

CLAIMS FILING

This appendix contains the information about the following:

- Instructions for billing using the CMS-1500 Claim Form
- Example of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim using the 213 Adjustment/Void Form
- Example of 213 Adjustment/Void Form
- Instructions for billing using the ADA Dental Claim Form
- Example of the ADA Dental Claim Form
- Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form
- Example of the 209 Adjustment/Void Form
- Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form
- Example of the 210 Adjustment/Void Form

CMS 1500 (08/05) Billing Instructions for FQHC Services

Federally Qualified Health Center (FQHC) 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 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).

Claims should be submitted to:

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

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CMS 1500 (08/05) 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 ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Required – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	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	Patient Status	Optional .	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other 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) Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
9c	Employer's Name or School Name	Situational – Complete if appropriate or 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	Employer's Name or School Name	Situational – Complete if appropriate or 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.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabelled	Optional.	If the claim date of service is prior to the elimination of the CommunityCARE Program and it is applicable, the PCP's 7-digit referral authorization number must be entered in block 17a.
17b	NPI	Optional.	

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Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization 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 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>	<p><u>CURRENTLY, FOHC PROVIDERS ARE NOT REQUIRED TO ENTER THIS INFORMATION.</u></p> <p>Physicians and other provider types who administer drugs and biologicals must enter this new drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only.</p> <p>This information must be entered in addition to the procedure code(s).</p>

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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	Optional.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</p> <p>Encounter Codes:</p> <ul style="list-style-type: none"> • FQHC encounter visit: T1015 • FQHC obstetrical service: T1015 w/TH modifier. • FQHC 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>Enter the appropriate encounter procedure on the first line.</p> <p>If both the encounter code and the detail line(s) are not present, the claim will deny.</p> <p>When billing behavioral health services provided by a clinical psychologist or licensed social worker, modifier AH must be appended to the behavioral health detail code for the psychologist and modifier AJ must be appended to the behavioral health detail code for the social worker.</p>
24E	Diagnosis Pointer	<p>Required -- Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
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	Situational -- Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	

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Locator #	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	<p>Situational – If appropriate, entering the Rendering Provider's 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 at this time.</p>	When billing for behavioral health services provided by a clinical psychologist or licensed social worker, the FOHC provider number must be entered as the billing and attending number on the claim.
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	<p>Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor.</p> <p>Enter '0' if the third party did not pay.</p> <p>If TPL does not apply to the claim, leave blank.</p>	
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	<p>Optional.</p> <p>Optional.</p>	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	The revised form accommodates entry of the Service Location NPI.

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Locator #	Description	Instructions	Alerts
32b	Unlabelled	Situational – Complete if appropriate or leave blank. If site numbers are applicable, the provider must enter the Qualifier LU followed by the three digit site number . Do not enter a space between the qualifier and site number (example "LU001").	
33	Billing Provider Info & Ph #	Required -- Enter the provider name, 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.	Format change with addition of 33a and 33b for provider numbers.

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Example of CMS-1500 Claim Form

1500										CARRIER
HEALTH INSURANCE CLAIM FORM										PICA
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05										PICA
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										5632147896325
3. PATIENT'S BIRTH DATE										4. INSURED'S NAME (Last Name, First Name, Middle Initial)
01 05 10										7. INSURED'S ADDRESS (No., Street)
5. PATIENT'S ADDRESS (No., Street)										CITY
6. PATIENT RELATIONSHIP TO INSURED										STATE
8. PATIENT STATUS										ZIP CODE
Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER
10. IS PATIENT'S CONDITION RELATED TO:										a. INSURED'S DATE OF BIRTH
a. EMPLOYMENT? (Current or Previous)										SEX
b. AUTO ACCIDENT? PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT?										c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE
1. 149 0										23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE										F. \$ CHARGES
B. PLACE OF SERVICE										G. DAYS OR UNITS
C. EMG										H. EPDOT Family Plan
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										I. ID QUAL
E. DIAGNOSIS POINTER										J. RENDERING PROVIDER ID. #
1 01 10 12 01 10 12 72 T1015 1 145 00 1										1236548
2 01 10 12 01 10 12 72 99213 1 0 00 1										1236549875
3										1236548
4										1236549875
5										NPI
6										NPI
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For good claims, see back)										28. TOTAL CHARGE
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)										33. BILLING PROVIDER INFO & BILL TO
32. SERVICE FACILITY LOCATION INFORMATION										Always Open FQHC
123 Main St.										Any Town, LA 700000
SIGNED DATE										a. 1326547895 b. 1234567

