT YES / NO
12. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14. DATE FIRST CONSULTED YOU FOR THIS CONDITION
15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES / NO
16. DATE PATIENT ABLE TO RETURN TO WORK
17. DATES OF TOTAL DISABILITY FROM / THROUGH
DATES OF PARTIAL DISABILITY FROM / THROUGH
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A. REFERRING ID NUMBER
19. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED / DISCHARGED
20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21. WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES / NO CHARGES
22. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR 4. DX CODE.
1 367 1
2
3
23. ATTENDING NUMBER
23. PRIOR AUTHORIZATION NO.: 123456789

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	EPSDT/ FAMILY PLAN	TRL $
04	16	10	04	16	10	11	V2025	1	65 00	1		45.00

25. CONTROL NUMBER: 0300062103200
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 11/09/2010

26. REASONS FOR ADJUSTMENT
01 THIRD PARTY LIABILITY RECOVERY
02 PROVIDER CORRECTIONS
03 FISCAL AGENT ERROR
X 90 STATE OFFICE USE ONLY - RECOVERY
99 OTHER - PLEASE EXPLAIN
Private insurance paid

ADJUSTMENT

28. REASONS FOR VOID
10 CLAIM PAID FOR WRONG RECIPIENT
11 CLAIM PAID TO WRONG PROVIDER
99 OTHER - PLEASE EXPLAIN

29. SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Ima Biller 6/01/2010
30. YOUR PATIENT'S ACCOUNT NUMBER

31. PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
GLASSES R US
123 Smiley St.
Sunny, LA 70000
Provider# 9999999 1234567898

MOLINA - 213
5/97

FISCAL AGENT COPY