LOUISIANA MEDICAID PROGRAM

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPAGE(S) 28

CLAIMS FILING

This appendix contains the information about the following:

- Instructions for billing using the CMS-1500 Claim Form
- Sample of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim
- Sample 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

LOUISIANA MEDICAID PROGRAMISSUED:04/30/14REPLACED:03/25/13CHAPTER 22:FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D:CLAIMS FILINGPAGE(S) 28

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 web site at <u>www.lamedicaid.com</u>, 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 a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

PAGE(S) 28

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 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	Situational – 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).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient. Situational – Complete correctly if the recipient has other	
4	Insured's Name	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.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. This carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	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.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

Locator #	Description	Instructions	Alerts
9с	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.	
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	Situational – Complete if applicable. In the following circumstances, entering the name of the appropriate physician block is required : 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.	
17a	Unlabelled	Leave Blank.	
17b	NPI	Leave Blank.	

ISSUED: REPLACED:

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPAGE

PAGE(S) 28

04/30/14 03/25/13

Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
	ICD Ind.	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	The most specific diagnosis codes must be used. General codes are not acceptable.
21	Diagnosis or Nature of Illness	Required – Enter the most current ICD diagnosis code.	Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD-
	or Injury	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	10-CM codes will be announced at a later date.
		Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.	
		Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.	Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12)
22	Resubmission	Appropriate reason codes follow:	required to use the CMS 1500 (02/12).
	Code	Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other	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.
		Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	

ISSUED:04/30/14REPLACED:03/25/13

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

Locator #	Description	Instructions	Alerts
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	Situational – Applies to the detail lines for drugs and biologicals only. CURRENTLY, THIS IS NOT A REQUIREMENT FOR FQHC PROVIDERS. 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. Claims for these drugs shall include the NDC from the label of the product administered. 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. 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. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	FQHCs 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.	

 ISSUED:
 04/30/14

 REPLACED:
 03/25/13

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

Locator #	Description	Instructions	Alerts
24B	Place of Service	Required Enter the appropriate place of service code for the services rendered.	
24C	EMG	Situational – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	 Required Enter the procedure code(s) for services rendered. Enter the appropriate encounter procedure code on the first line. Encounter Codes: FQHC encounter visit: T1015 FQHC obstetrical service: T1015 w/TH modifier. FQHC EPSDT service: T1015 w/EP modifier. 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. 	If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required. For claims involving TPL, a claim line with the encounter code and the encounter rate must be added to the claim.
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A" "B", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$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.	
241	I.D. Qual.	Optional.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	
25	Federal Tax I.D. Number	Optional.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

PAGE(S) 28

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	Rsvd for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional . – The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabelled	Optional.	
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional	
33b	Unlabelled	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 form on the following page

