

CLAIMS FILING

This appendix contains the following information:

- Instructions for billing using the CMS-1500 Claim Form
- Samples of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim
- Samples of a CMS-1500 Claim Form Adjustment
- Instructions for billing using the ADA Dental Claim Form
- Sample of the ADA Dental Claim Form
- Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form
- Sample of the 209 Adjustment/Void Form
- Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form
- Sample of the 210 Adjustment/Void Form

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CMS 1500 (02/12) Billing Instructions for FQHC Services

Hard copy billing of FQHC services are 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 will 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 website at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

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) Billing Instructions for FQHC 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 I.D. 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	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). 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	Leave Blank.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

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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 commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. This carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
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	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
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	<p>Situational – Complete if applicable.</p> <p>In the following circumstances, entering the name of the appropriate physician block is required:</p> <p>If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.</p>	
17a	Unlabeled	Leave Blank.	
17b	NPI	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

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Locator #	Description	Instructions	Alerts
21	<p>ICD Indicator</p> <p>Diagnosis or Nature of Illness or Injury</p>	<p>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.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>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</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.</p> <p>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.com).</p>
22	Resubmission Code	<p>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.</p> <p>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.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>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).</p> <p>To adjust or void a claim, only the encounter line should be adjusted/voided since all payment is made on this line. The internal control number of the encounter line is used.</p>

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Locator #	Description	Instructions	Alerts
23	Prior Authorization (PA) Number	Situational – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the 9 digit numeric PA number is required to be entered.	
24	Supplemental Information	<p>Situational – Applies to the detail lines for drugs and biologicals only.</p> <p><u>CURRENTLY, THIS IS NOT A REQUIREMENT FOR FOHC PROVIDERS.</u></p> <p>In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and shall be entered in the shaded section of 24A through 24G. <u>Claims for these drugs shall include the NDC from the label of the product administered.</u></p> <p>To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the 11-digit NDC. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.</p> <p>Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.</p> <p>The following qualifiers are to be used when reporting NDC units:</p> <p>F2 International Unit ML Milliliter GR Gram UN Unit</p>	FOHCs who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s)
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.	

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Locator #	Description	Instructions	Alerts
24C	EMG	Situational – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered.</p> <p>Enter the appropriate encounter procedure code on the first line.</p> <p>Encounter Codes:</p> <ul style="list-style-type: none"> • FOHC encounter visit: T1015 • FOHC obstetrical service: T1015 w/TH modifier. • FOHC EPSDT service: T1015 w/EP modifier. <p>In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.</p>	<p>If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.</p> <p>For claims involving TPL, a claim line with the encounter code and the encounter rate must be added to the claim.</p>
24E	Diagnosis Pointer	<p>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A" "B", etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
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	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional.	
24J	Rendering Provider I.D. #	<p>Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required.</p> <p>Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.</p>	
25	Federal Tax I.D. Number	Optional.	

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Locator #	Description	Instructions	Alerts
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	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.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Optional.	
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> appear on paper claims.


Sample forms are on the following pages

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Sample of FQHC CMS-1500 Claim Form with ICD-9 Diagnosis Code
(Dates BEFORE 10/1/15)

 **HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE		3. PATIENT'S BIRTH DATE MM DD YY 06 19 85 M F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER (Specify) 10d. RESERVED FOR LOCAL USE YES NO	
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. SIGNED DATE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 10a and 10d	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. QUAL 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 9 A. V250.1 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PRIOR Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 03 02 14 03 02 14 11 T1015 A 150.00 1 NPI 1236548		1236548	
2 03 02 14 03 02 14 11 99213 A 00 1 NPI 1236548		1236548	
3 N400703680101 UN150.00 DEPO-ROVERA INJ 03 02 14 03 02 14 11 J0150 A 00 150 NPI 1236548		1236548	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe, MD DATE 3/9/14		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES NO	
32. SERVICE FACILITY LOCATION INFORMATION a. b.		28. TOTAL CHARGE \$ 150.00 29. AMOUNT PAID \$ 30. BALANCE DUE \$	
		33. BILLING PROVIDER INFO & PH # (225) 555-4957 Always Open RHC/FQHC 123 Main St Any Town, LA 70000 a. 1326547895 b. 1234567	