Adjustments and Voids

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 0198156789000.
2. The claim is adjusted on the remittance advice dated 12/11/2010, ICN 0345126742100
3. If the claim requires further adjustment or needs to be voided, the most recently approved Control number (0345126742100) 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, and 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 re-bill Medicare for a corrected payment. If these adjustments do not “crossover” from Medicare to Medicaid, the provider must submit the adjustment hard copy.

In these cases, it is necessary for the provider to file a hard copy adjustment claim (Molina Form 213) with Medicaid. These should be sent with a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached to:

**Molina Medicaid Solutions
Attention: Crossover Adjustments
P.O. Box 91023
Baton Rouge, LA 70821**

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. 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. Insured's Name – Leave blank.
8. Patient's Relationship to Insured – Leave blank.
9. Insured's Group No. – Complete if appropriate or blank.
10. Other Health Insurance Coverage – Complete with 6-digit TPL carrier code if appropriate or leave blank.

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11. Was Condition Related to – Leave blank.
12. Insured's Address – Leave blank.
13. Date of – Leave blank.
14. Date First Consulted You for This Condition – Leave blank.
15. Has Patient Ever had Same or Similar Symptoms – Leave blank.
16. Date Patient Able to Return to Work – Leave blank.
17. Dates of Total Disability-Dates of Partial Disability – Leave blank.
18. Name of Referring Physician or Other Source – Leave blank.
- 18a. Referring ID Number – Leave blank.
19. For Services Related to Hospitalization Give Hospitalization Dates – Leave blank
20. Name/Address of Facility Where Services Rendered (if other than home or office) – Leave blank.
21. 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. Attending Number – Leave this space blank.
24. 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 as it appears on the original claim.

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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. Leave blank.
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. *The form will be returned if this information is not entered.*
32. Patient's Account Number – Enter the patient's provider-assigned account number.

REQUIRED items must be completed or form will be returned.

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Example of 213 Adjustment Form

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (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. <input checked="" type="checkbox"/> VOID <input type="checkbox"/>	
PATIENT AND INSURED (SUBSCRIBER) INFORMATION	
2. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Adalam, Mary	3. PATIENT'S DATE OF BIRTH 06/11/89
4. MEDICAID ID NUMBER 1234567891234	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
6. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	7. INSURED'S NAME
8. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	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 MEDICAL ASSISTANCE NUMBER. 060606	11. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>
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. DATE PATIENT ABLE TO RETURN TO WORK	16. DATES OF TOTAL DISABILITY FROM THROUGH
17. DATES OF PARTIAL DISABILITY FROM THROUGH	18. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	20. REFERRING ID NUMBER
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	22. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE. 1 V222 2 3	24. ATTENDING NUMBER 1234567
25. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY 04 16 12 04 16 12	26. PLACE OF SERVICE 72
27. PROCEDURE T1015	28. DIAGNOSIS CODE 1
29. CHARGES 145.00	30. DAYS OR UNITS 1
31. EPSDT FAMILY PLAN 45.00	32. TPL \$
33. CONTROL NUMBER 2076156789501	34. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID 05/01/12
35. 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 Private insurance paid	
36. 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	
37. 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 6/01/2012	38. PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE Always Open FQHC 123 Smiley St. Sunny, LA 70000 NPI #1234567897 Provider# 9999999
39. YOUR PATIENT'S ACCOUNT NUMBER	