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

PAGE(S) 28

Sample of FQHC CMS-1500 Claim Form

PICA	ORM CLAIM COMM	TTEE (NUCC) 02/12									
- COA											PICA
MEDICARE MEDICAID		CHAMPV	HEALTH PLAN	FECA N BLK LUNG	OTHER	1a. INSURED'S		ER		(For Program	n in Item 1)
(Medicare #) X (Medicaid PATIENT'S NAME (Last Name		(Member I	D#) (ID#)] 3. PATIENT'S BIRTH	(ID#) DATE SEX	(ID#)	123456789 4. INSURED'S			Cont Marrie M	Edd - Intelli	
	e, First Name, Middle	(initial)	MM DD	¥Y 85 M	FХ	4. INSURED ST	NAME (Last	Name,	Pirst Name, M	iddre mital)	
PATIENT'S ADDRESS (No., §	Street)		6. PATIENT RELATIK			7. INSURED'S	ADDRESS (I	No., Str	eet)		
			Self Spouse	Child Oth	her						
TY		STATE	8. RESERVED FOR 1	NUCC USE		СПҮ					STATE
P CODE	TELEPHONE (Inclu	ude Area Code)	-			ZIP CODE			TELEPHONE	(Indude Area (Code)
	()								()		
OTHER INSURED'S NAME (L	ast Name, First Nam	e, Middle Initial)	10. IS PATIENT'S C	ONDITION RELATE	D TO:	11. INSURED'S	POLICY GF	ROUP	OR FECA NUM	MBER	
OTHER INSURED'S POLICY		R	a. EMPLOYMENT? (a. INSURED' MM	DD Y	BIRTH Y		SEX	F
PL Code if applicable RESERVED FOR NUCC USE			YE: b. AUTO ACCIDENT		CE (State)	b. OTHER CLA	M ID (Desig	inated h	M NUCC)		r
			YE		ore (orand)				,,		
RESERVED FOR NUCC USE			c. OTHER ACCIDEN			c. INSURANCE	PLAN NAM	E OR P	ROGRAMINA	ME	
			YE	-							
INSURANCE PLAN NAME OF	R PROGRAM NAME		10d. RESERVED FO	R LOCAL USE		d. IS THERE AN					
READ	BACK OF FORM BE	FORE COMPLETING	& SIGNING THIS FOR	RM		YES 13. INSURED'S	NO OR ALITHO		es, complete il		
PATIENT'S OR AUTHORIZE to process this claim. I also red below.	D PERSON'S SIGNA	TURE I authorize the	release of any medica	l or other information	necessary tent	payment of		efits to t	the undersigne		
SIGNED		SA	AMPL	E FO	RN	/ ⋤⊕	R				
	SS, INJURY, or PREC	SNANCY (LMP) 15.0		E FO	RN	16. DATES PAT		ILE TO	WORK IN CU		JPATION YY
DATE OF CURRENT ILLNES	QUAL.	Ηø		<u>E FO</u> LÊ Ŏ	RI NL	16. DATES PAT MM KOM			то		
DATE OF CURRENT ILLNES	QUAL.	SOURCE 17a.		E FO LÊ Ŏ		18. HOSPITALIZ			WORK IN CU TO LATED TO CL TO		
DATE OF CURRENT ILLNES	QUAL. DVIDER OR OTHER	SOURCE 17a. 71b.		E FO LÊ Ŏ		16. DA TES PAT MM 18. HOSPITALIZ FROM 20. OUTSIDE L	ZATION DAT		то	JRRENT SER	
DATE OF CURRENT ILLNES	QUAL. DVIDER OR OTHER	SOURCE 17a. 71b.		E FO LÊ Ŏ		18. HOSPITALIZ MM FROM	ZATION DAT		TO LATED TO CL TO	JRRENT SER	
DATE OF CURRENT ILLNES MM DD CORE NAME OF REFERRING PRO ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OF	QUAL DVIDER OR OTHER	SOURCE 17a. 7 1b. 1 by NUCC)				FROM 20. OUTSIDE L	AB?	rëş re	TO LATED TO CL TO	JRRENT SER MM DD GES	
DATE OF CURRENT LLINES MM DD CORRENT LLINES NAME OF REFERRING PRO ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI	QUAL DVIDER OR OTHER	SOURCE 17a. 7 1b. 1 by NUCC) RY Relate A-L to se C. L	NPI			18. FIOSPITALI FROM 20. OUTSIDE L YES 22. RESUBMIS CODE	AB? NO	ręşre	TO LATED TO CL TO \$ CHAR	JRRENT SER MM DD GES	
DATE OF CURRENT ILLNES MM DD CORRESPONDED NAME OF REFERRING PRO ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI	QUAL DVIDER OR OTHER MATION (Designated FILLNESS OR INJU	SOURCE 17a. 71b. 1 by NUCC) RY Relate A-L to se	NPI	ICD Ind 9	RM	18. FIOSPITALI FROM 20. OUTSIDE L YES	AB? NO	ręşre	TO LATED TO CL TO \$ CHAR	JRRENT SER MM DD GES	
DATE OF CURRENT ILLNES MM DD COR I CONTRACTOR OF REFERRING PRO ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI , V2501	DUAL DVIDER OR OTHER: MATION (Design ated FILLNESS OR INJUI B. F. J. D. CE	SOURCE 17a. 71b. 1by NUCC) RY Relate A-L to se C. L K. L K. L C. D.PROCE	NPI Invice line below (24E)	ICD Ind 9	E.	18. FIOSPITALI FROM 20. OUTSIDE L YES 22. RESUBMIS CODE	AB? NO SION		TO LATED TO CL TO \$ CHAR ORIGINAL RE IBER	GES	J.
DATE OF CURRENT ILLNES MM DD () NAME OF REFERRING PRC ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OF DIAGNOSIS OR NATURE OF L L L DATE(S) OF SERVIC From	DUAL. DVIDER OR OTHER : MATION (Designated F ILLNESS OR INJU B F J	SOURCE 178. 7 15. 15 y NUCC) RY Relate A-L to se 	NPI rvice line below (24E) EDURES, SERVICES, kein Unusual Circumst	ICD Ind 9 D H DR SUPPLIES DR SUPPLIES DR SUPPLIES		18. FIOSPITALI FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT		ręşre	TO LATED TO C TO \$ CHAR ORIGINAL RE MBER H. L. PROT ID. PROT ID. PROT ID.	GES F. NO.	