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Sample of FQHC CMS-1500 Claim Form with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE ID#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE										3. PATIENT'S BIRTH DATE (MM DD YY) 06 19 85 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPLE Code if applicable										a. EMPLOYMENT? (Current or Previous) YES NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES NO PLACE (State) STATE									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of my medical record 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										11. INSURED'S POLICY GROUP OR FECA NUMBER									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS or NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD-10 0										20. OUTSIDE LAB? YES NO \$ CHARGES									
A. Z30011 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTNER F. \$ CHARGES G. DAY'S OR UNITS H. SPRT/Rate Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
10 10 15 10 10 15 11 T1015 A 160 00 NPI 1236548										1236548									
10 10 15 10 10 15 11 99213 A 0 00 NPI 1236548										1236548									
N400703680101 UN150.00 DEPO-ROVERA INJ J1050 A 0 00 NPI 1236548										1236548									
10 10 15 10 10 15 11 10150 A 0 00 NPI 1236548										1236548									
										NPI									
										NPI									
										NPI									
										NPI									
										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claim, see back) X YES NO									
1234										28. TOTAL CHARGE \$ 160 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 160 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15										32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (800) 222-3333 ALWAYS OPEN RHC/FQHC CLINIC 123 MAIN ST ANY TOWN, LA 70000									


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Sample of a Claim Form



HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (IDM/DoD) (Member ID#) (ID#) (ID#) (ID#)</small>				1a. INSURED'S I.D. NUMBER (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY		STATE		CITY		STATE	
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY	
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, complete Items 9, 9a, and 9d.</small>	
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 _____							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL. MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)				ICD Ind. _____		22. RESUBMISSION CODE	
A. _____ B. _____ C. _____ D. _____				E. _____		ORIGINAL REF. NO. _____	
E. _____ F. _____ G. _____ H. _____				I. _____		23. PRIOR AUTHORIZATION NUMBER	
I. _____ J. _____ K. _____ L. _____				24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	
C. _____ D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE		C. _____ D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
E. DIAGNOSIS POINTER				F. \$ CHARGES		G. DAYS ON UNITS	
H. _____ I. _____ J. _____ K. _____ L. _____				M. _____ N. _____		O. _____ P. _____	
25. FEDERAL TAX I.D. NUMBER				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE				29. AMOUNT PAID		30. Bill for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	
SIGNED _____ DATE _____				a. NPI b. _____		c. NPI d. _____	

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Adjustments and Voids

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 internal 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.**

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.

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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 isare on the following pages

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Sample of FQHC CMS-1500 Claim Form Adjustment with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)



HEALTH INSURANCE CLAIM FORM

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

PICA		PICA								
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	2. MEDICAID (Medicaid #) <input checked="" type="checkbox"/>	3. TRICARE (ID#DoD#) <input type="checkbox"/>	4. CHAMPVA (Member ID#) <input type="checkbox"/>	5. GROUP HEALTH PLAN (ID#) <input type="checkbox"/>	6. FECA BLK LUNG (ID#) <input type="checkbox"/>	7. OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE				3. PATIENT'S BIRTH DATE MM DD YY 06 19 85		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()				6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? YES NO \$ CHARGES				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				22. RESUBMISSION CODE A 99 ORIGINAL REF. NO. 4090145678600						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 9 A. V2501 B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTNER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 02 14 03 02 14 11			T1015		A	150.00	1		NPI	1236548 1236549875
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE \$ 150.00	29. AMOUNT PAID \$	30. BALANCE DUE \$		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe, MD DATE 3/9/14		32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open RHC/FQHC 123 Main St Any Town, LA 70000 a. 1326547895 b. 1234567						

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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Sample of FQHC CMS-1500 Claim Form Adjustment with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

HEALTH INSURANCE CLAIM FORM		PICA	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE #) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		1234567890123	
3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
LOU, JANNIE			
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
TPL Code if applicable		YES NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? (Place (State))	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? (Place (State))	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I, the undersigned, hereby certify that the information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below.)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)	
DATE		b. OTHER CLAIM ID (Designated by NUCC)	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL.		c. INSURANCE PLAN NAME OR PROGRAM NAME	
15. OTHER DATE (MM DD YY) QUAL.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-L to service line below (24E) ICD-10 0		20. OUTSIDE LAB? \$ CHARGES	
A. Z30011 B. C. D. E. F. G. H. I. J. K. L.		YES NO	
24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE (EMG) C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-10 QUAL. J. RENDERING PROVIDER ID. #		22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 5299198798700	
10 10 15 10 10 15 11 T1015 A 160 00 NPI 1236548		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN		28. TOTAL CHARGE \$ 160 00	
26. PATIENT'S ACCOUNT NO. 1234		29. AMOUNT PAID \$	
27. ACCEPT ASSIGNMENT? (For grt. date, see back) X YES NO		30. BALANCE DUE \$ 160 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		33. BILLING PROVIDER INFO & PH# (800) 222-3333	
32. SERVICE FACILITY LOCATION INFORMATION		ALWAYS OPEN RHC/FQHC CLINIC	
SIGNED Ima Biller DATE 10/15/15		123 MAIN ST	
a. 1326547895		ANY TOWN, LA 70000	
b. 1234567			