FISCAL AGENT COPY

UNISYS - 213
5/97

ADA Claim Form Billing Instructions for FQHC Services

Medicaid EPSDT Dental, EDSPW 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, EDSPW 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, EDSPW 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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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 eight-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 thirteen-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the sixteen-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.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

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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 1st 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>	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

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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>	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

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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 eight-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.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING**PAGE(S) 30**

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	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

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Example 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		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Brown, Wade 8269 Chilly Rd Winter, LA 70000																									
2. Predetermination/Prior Authorization Number 123456789		13. Date of Birth (MM/DD/YYYY) 08/14/2004																									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 3. Company/Plan Name, Address, City, State, Zip Code		14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F																									
15. Policyholder/Subscriber ID (SSN or ID#) 1234567890123		16. Plan/Group Number																									
OTHER COVERAGE 4. Other Dental or Medical Coverage? <input checked="" type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		17. Employer Name																									
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#)		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																									
9. Plan/Group Number TPL Carrier Code		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																									
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		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																									
11. Other Insurance Company/Dental Benefit Plan Name, 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				Permanent Primary																							
34. (Place an "X" on each missing tooth)				32. Other Fee(s)																							
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	O	P	Q	N	M	L	K	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) Radiographs Oral images Models <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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														TREATING DENTIST AND TREATMENT LOCATION INFORMATION 53. 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													
50. License Number 222-999-4444														55. License Number 99999													
51. SSN or TIN 1234567														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.adaclaim.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 or Expanded Dental Services for Pregnant Women 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) 30**

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

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Example of 209 Adjustment/Void Form (EPSDT)

Patient ID/Account Number

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

FOR PREAUTHORIZATION
MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1316 FLORIDA AVE., BOX 518
NEW ORLEANS, LA 70119

FOR PAYMENT
REMIT TO:
Molina Medicaid Solutions
P.O. BOX 91922
BATON ROUGE, LA 70821
(800) 475-5783
(225) 924-5040

SAMPLE

FOR OFFICE USE ONLY

1. PATIENT'S LAST NAME (PRINT) Smith 2. FIRST NAME Sally 3. INITIAL L 4. MEDICAL ASSISTANCE ID NUMBER
1 2 3 4 5 6 7 8 9 0 1 2 3
5. DATE OF BIRTH 02 15 2002 6. SEX ☐ M ☒ F

7. REFERRING AGENCY NO. 8. DATE OF REFERRAL 9. REFERRED FOR:
☐ EMERGENCY ☐ BASIC SCREENING 10. DENTIST OR GROUP REFERRED TO:
NAME _____
ADDRESS _____
TEL. NO. _____

11. REFERRED BY (SIGNATURE) 12. TELEPHONE NO. 13. PATIENT ID / ACCOUNT # ASSIGNED BY DENTIST
1800000

14. PAY TO: DENTIST OR GROUP 15. PAY TO: DENTIST OR GROUP PROVIDER NO. 16. ARE X-RAYS ENCLOSED?
NAME _____ A. EMPLOYMENT ☐ YES ☐ NO
ADDRESS _____ B. ACCIDENT/INJURY ☐ YES ☐ NO
CITY _____ ST. _____ ZIP _____

17. IF PROGRESS, IS THIS THE INITIAL PLACEMENT? ☐ YES ☐ NO 18. IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OPS DENTAL PROGRAM ☐

19. 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. DATE SERVICE PERFORMED MO. DAY YE.	F. ADJUSTED FEE (FOR STATE USE ONLY)	G. USUAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown	02 16 12		135 00
19. ORAL CAVITY				01		