ADDITIONAL CLAIM INFOR ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI V2501 	DUAL VIDER OR OTHER VIDER OR OTHER MATION (Designated FILLNESS OR INJU B. FILLNESS OR INJU B. FILL SCONTINUE B. D SCONTINUE B.	SOURCE 178. 71b I by NUCC) RY Relate A-L to se C L G L C DPROCE EMG CPTINCE	NPI Invice line below (24E) DURES, SERVICES, Viela Unusual Circumsta CS MOD	ICD Ind 9	E, IAGNOSIS POINTER	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE			TO LATED TO C TO \$ CHAR ORIGINAL RE ORIGINAL RE MBER H. I. ID. MM QUAL.	JRRENT SER DD GES F. NO. RENE PROVI	J. JERING DER ID. #
DATE OF CURRENT ILLNES MM DD V V NAME OF REFERENCE PRO ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI V2501 L A. DATE(S) OF SERVIC M DD YY MM C	AUAL ANDER OR OTHER: MATION (Design ated FILINESS OR INJUE B F J DE B PLACE OI	SOURCE 178. 7 15. 15 y NUCC) RY Relate A-L to se 	NPI Invice line below (24E) DURES, SERVICES, Viela Unusual Circumsta CS MOD	ICD Ind 9	E. IAGNOSIS	18. FIOSPITALI FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F.			TO LATED TO C TO \$ CHAR ORIGINAL RE ORIGINAL RE MBER H. L L RROT ID. INPI OUL.	I I I I I I I I I I I I I I I I I I I	J. JERING DER ID. #
DATE OF CURRENT ILLINES MM DD () NAME OF REFERRING PR() ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI 	DUAL VIDER OR OTHER VIDER OR OTHER MATION (Designated FILLNESS OR INJU B. FILLNESS OR INJU B. FILL SCONTINUE B. D SCONTINUE B.	SOURCE 178. 71b I by NUCC) RY Relate A-L to se C L G L C DPROCE EMG CPTINCE	NPI rvice line below (24E) EDURES, SERVICES, Vain Unusual Circumst CS MOC 5	ICD Ind 9	E, IAGNOSIS POINTER	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE			TO LATED TO C TO \$ CHAR ORIGINAL RE MBER H. L. NPI L. NPI 1	JRRENT SER DD GES F. NO. RENE PROVI	J. DERING DER ID. # 75
DATE OF CURRENT ILLNES MM Image: Constraint of the second sec	DUAL	SOURCE 178. 7 Tb. Ty NUCC) RY Relate A-L to se C L C L C DPROCE EMG CPT/HOE EMG CPT/HOE ROVERA INJ	NP1 Invice line below (24E) EDURES, SERVICES, Viale Unusual Circumsta CCS MOC 5 3	ICD Ind 9	E. IAGNOSIS POINTER A A	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE	AB? NO SION HORIZATIC SION HORIZATIC D	G. G. G. S. C. C. C. C. C. C. C. C. C. C	TO LATED TO CL TO \$ CHAR ORIGINAL RE BER H H NPI ID NPI	RENC PROVI 1236548 12365498 12365498	J. DERING DER ID. # 75 75
	DUAL VIDER OR OTHER : MATION (Designated B. FILINESS OR INJUR B. J. J. D2 14 D2 14 D2 14	SOURCE 178 7 15 16 y NUCC) RY Relate A-L to se C L C DPROCE EMG CPT/HOF I T101	NP1 Invice line below (24E) EDURES, SERVICES, Viale Unusual Circumsta CCS MOC 5 3	ICD Ind 9	E. IAGNOSIS POINTER	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE	AB? NO SION HORIZATIC SION HORIZATIC D		TO LATED TO CL TO \$ CHAR ORIGINAL RE BER H H NPI ID NPI	RENT SER MM DO GES F. NO. RENC PROVI 1236548 12365498 12365498	J. DERING DER ID. # 75 75
DATE OF CURRENT ILLINES MM DI CONTRACTOR OF REFERENCIA OF REFERENCIA OF REFERENCIA OF REFERENCIA OF REFERENCIA OF SERVICE ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OF I V250 1 . V250 1 . DATE(S) OF SERVICE M DD YY MM C 3 02 14 03 0 3 02 14 03 0 400703680101 UN1	DUAL	SOURCE 178. 7 Tb. Ty NUCC) RY Relate A-L to se C L C L C DPROCE EMG CPT/HOE EMG CPT/HOE ROVERA INJ	NP1 Invice line below (24E) EDURES, SERVICES, Viale Unusual Circumsta CCS MOC 5 3	ICD Ind 9	E. IAGNOSIS POINTER A A	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE	AB? NO SION HORIZATIC SION HORIZATIC D	G. G. G. S. C. C. C. C. C. C. C. C. C. C	TO LATED TO C TO \$ CHAR ORIGINAL RE MBER H. L NPI NPI NPI	RENC PROVI 1236548 12365498 12365498	J. DERING DER ID. # 75 75
Date of current lines MM OF CURRENT LINES MM OF REFERRING PRO ADDITIONAL CLAIM INFOR OF CONTRACT DIAGNOSIS OR NATURE OF OF CONTRACT I I	DUAL	SOURCE 178. 7 Tb. Ty NUCC) RY Relate A-L to se C L C L C DPROCE EMG CPT/HOE EMG CPT/HOE ROVERA INJ	NP1 Invice line below (24E) EDURES, SERVICES, Viale Unusual Circumsta CCS MOC 5 3	ICD Ind 9	E. IAGNOSIS POINTER A A	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE	AB? NO SION HORIZATIC SION HORIZATIC D	G. G. G. S. C. C. C. C. C. C. C. C. C. C	TO LATED TO CL TO \$ CHAR ORIGINAL RE BER H H NPI ID NPI	RENC PROVI 1236548 12365498 12365498	J. DERING DER ID. # 75 75