NUCC Instruction Manual available at: www.nucc.org

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

ADA Claim Form Billing Instructions for FQHC Services

Medicaid EPSDT Dental and Adult Denture Program Services

The 2006 American Dental Association Claim Form is the only hardcopy dental claim form accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program or Adult Denture Program. These claim forms may be obtained by contacting the American Dental Association or your dental supply company.

The following billing instructions correspond to the 2006 ADA Claim Form.

Required information must be entered to ensure claims processing.

Situational information may be required only in certain situations as detailed in each instruction item.

Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form.

EPSDT Dental Program and Adult Denture Program claims should be submitted to:

Molina Medicaid Solutions
P. O. Box 91022
Baton Rouge, LA 70821

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APPENDIX D: CLAIMS FILING

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ADA Claim Form Billing Instructions for FQHC Services

Locator #	Description	Instructions	Alerts
1	Type of Transaction	<p>Required -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.</p> <p>Situational – Check box marked “EPSDT Title XIX” if patient is Medicaid eligible and under 21 years of age.</p> <p>If block is not checked, the claim will be processed as an adult claim.</p>	<p>If a claim is being submitted for payment, you must mark “Statement of Actual Services” in Block 1 of the claim form.</p> <p>Claims for payment that are sent to Molina Medicaid Solutions should never include radiographs.</p>
2	Predetermination / Preauthorization Number	Situational – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.	
3	Company / Plan Name, Address, City, State, Zip Code	Situational – Enter the primary payer information if applicable.	
4	Other Dental or Medical Coverage?	Situational – If yes, complete Block 9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	Situational.	
6	Date of Birth (MM/DD/CCYY)	Situational.	
7	Gender	Situational.	
8	Policyholder/Subscriber ID	Situational.	
9	Plan/Group Number	<p>Situational – Enter the third party's carrier code if a third party is involved.</p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block. This code is returned through MEVS recipient eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, www.lamedicaid.com.. (The carrier code list can be found at www.lamedicaid.com under the Forms/Files link)</p> <p>If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.</p>	

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Locator #	Description	Instructions	Alerts
10	Patient's Relationship to Person Named in #5	Situational.	
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	Situational.	
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Required -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS. Recipient's address is optional .	
13	Date of Birth (MM/DD/CCYY)	Required -- Enter the recipient's 8-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.	
14	Gender	Optional – Check appropriate block.	
15	Policyholder/Subscriber ID	Required -- Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the 16-digit Card Control Number (CCN) from the recipient's Medicaid card.	
16	Plan / Group Number	Situational.	
17	Employer Name	Situational.	
18	Relationship to Policyholder/Subscriber in #12 above.	Situational.	
19	Student Status	Situational.	
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Situational. This field should be used only when other private insurance is primary. Note: The Medicaid recipient's name is required to be entered in Block 12.	
21	Date of Birth (MM/DD/CCYY)	Situational.	
22	Gender	Situational.	
23	Patient ID / Account # (Assigned by Dentist)	Optional – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.	
24	Procedure Date (MM/DD/CCYY)	Required -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. A service must have been performed/delivered before billing Medicaid for payment.	