20. CONTROL NUMBER 2061198765400 21. DATE OF REMITTANCE ADVICE THAT USED CLAIM WAS PAID: 03/16/2012

22. REASONS FOR ADJUSTMENT

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

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

23. REASONS FOR VOID

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

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

25. REQUEST FOR AUTHORIZATION - SEND TO OPS DENTAL PROGRAM

26. REQUEST FOR PRE AUTHORIZATION - FOR STATE USE ONLY

27. APPROVED - YES ☐ NO ☐ W/EXCEPTIONS ☐
PA 123456780

28. APPROVED - YES ☐ NO ☐ W/EXCEPTIONS ☐
Dr. Joe Smiley, DDS
1888888 11/05/2012

29. PROVIDER NUMBER _____ DATE _____

30. PROVIDER NUMBER _____ DATE _____

MOH/BA-289
10/04

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

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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) 30**

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

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Example of 210 Adjustment/Void Form (Adult)

FOR PREAUTHORIZATION MAIL TO: LSU SCHOOL OF DENTISTRY MEDICAL DENTAL PROGRAM 1100 FLORIDA AVE., BOX 510 NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO: Molina Medicaid Solutions P.O. BOX 91022 BATON ROUGE, LA 70821 (504) 473-2753 (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

FOR OFFICE USE ONLY

1. ADULT ☒ VOID ☐

2. PATIENT'S LAST NAME (PRINT) Que

3. FIRST NAME Susie

4. PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)

5. REFERRING AGENCY NO.

6. DATE OF REFERRAL

7. DENTIST OR GROUP REFERRED TO: NAME L ADDRESS 1 2 3 4 5 6 7 8 9 0 1 2 3 TEL. NO. 06 19 1955

8. PAY TO DENTIST OR GROUP NAME 1800000

9. PAY TO DENTIST OR GROUP PROVIDER NO. 1800000

10. ARE X-RAYS ENCLOSED? YES ☐ NO ☒

11. TREATMENT NECESSITATED BY: A. EMPLOYMENT ☐ YES ☒ NO B. ACCIDENT/INJURY ☐ YES ☒ NO

12. IF PROSTHESIS IS THIS THE INITIAL PLACEMENT? YES ☐ NO ☒

13. PROCEDURE CODE D0999

14. DESCRIPTION OF SERVICE Encounter All Inclusive

15. DATE SERVICE PERFORMED MO. 01 DAY 20 YEAR 12

16. ADJUSTED FEE (FOR STATE USE ONLY) 125.00

17. USUAL AND CUSTOMARY FEE 125.00

18. ORAL CAVITY

19. TOOTH #

20. PAID OR PAYABLE BY OTHER CARRIER \$ 125.00

21. IS THE PATIENT EDENTULOUS? MAXILLARY: NO ☐ YES ☐ DATE OF LAST EXTRACTIONS MANDIBULAR: NO ☐ YES ☐ DATE OF LAST EXTRACTIONS

22. DOES PATIENT PRESENTLY WEAR A DENTURE? MAXILLARY: NO ☐ YES ☐ FULL ☐ PARTIAL ☐ MO. YR. MANDIBULAR: NO ☐ YES ☐ FULL ☐ PARTIAL ☐ MO. YR.

23. COMMENTS:

24. 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 ☐ NO ☒

25. CONTROL NUMBER 2131198765400

26. DATE OF PERMITTANCE ADVICE THAT LISTED CLAIM WAS PAID 05/18/12

27. REASONS FOR ADJUSTMENT 01 THIRD PARTY LIABILITY RECOVERY Billed wrong charge amount. 02 PROVIDER CORRECTIONS Initially billed \$12.50 instead of \$125.00 03 FISCAL AGENT ERROR 90 STATE OFFICE USE ONLY - RECOVERY 99 OTHER - PLEASE EXPLAIN

28. 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.

29. REQUEST FOR AUTHORIZATION - SEND TO OPS DENTAL PROGRAM ATTENDING DENTIST'S SIGNATURE Dr. Joe Smiley, DDS PROVIDER NUMBER 1888888 DATE 05/20/12

30. REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY) APPROVED YES ☐ NO ☐ W/EXCEPTIONS ☐

MOLINA 210 1004