DATE OF CURRENT ILLINES MM DI CONTRACTOR OF REFERENCIA OF REFERENCIA OF REFERENCIA OF REFERENCIA OF REFERENCIA OF SERVICE ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OF I V250 1 . V250 1 . DATE(S) OF SERVICE M DD YY MM C 3 02 14 03 0 3 02 14 03 0 400703680101 UN1	DUAL	SOURCE 178. 7 Tb. Ty NUCC) RY Relate A-L to se C L C L C DPROCE EMG CPT/HOE EMG CPT/HOE ROVERA INJ	NP1 Invice line below (24E) EDURES, SERVICES, Viale Unusual Circumsta CCS MOC 5 3	ICD Ind 9	E. IAGNOSIS POINTER A A	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE	AB? NO SION HORIZATIC SION HORIZATIC D	G. G. G. S. C. C. C. C. C. C. C. C. C. C	TO LATED TO C TO \$ CHAR ORIGINAL RE MBER H. L NPI NPI NPI	RENC PROVI 1236548 12365498 12365498	J. DERING DER ID. # 75 75
Date of current lines MM OF CURRENT LINES MM OF REFERRING PRO ADDITIONAL CLAIM INFOR OF CONTRACT DIAGNOSIS OR NATURE OF OF CONTRACT I I	DUAL	SOURCE 178. 7 Tb. Ty NUCC) RY Relate A-L to se C L C L C DPROCE EMG CPT/HOE EMG CPT/HOE ROVERA INJ	NP1 Invice line below (24E) EDURES, SERVICES, Viale Unusual Circumsta CCS MOC 5 3	ICD Ind 9	E. IAGNOSIS POINTER A A	E. HOSPITALIS FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE	AB? NO SION HORIZATIC SION HORIZATIC D	G. G. G. S. C. C. C. C. C. C. C. C. C. C	TO LATED TO CI TO \$ CHAR ORIGINAL RE MBER HU, L, I, L, L, I, L,	RENC PROVI 1236548 12365498 12365498	J. DERING DER ID. # 75 75
DATE OF CURRENT ILLNES MM DD CONTINUE OF REFERENCE PRO- ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI I U250 1 A DATE(S) OF SERVIC M DD YY MM C 3 02 14 03 0 3 02 14 03 0 3 02 14 03 0 100703680101 UN1 3 02 14 03 0	2041 WIDER OR OTHER MATION (Designated FILINESS OR INJUI B. F. J. DD YY BRY D2 14 11 50.00 D2 14 11 50.00 D2 14 11 I I	SOURCE 172. The source	NP1 rvice line below (24E) DURES, SERVICES, Viein Unusual Circumsta S S S S S S S S S S S S S S S S S S S	ICD Ind 9	A A A A A	18. ROSPITAL FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 23. PRIOR AUT F. \$ CHARGE 150		G. 10 10 10 10 10 10 10 10 10 10 10 10 10	TO LATED TO CI TO \$ CHAR ORIGINAL RE NBER NPI NPI NPI NPI NPI	RENT GER GES F. NO. 1236548 12365498 12365498 12365498 12365498	J. DERING DER ID. # 75 75
DATE OF CURRENT ILLNES MM DD CONTINUE OF REFERENCE PRO- ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE OI I U250 1 A DATE(S) OF SERVIC M DD YY MM C 3 02 14 03 0 3 02 14 03 0 3 02 14 03 0 100703680101 UN1 3 02 14 03 0	2041 WIDER OR OTHER MATION (Designated FILINESS OR INJUI B. F. J. DD YY BRY D2 14 11 50.00 D2 14 11 50.00 D2 14 11 I I	SOURCE 178. 7 Tb. Ty NUCC) RY Relate A-L to se C L C L C DPROCE EMG CPT/HOE EMG CPT/HOE ROVERA INJ	NP1 rvice line below (24E) DURES, SERVICES, Viein Unusual Circumsta S S S S S S S S S S S S S S S S S S S	ICD Ind 9 D H D H SUPPLIES DI IFIER F I I I I I I I I I I I I I I I I I I I		18. ROSPITAL FROM 20. OUTSIDE L YES 22. RESUBMIS 23. PRIOR AUT F. \$ CHARGE 150 28. TOTAL CHARGE		G. I I I	TO LATED TO CI TO \$ CHAR ORIGINAL RE MBER HU, L, I, L, L, I, L,	RENT GER GES F. NO. 1236548 12365498 12365498 12365498 12365498 12365498	J. DERING DER ID. # 75 75
DATE OF CURRENT ILLNES MM DD VY MM C 3 02 14 03 0 3 02 14 03 0 4 00703680101 UN1 3 02 14 03 0 4 00703680101 UN1 4 03 0 4 00703680101 UN1 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0	DUAL VVIDER OR OTHER: MATION (Designated FILINESS OR INJUI B. F. J. DD YY B. DD YY SETO D2 14 11 50.00 DEPO-F02 14 R SSN EIN LOR SUPPLER	SOURCE 718 715 19 NUCC) RY Relate A-L Iose C. L G. D.PROCE EMG CPT/HCF T101 9921: ROVERA INJ J0151 28. PATIENTS -	NP1 rvice line below (24E) DURES, SERVICES, Viein Unusual Circumsta S S S S S S S S S S S S S S S S S S S	ICD Ind 9 D D D D D D D D D D D D D D D D D D D	A A A A A	18. ROSPITAL FROM 20. OUTSIDE L YES 22. RESUBMIS 23. PRIOR AUT F. \$ CHARGE 150 28. TOTAL CHARGE	AB7 NO SION COO COO COO COO COO COO COO COO COO C	G. (() () () () () () () () () (TO LATED TO CI TO \$ CHAR ORIGINAL RE MBER H. L NPI UL NPI NPI NPI	RENT GR GES GES F. NO. 1236548 12365498 12365498 12365498 12365498 12365498 12365498 12365498	J. DERING DER ID # 75 75 75 ANCE DUE
DATE OF CURRENT ILLINES MM DD Image: Constraint of the second secon	2004.	SOURCE 718 715 19 NUCC) RY Relate A-L Iose C. L G. D.PROCE EMG CPT/HCF T101 9921: ROVERA INJ J0151 28. PATIENTS -	NPI Invice line below (24E) In	ICD Ind 9 D D D D D D D D D D D D D D D D D D D		18. ROSPITAL FROM 20. OUTSIDE L YES 22. RESUBMIS 23. PRIOR AUT F. \$ CHARGE 150 28. TOTAL CH \$	AB? NO SION HORIZATIO	(() () () () () () () () () (TO LATED TO C TO S CHAR ORIGINAL RE MBER H. L ID ID ID ID ID ID ID ID ID ID ID ID ID	RENT GER GES F. NO. 1236548 12365498 12365498 12365498 12365498 12365498	J. DERING DER ID # 75 75 75 ANCE DUE