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Locator #	Description	Instructions	Alerts
25	Area of Oral Cavity	<p>Situational – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding oral cavity designator.</p> <p>If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter in Block 27.</p>	Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
26	Tooth System	Leave Blank	
27	Tooth Number(s) or Letter(s)	<p>Situational – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number or letter.</p> <p><u>If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator in Block 25.</u></p>	Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
28	Tooth Surface	<p>Situational – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes:</p> <ul style="list-style-type: none"> B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial, and O = Occlusal <p>Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.</p>	

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Locator #	Description	Instructions	Alerts
29	Procedure Code	Required – Enter the all inclusive encounter code (D0999) on the first line then enter the appropriate dental procedure codes from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.	REMINDER: The all-inclusive encounter code (D0999) must be entered on the first line of the claim form. Tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered.
30	Description	Required – Enter the description of the service performed.	
31	Fee	Required -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.	
32	Other Fee(s)	Leave Blank	
33	Total Fee	Required – Total of all fees listed on the claim form.	
34	(Place an 'X' on each missing tooth)	<p>Situational – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".</p> <p>In the following circumstances, this information is required:</p> <p>If the claim is for the Adult Denture Program.</p> <p>If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy.</p>	

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Locator #	Description	Instructions	Alerts
35	Remarks	<p>Situational – Enter the amount paid by the primary payor if block 9 is completed.</p> <p>Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [\$0] payment) in this block.</p> <p>Enter any additional information required by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include).</p> <p>For prior authorization requests, if the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.</p>	
36	Authorizations	Optional.	
37	Authorizations	Optional.	
38	Place of Treatment	<p>Situational – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48.</p> <p>If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is required.</p>	
39	Number of Enclosures	<p>Situational – Enter 00 to 99 in applicable boxes.</p> <p>Claims submitted for prior authorization are required to contain the identified attachments.</p> <p>Claims submitted for payment should not contain any of the attachments listed in Block 39.</p>	

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Locator #	Description	Instructions	Alerts
40	Is Treatment for Orthodontics?	Situational – Complete if applicable. Claims requesting comprehensive orthodontic services are required to enter information in this block. Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.	
41	Date Appliance Placed	Situational.	
42	Months of Treatment Remaining.	Situational.	
43	Replacement of Prosthesis	Situational – Check appropriate box if applicable; if checked, complete Block 44 if known.	
44	Date Prior Placement	Situational – If Block 43 is checked and if known, enter the appropriate 8-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	Situational – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is required . Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	Situational. If Block 45 is completed, then this block is required . Enter the eight-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	Situational. If Auto Accident is checked in Block 45, this block is required . Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	Required. Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group. Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	Optional – Enter the billing provider's 10-digit NPI number.	
50	License Number	Optional.	
51	SSN or TIN	Optional.	
52	Phone Number	Required -- Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	Required – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	
53	Signature	Optional.	

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Locator #	Description	Instructions	Alerts
54	NPI	Optional – Enter the 10-digit NPI of the treating (attending) dental provider	
55	License Number	Required – Enter the license number of the treating (attending) dental provider.	
56	Address, City, State, Zip Code	Situational – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.	
56A	Provider Specialty Code	Optional.	
57	Signature	Optional.	
58	NPI	Optional – Enter the 10-digit NPI of the treating (attending) dental provider	