LOUISIANA MEDICAID PROGRAM

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPAGE(S) 28

Adjustments and Voids

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

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

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

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

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

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

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

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

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

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.

LOUISIANA MEDICAID PROGRAM

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPAGE(S) 28

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.

A sample form is on the following page

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS FILING

PAGE(S) 28

Sample of a Claim Form Adjustment

HEALTH INSURANCE CLAIM FORM	2	
1. MEDICARE MEDICAID TRICARE CHAM	VA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Memb		1234567890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY 06 19 85 M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
CITY STAT	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	_	ZIP CODE TELEPHONE (Indude 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)	a. INSURED'S DATE OF BIRTH SEX
TPL Code if applicable	YES NO	MM DD TY M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLET 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize to process this claim. I also request payment of government benefits eith below.	he release of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED S	AMPLE FORM	I FOR
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	a	MM DD YY
7 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	b. NPI	FROM TO 20. OUTSIDE LAB? \$ CHARGES
		YES NO
	service line below (24E) ICD Ind. 9	22. RESUBMISSION CODE ORIGINAL REF. NO.
А. [V2501 В.]	D	A 99 4090145678600
E F G	<u>н</u>	23. PRIOR AUTHORIZATION NUMBER
	L. L. CEDURES, SERVICES, OR SUPPLIES E. xolain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. DAYS ERACT ID. RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/		\$ CHARGES UNITS Famy QUAL. PROVIDER ID. # 1236548
03 02 14 03 02 14 11 99	13 A	80 00 1 NPI 1236549875
		NPI
		NPI
		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 29. AMOUNT PAID 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE	FACILITY LOCATION INFORMATION	\$ 80 00 \$ \$ 33. BILLING PROVIDER INFO & PH# (225) 555-4957
INCLUDING DEGREES OR CREDENTIALS (Icertify that the statements on the reverse apply to this bill and are made a part thereol.)		Always Open 500 Main St. Any Town, LA 70000
SIGNED John Doe, MD DATE 3/9/14 a.	h	a. 1326547895 b. 1987654
SIGNED JOIN DOE, MD DATE 3/9/14 a.		APPROVED OMB-0938-1197 FORM CMS-1500 (02-1

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 <u>required</u> 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

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22:FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D:CLAIMS FILINGPA

PAGE(S) 28

ADA Claim Form Billing Instructions for FQHC Services

Locator #	Description	Instructions	Alerts
1	Type of Transaction	Required Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization. Situational – Check box marked "EPSDT Title XIX" if patient is Medicaid eligible and under 21 years of age. If block is not checked, the claim will be processed as an adult claim.	If a claim is being submitted for payment, you must mark "Statement of Actual Services" in Block 1 of the claim form. Claims for payment that are sent to Molina Medicaid Solutions should never include radiographs.
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	Situational – Enter the third party's carrier code if a third party is involved. 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, <u>www.lamedicaid.com</u> (The carrier code list can be found at www.lamedicaid.com under the Forms/Files link) 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.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

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	Required Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS.	
	ID	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 PA

PAGE(S) 28

04/30/14 03/25/13

Locator #	Description	Instructions	Alerts
25	Area of Oral Cavity	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. If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter in Block 27.	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)	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. <u>If a tooth number or letter is required by Medicaid, do not</u> enter an oral cavity designator in Block 25.	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	Situational – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial, and O = Occlusal Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.	