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Sample of ADA Claim Form

ADA Dental Claim Form

MSA 07-02
Attachment 1

HEADER INFORMATION																																																																																										
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input checked="" type="checkbox"/> EPSDT/Title XIX																																																																																										
2. Predetermination/Prior Authorization Number 123456789																																																																																										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																																																																																										
3. Company/Plan Name, Address, City, State, Zip Code Brown, Wade 8269 Chilly Rd Winter, LA 70000																																																																																										
13. Date of Birth (MM/DD/YYYY) 08/14/2004																																																																																										
14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																										
15. Policyholder/Subscriber ID (SSN or ID#) 1234567890123																																																																																										
OTHER COVERAGE																																																																																										
4. Other Dental or Medical Coverage? <input checked="" type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																										
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																										
6. Date of Birth (MM/DD/YYYY)																																																																																										
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F																																																																																										
8. Policyholder/Subscriber ID (SSN or ID#)																																																																																										
9. Plan/Group Number TPL Carrier Code																																																																																										
10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																										
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																										
PATIENT INFORMATION																																																																																										
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																																																																																										
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PFS																																																																																										
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																										
21. Date of Birth (MM/DD/YYYY)																																																																																										
22. Gender <input type="checkbox"/> M <input type="checkbox"/> F																																																																																										
23. Patient ID/Account # (Assigned by Dentist)																																																																																										
RECORD OF SERVICES PROVIDED																																																																																										
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee																																																																																			
1 2/4/12					D0999	Encounter - All Inclusive	100.00																																																																																			
2 2/4/12	10				D4341	Periodontal Scaling and Root Planing	110.00																																																																																			
3 2/4/12			13		D2954	Post & Core	94.00																																																																																			
4 2/4/12			15		D2931	Stainless Steel Crown	140.00																																																																																			
5																																																																																										
6																																																																																										
7																																																																																										
8																																																																																										
9																																																																																										
10																																																																																										
MISSING TEETH INFORMATION																																																																																										
34. (Place an "X" on each missing tooth)																																																																																										
<table border="1"> <tr> <td colspan="16">Permanent</td> <td colspan="10">Primary</td> <td>32. Other Fee(s)</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										Permanent																Primary										32. Other Fee(s)	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	A	B	C	D	E	F	G	H	I	J																												
Permanent																Primary										32. Other Fee(s)																																																																
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	A	B	C	D	E	F	G	H	I	J																																																																	
33. Total Fee: 444.00																																																																																										
35. Remarks If TPL involved: write the words "Carrier Paid" and enter the amount paid by the TPL here.																																																																																										
AUTHORIZATIONS																																																																																										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.																																																																																										
X Patient/Guardian signature _____ Date _____																																																																																										
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.																																																																																										
X Subscriber signature _____ Date _____																																																																																										
ANCILLARY CLAIM/TREATMENT INFORMATION																																																																																										
38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																																										
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)																																																																																										
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																										
41. Date Appliance Placed (MM/DD/YYYY)																																																																																										
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																										
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																										
44. Date Prior Placement (MM/DD/YYYY)																																																																																										
45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																										
46. Date of Accident (MM/DD/YYYY)																																																																																										
47. Auto Accident State																																																																																										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																																																																																										
48. Name, Address, City, State, Zip Code XYZ Dental Group 8956 No Cavity Ave. Smiley, LA 70000																																																																																										
49. NPI 1987654321																																																																																										
50. License Number																																																																																										
51. SSN or TIN 1234567																																																																																										
52. Phone Number (222) 999-4444																																																																																										
53. Additional Provider ID 1234567																																																																																										
TREATING DENTIST AND TREATMENT LOCATION INFORMATION																																																																																										
54. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																																																																																										
X Dr. Mary Cleanteeth 3/20/12 Signed (Treating Dentist) Date																																																																																										
54. NPI 1234567890																																																																																										
55. License Number 99999																																																																																										
56. Address, City, State, Zip Code																																																																																										
57. Phone Number () -																																																																																										
58. Additional Provider ID 1987654																																																																																										

© 2005 American Dental Association
J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)To Reorder call 1-800-947-4746
or go online at www.adaclaiming.org

EPSDT Dental Services Adjustment/Void (209) and Adult Dental Services Adjustment/Void (210) Form

The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service.

Additionally, when submitting adjustments/voids for the Adult Denture Program for all dates of service, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04).

For both adjustment/void forms, the Form Locator 15 has been renamed as “Patient I.D./Account# Assigned by Dentist”. If the patient’s account (medical record) number is entered here, it will appear on the Medicaid Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

Providers can obtain these forms from Molina Medicaid Solutions or through the Louisiana Medicaid website at www.lamedicaid.com. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

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Instructions for Completing 209 Adjustment/Void Form (EPSDT)

Locator #	Description	Instructions	Alerts
1	Adj/Void	Check the appropriate box.	
2 3 4	Patient's Last Name First Name MI	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. Void - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
7	Date of Birth	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
8	Sex	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider No.	Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. Void - Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required	
19	Treatment Necessitated By	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**APPENDIX D: CLAIMS FILING****PAGE(S) 32**

Locator #	Description	Instructions	Alerts
20	Payment Source Other Than Title XIX	Adjust - Enter the information exactly as it appeared on the original invoice, unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. Void - Enter the information exactly as it appeared on the original invoice.	
21, 22		Leave these spaces blank.	
23	Diagram	Not required.	
24	Examination and Treatment Plan	Adjust - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted Void - Enter the information exactly as it appeared on the original invoice.	
25	Paid or Payable by Other Carrier	Adjust - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero (\$0). Void - Enter the information exactly as it appeared on the original invoice.	
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved.	
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for Prior Authorization	Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.	
32	Attending Dentist's Signature - Provider Number	The attending provider number must be entered in this field.	