ISSUED: REPLACED:

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

PAGE(S) 28

04/30/14 03/25/13

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)	 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 "/". In the following circumstances, this information is required: If the claim is for the Adult Denture Program. If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy. 	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS APPENDIX D: CLAIMS FILING PA

Locator #	Description	Instructions	Alerts
		Situational – Enter the amount paid by the primary payor if block 9 is completed.	
		Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [\$0] payment) in this block.	
35	Remarks	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).	
		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.	
36	Authorizations	Optional.	
37	Authorizations	Optional.	
38	Place of Treatment	Situational – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48.	
		If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is required .	
		Situational – Enter 00 to 99 in applicable boxes.	
39	Number of Enclosures	Claims submitted for prior authorization are required to contain the identified attachments.	
		Claims submitted for payment should not contain any of the attachments listed in Block 39.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

Locator #	Description	Alerts	
40	Is Treatment for Orthodontics?	Situational – Complete if applicable. Claims requesting comprehensive orthodontic services are required to enter information in this block.	
	orthodonics.	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 CENTERSAPPENDIX D: CLAIMS FILINGPA

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

PAGE(S) 28

Sample of ADA Claim Form

ADIA. Dental Claim Form	MSA 07-02
HEADER INFORMATION	Attachment 1
1. Type of Transaction (Mark all applicable boxes)	
Statement of Actual Services Prequest for Predetermination/Preauthorization	
EPSOT/Title XIX	
2. Predetermination/Preautholization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
123456789	12. Policyholdes/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	Brown, Wade
 Company/Flan Name, Address, City, Stale, Zp Code 	
	8269 Chilly Rd
	Winter, LA 70000
	13. Date of Birth (MMDD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)
	08/14/2004
OTHER COVERAGE	16. Plan/Group Number 17. Employer Name
4. Other Dental or Medical Coverage? XNo (Skip 5-11) Ves (Complete 5-11)	
5. Name of Policyholdes/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION
	18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status
6. Date of Birth (MMOD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Sell Spouse Dependent Child Other FTS PTS
□ ^M □F	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
9. Plan/Group Number 10. Patient's Felationship to Person Named in #5	1
TPL Carrier Code ser spouse Dependent Coner	
15. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zp Code	1
	21. Date of Birth (MM/DD/DCYY) 22. Gendler 25. Patient ID/Account # (Assigned by Dentist)
RECORD OF SERVICES PROVIDED	
24. Procedure Date 25. Ama 25. 27. Tooth Number(s) 28. Tooth 29. Procedure Cate Control (Control Control Contr	tun
24. Procedure Date (MMDD/CC/Y) Collar Tooth Cavity System of L45er(IX) Sufface Code	30. Description 31. Fee
1 2/4/12 D099	99 Encounter - All Inclusive 100 00
1 2/4/12 D099 2 2/4/12 10 D434	99 Encounter - All Inclusive 100 00 11 Periodontal Scaling and Root Planing 110 00
2/4/12 13 D298	54 Post & Core 94 00
4 2/4/12 15 D29	31 Stainless Steel Crown 140.00
5	
6	
7	
a	
0	
MISSING TEETH INFORMATION Permanent	Pimary 32. Other
1 2 3 4 5 6 7 8 9 10 11 12	13 14 15 16 A B C D E F G H I J F4600
34. (Place an % on each missing tooth) 32 31 30 29 28 27 26 25 24 23 22 21	
35. Remarks	
If TPL involved: write the words "Carrier P	aid" and enter the amount paid by the TPL here.
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION
All these have been already of the trackment along and according from the part to be conservable for all	58 Block of Restaurant 10 Number of Environment (10 to 50)
charges for detail services and materials not paid by this dential benefit pain, unress prohibited by tiles, or the treating dential or dental practice has a contractual algorement with my pain prohibiting all or a portion or such charges. To the extent permitted by tiles, I consent to your use and disclosure of my potected heath information to carry our payment achivities in consent to your use and disclosure of my potected heath information to carry our payment achivities in consent to your use and disclosure of my potected heath information to carry our payment achivities in consent to your use and extensions.	Provider's Office Hospital ECF Other
such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health	40. Is Treatment for Orthodoxtics? 41. Date Applance Placed (MMDD/CCYY)
internation to carry out payment activities in connection with this olam.	No (Skip 41-42) Yes (Complete 41-42)
X	
Patient/Suardian signature Date	42. Months of Treatment 42. Replacement of Prosthesis? 44. Date Price Placement (MMCD/CCYY)
37. Thereby sufficize and direct payment of the dentisi benefits otherwise payable to me, directly to the below named	45. Treatment Reputing from
dentiat or dental entity.	
X	Occupational illness/injury Auto accident Other accident Auto Accident Zeture Accident Constant
Subscriber signature Date	The case of Proceeding (Interformed County)
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentst or dental entity is not submitting claim on behalf of the patient or insured/subscriber)	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.
48. Name, Address, City, State, Zp Code	Dr Mary Cleanteeth 3/20/12
XYZ Dental Group	X Sgred (Treating Central Control Cont
8956 No Cavity Ave.	
Smiley, LA 700000	54. NP1234567890 55. License Number 999999
	56. Address, City, State, Zip Code SSA. Provider Specialty Code
49. NP1 50. License Number 51. SSN or TIN	
1987654321	10 miles
32 Phone (222)999-4444 SUA Additional Provider to 1234567	57. Phone () - 58. Addisonal Provider ID 1987654
© 2006 American Dental Association J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)	To Receder call 1-800-047-4746 or go chine at www.adacatalog.org