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Molina Medicaid Solutions for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

PAGE(S) 32

Sample of 209 Adjustment/Void Form (EPSDT)

Patient ID/Account
Number

SAMPLE

FOR OFFICE USE ONLY

FOR PREAUTHORIZATION

MAIL TO:
USU SCHOOL OF DENTISTRY
MEDICID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT

REMIT TO:
Medica Medical Solutions
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 475-2783
(225) 924-5049

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
EPSDT DENTAL SERVICES

1 SEX
☒ M ☐ F

2 PATIENT'S LAST NAME (PRINT)

Smith

3 FIRST NAME

Sally

4 MI

L

5 MEDICAL ASSISTANCE CL NUMBER

1 2 3 4 5 6 7 8 9 0 1 2

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (RL NO.)

7 DATE OF BIRTH

02 15 2002

8 SEX

☐ M ☒ F

9 REFERRING AGENCY NO.

10 DATE OF REFERRAL

11 REFERRED FOR:

☐ EMERGENCY
☐ BASIC SCREENING

12 CONTROL OR GROUP REFERRED TO:

NAME

ADDRESS

TEL NO.

13 REFERRED BY (SIGNATURE)

14 TELEPHONE NO.

15 PATIENT IS / WOULD BE ASSIGNED BY IDENT

16 PAY TO: DENTIST OR GROUP

17 PAY TO: DENTIST OR GROUP PROVIDER NO.

1800000

18 ARE X-RAYS ENCLOSED?

☐ YES ☐ NO

19 NUMBER OF X-RAYS

20 PATIENT SOURCE OTHER THAN TITLE XIX

IN CARRIER CODE:

1.

2.

3.

21 IF RECEIPT, IS THIS THE FINAL PLACEMENT?

☐ YES

☐ NO

22 IF ADULT EMERGENCY SERVICE,
CHECK BLOCK AND SEND TO OPS DENTAL PROGRAM

☐

23 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	E. UNITS	F. DATE SERVICE PERFORMED MO. DAY YR.	G. ADJUSTED FEE (FOR STATE USE ONLY)	H. ORIGINAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown	02 16 12	02 16 12	135	00
IL			01			\$	
ORAL CAVITY							

24 CONTROL NUMBER

2061198765400

THIS IS FOR CHANGING OR VOIDING A FID
ITEM. (THE CORRECT CONTROL NUMBER AS
SHOWN ON THE REIMBURSEMENT ADVISE IS
NECESSARY.)

25 DATE OF REIMBURSEMENT ADVISE THAT
USED CLAIM WAS PAID:

03/16/2012

26 REASONS FOR ADJUSTMENT

☐ 01 THIRD PARTY LIABILITY RECOVERY
☒ 02 PROVIDER CORRECTIONS
☐ 03 FISCAL AGENT ERROR
☐ 90 STATE OFFICE USE ONLY - RECOVERY
☐ 99 OTHER - PLEASE EXPLAIN

Billed wrong tooth #. should
be tooth #16, not 15.

27 REASONS FOR VOID

☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☐ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

28 REQUEST FOR AUTHORIZATION - SEND TO OPS DENTAL PROGRAM

ATTENDING DENTIST'S SIGNATURE

29 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)

APPROVED - YES ☐ NO ☐ W/EXCEPTIONS ☐

PA 123456780

Dr. Joe Smiley, DDS

1888888 11/05/2012

PROVIDER NUMBER

DATE

AUTHORIZED SIGNATURE

DATE

PROVIDER NUMBER

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

PAGE(S) 32

Instructions for Completing 210 Adjustment/Void Form (Adult)

Locator #	Description	Instructions	Alerts
1	Adj/Void	Check the appropriate box.	
2 3 4	Patient's Last Name First Name MI	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. Void - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
7	Date of Birth	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
8	Sex	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider No.	Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. Void - Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required.	
19	Treatment Necessitated By	Adjust - Enter the information exactly as it appeared on the original invoice. Void - Enter the information exactly as it appeared on the original invoice.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

PAGE(S) 32

Locator #	Description	Instructions	Alerts
20	Payment Source Other Than Title XIX	Adjust - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. Void - Enter the information exactly as it appeared on the original invoice.	
21		Not required.	
22		Leave blank.	
23	A-G	Adjust - Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. Void - Enter the information exactly as it appeared on the original invoice.	
24	Paid of Payable by Other Carrier	Adjust - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero (\$0). Void - Enter the information exactly as it appeared on the original invoice.	
25	Other Information	Leave blank.	
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved.	
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for Prior Authorization	Enter the 9- digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.	
32	Attending Dentist's Signature - Provider Number	The attending provider number must be entered in this field.	