© 2006 American Dental Association J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

LOUISIANA MEDICAID PROGRAM

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D: CLAIMS FILINGPA

PAGE(S) 28

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 <u>www.lamedicaid.com</u>. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22:FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D:CLAIMS FILINGPA

PAGE(S) 28

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 PA

PAGE(S) 28

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) 28

Sample of 209 Adjustment/Void Form (EPSDT)

				ID/Account lumber	
FOR PREAUTHORIZATION FOR PAYMENT MAIL TO EIMHT TO: LUI UCHOLO, OF DENTSTEY MIDICAD DISTAL, ROS 210 MIDICAD DISTAL, ROS 210 P.O. 80X 19927 MIDICAD DISTAL, ROS 210 AND ROSALL, SOX 510 MIDICAD DISTAL, ROS 210 AND ROSALL, SOX 510 MIDICAD DISTAL, ROS 210 AND ROSALL, SOX 510 MIDICAD, SOX 510 AND ROSALL, SOX 510 MIDICAD, SOX 510 <t< th=""><th>Solutions BUR</th><th>STATE OF LOUISIANA IMENT OF HEALTH AND HOD AU OF HEALTH SERVICES FRANK MEDICAL ASSISTANCE PROGRAM PROVIDER BULING FOR EPSDT DENTAL SERVICES</th><th>' L</th><th></th><th>IPLE</th></t<>	Solutions BUR	STATE OF LOUISIANA IMENT OF HEALTH AND HOD AU OF HEALTH SERVICES FRANK MEDICAL ASSISTANCE PROGRAM PROVIDER BULING FOR EPSDT DENTAL SERVICES	' L		IPLE
2 PARENTS LAST NAME (RENT)	2 RET NO	а —		MEDICAL ASSISTANCE LD. NUMB	a
Smith PATIENTS ADDRESS (STREET HUMBER, COX, START, 2P CO	Sall	у /	L	1 2 3 4 5	67890123
A NUMBER ADDRESS (SINGLE HOMBO), CON, SINCE, SP CO	opter wot		. ľ	02 15	2002 🗆 🗠 🔀 F
E ETRIBAGIAGENCY NO.	APORA.	ENERGENCY	OR GROUP REMEMBED TO:		
Terreson soward	MENO.		WRESS		
WAY TO DEVISITOR GROUP		TEL	NO	ARE IN HAVE ENCLOSED	
F .		1800000		VES NO	
NAME		A. EMPLOYMENT	1 165	PATHENT SOURCE OTHER THAN T THE CARRIER CODE:	A g au
ADDRESS		B. ACCIDENT/INUU		1	
CITYST.	ZP			2	
	F ADULT EMBIGENCY SE CHECK BLOCK AND SEND	EVICE,		3	
	EXAMINATION AND	C TREATMENT PLAN - UST IN ORDER	FROM TOOTH NO. 1		
FACIAL	FOR SURACE PRO	CIDURE DISCIDURE	INCE	DATE SERVICE PERIORMED	F. G. ADASTED HE IPOR STATE USUAL AND USE ONATI CUSTOMARY HE
6 ⁴⁹⁹⁹⁹ 60		2931 Stainless Steel	0	02 16 12	135 00
03 02 00 LINGUALI 0 150 02 00 LINGUALI 0 150 01 00 00	R. ORAL CAVITY	01		AND CH NATABLE CTHER CA	
and the second					
RIGHT BUEFT	2061198765	ITEM.	NE CHANGING OR VOE INE CONRECT CONTROL IN IN ON THE REWITTANCE IS REQUIRED.)	ADVICE IS 03/16/	entred abidi heat wite heb. /2012
A INK IN RESTORATIONS INCLATE RASSING TEETH WITH AN X. C. INDICATE CROWNS WITH	02 PROV 03 FISCA 90 STATE	USEMENT PARTY LIABLITY RECOVERY DER CORRECTIONS L AGENT ERROR OFFICE USE ONLY - RECOVERY R - PLEASE EXPLAIN		ed wrong tooth both #16, not 19	
ANO.					
D. INDICATE TEETH TO BE EXTRACTED WITH-/.	REASONS FOR VO	D			
	11 CLAIM	PAD FOR WRONG RECIPIENT PAD TO WRONG PROVIDER - REASE EXPLAIN			
	L				
I HAVE READ THE CRETERCATION ON THE REV ROUEST FOR AUTHORIZATION - SIND TO ON DIMAL	TROGAN	EQUEST FOR THE AUTHORIZATION FOR STATE US	0401	- 10-4-S	niley. DDS
ATTENDING DEVISIONS SCHARTS		APPROVED - YES NO PA 123456780	W/EXCEPTIONS		THOMO CONTENTS SOLATOR
RONDERHUMBER	648 7	URORZO SONAUR		I88888	NOVERINGHER
					MOLEA.209