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Molina Medicaid Solutions for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

PAGE(S) 32

Sample of 210 Adjustment/Void Form (Adult)

FOR PREAUTHORIZATION MAIL TO: LSU SCHOOL OF DENTISTRY MEDICAID DENTAL PROGRAM 1105 FLORIDA AVE., BOX 570 NEW ORLEANS, LA 70119		FOR PAYMENT REMIT TO: Molina Medicaid Services P.O. BOX 91022 BAYON ROUGE, LA 70821 (504) 473-1700 (225) 924-5040		STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS BUREAU OF HEALTH SERVICES FINANCING MEDICAL ASSISTANCE PROGRAM PROVIDER BILLING FOR ADULT DENTAL SERVICES		Patient ID/Account Number	
SAMPLE							
1. AGE <input checked="" type="checkbox"/> ADULT <input type="checkbox"/> VOID		2. PATIENT'S LAST NAME (PRINT) Que		3. FIRST NAME Susie		4. MI L	
5. PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)				6. MEDICAL ASSISTANCE I.D. NUMBER 1 2 3 4 5 6 7 8 9 0 1 2 3			
7. DATE OF BIRTH 06 19 1955				8. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F			
9. REFERRING AGENCY NO.		10. DATE OF REFERRAL		11. DENTIST OR GROUP REFERRED TO: NAME _____ ADDRESS _____ TEL. NO. _____			
12. REFERRED BY: (SIGNATURE)		13. TELEPHONE NO.		14. PAY TO: DENTIST OR GROUP PROVIDER NO. 1800000			
15. NAME _____ ADDRESS _____ CITY _____ ST. _____ ZIP _____		16. TREATMENT NECESSITATED BY: A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. ACCIDENT/INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		17. ARE X-RAYS ENCLOSED? <input type="checkbox"/> YES <input type="checkbox"/> NO 18. PAYMENT SOURCE OTHER THAN TITLE XIX TRP CARRIER CODE: 1. _____ 2. _____ 3. _____			
19. IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		20. A. PROCEDURE CODE D0999		21. B. DESCRIPTION OF SERVICE Encounter All Inclusive		22. C. DATE SERVICE PERFORMED MO. 01 DAY 20 YEAR 12	
23. D. ADJUSTED FEE (FOR STATE USE ONLY) 125.00		24. E. USUAL AND CUSTOMARY FEE 125.00		25. F. ORAL CAVITY		26. G. TOOTH #	
27. (1) IS THE PATIENT EDENTULOUS? MAXILLARY: NO <input type="checkbox"/> YES <input type="checkbox"/> DATE OF LAST EXTRACTIIONS 11/11 MANDIBULAR: NO <input type="checkbox"/> YES <input type="checkbox"/> DATE OF LAST EXTRACTIIONS 11/11		28. (2) DOES PATIENT PRESENTLY WEAR A DENTURE? MAXILLARY: NO <input type="checkbox"/> YES <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> MO. _____ YR. _____ MANDIBULAR: NO <input type="checkbox"/> YES <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> MO. _____ YR. _____		29. COMMENTS: _____ _____ _____			
INFORMATION FROM PATIENT (1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER _____ LOWER _____ (2) NAME AND ADDRESS OF DENTIST (3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
30. CONTROL NUMBER 2131198765400		31. THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REFERENCE ADVICE IS ALWAYS REQUIRED)		32. DATE OF REFERENCE ADVICE THAT LISTED CLAIM WAS PAID 05/18/12			
33. REASONS FOR ADJUSTMENT <input checked="" type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY <input type="checkbox"/> 02 PROVIDER CORRECTIONS <input type="checkbox"/> 03 FISCAL AGENT ERROR <input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN		34. Billed without charge amount. Initially billed \$12.50 instead of \$125.00					
35. REASONS FOR VOID <input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT <input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN							
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.							
36. REQUEST FOR AUTHORIZATION - SEND TO OPS DENTAL PROGRAM		37. REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY) APPROVED YES <input type="checkbox"/> NO <input type="checkbox"/> W/EXCEPTIONS <input type="checkbox"/>		38. Dr. Joe Saitley, DDS ATTENDING DENTIST'S SIGNATURE 1888888 05/20/12 PROVIDER NUMBER			