ISSUED: 04/30/14 REPLACED: 03/25/13

CHAPTER 22:FEDERALLY QUALIFIED HEALTH CENTERSAPPENDIX D:CLAIMS FILINGPA

PAGE(S) 28

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 PA

PAGE(S) 28

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 PA

PAGE(S) 28

Sample of 210 Adjustment/Void Form (Adult)

and the second second second	entrons BUT	ARTMENT (REAU OF HE MEDICAL PRO ADULT	TE OF LOUISIA OF HEALTH AN EALTH SERVICE: ASSISTANCE PP WIDER BILLING F COENTAL SERVI	ID HOSPITALS S FINANCING KOGRAM			NCE LD. NUMBER	LE
QUE PATENTS ACCHESS (STREET NUMBER, CITY, ST REFERRING ACENCY NO.	TATE, 2P CODE) (TEL.)	sie	/	/	M 10	MEDICAL ASSISTA	NCE LD. NUMBER	1000
PATIENTS ADDRESS (STREET NUMBER, CITY, ST REFERRING AGENCY NO.	TATE, 2P CODE) (TEL.)		/		1 1	1 1 1 2 1 3 1 /		
REFERRING AGENCY NO.	1.92 S.4.2048	NO.)						9 0 1 2
constant and the second second	OF REFERRAL		/			DATE OF BIRTH		
contraction and a second			-/	12 DENTIST C		06 19 19	05	M 🗙
and the second sec		۳ - I	/	NAME	In Uniour He	PERSED TO:		
REFERRED BY: (SIGNATURE) 16 TELL	EPHONE NO.	15 ACEN	ACCOUNT & MERICAND AP DE	ADORESS				
		-		TEL NO.,				
FAY TO DENTIST OR GROUP			17 PWY TO DENTE		WOER NO.	ARE X-RAYS DIC	NO NO	
			1800000			YES NUMBER OF X-RA	140	
CHESS			TREATMENT NE			TPL CARINER COL	E OTHER THAN TITLE : DF:	KOK .
TY ST	- 75		A. EMPLOYM	ENT	VES NO	1		
PROSTHESIS, IS THIS		22	B. ACCIDENT	THE R PARTY	T YES	2		
THE INITIAL PLACEMENT?	YES N	40	B. ACCIDENT	ANJURY	D NO	3		
	A PROCEDURE	8.	neenoemne	I OF FERMOR		C. DATE SERVICE	D. ADJUSTED FEE	E USUAL AND
	CODE		DESCRIPTION	N OF SERVICE		PERFORMED NO. DAY YEAR	(FOR STRICE USE ONLY)	CUSTOMARY FI
BOAL 0	D0999	Encour	nter All Inclu	usive		01 20 12		125 0
Popped F	ORAL			G. TO	00TH #		PAID OR PAYABLE BY OTHER CARRIER	\$
	COMMENTS:		F	LAST DENTURE	MADE?	UPPER	LOWER	
NDICATE TEETH TO BE EXTRACTED WITH A/.	(2) NAME AND (3) HAVE YOU		OF DENTIST	UNDER THE M	EDICAID PR	OGRAM?	YES 🗆 🛛	NO 🗆
INDICATE MISSING TEETH WITH AN X.	2131198765	400	•	THES IS FOR OWN ITEM, (THE CORE BHOWN ON THE ALIMN'S PEOUP	NIGING OR VOI RECT CONTROL E REDITTANOS REDI	NUMBER AD	5/18/12	745
	REASONS FOR ADJUSTMENT O1 THIRD PARTY LIABLITY RECOVERY			Bille	lilled wrong charge amount.			
SKETCH IN DESIGN OF		VIDER CORP	1000 1000 1000 1000		Initia	Illy billed \$12	2.50 instead	of
TO BE CONSTRUCTED		AL AGENT E			and the owner of the local division of			
TO BE REPLACED AND	90 STATE OFFICE USE ONLY - RECOVERY			312	25.00			
TEETH TO BE CLASPED.	99 OTHER-PLEASE EXPLAIN							
TEETH TO BE CLASPED.	REASONS FOR VOID							
				14.1				
	10 CLAI	M PAID FOR	WRONG RECIPIE		_			
	10 CLAI	MPADTOV	VRONG PROVIDE	я	1			
	10 CLAI	M PAID FOR M PAID TO V ER - PLIEASE	VRONG PROVIDE	R				
	10 CLAI 11 CLAI 19 OTH	M PAID TO V	IEXPLAIN	R	THEREWITH			
WAVE READ THE CERTIFICATION ON THE REVER	10 CLAR 11 CLAR 11 CLAR 19 OTHE	M PAID TO V	IEXPLAIN	R				
	10 CLAR 11 CLAR 11 CLAR 19 OTHE	M PAID TO V	CERTIFY THAT LA	R M IN COMPLIANCE FOR STATE USE ON			De Jos Sailay, 1	
WAVE READ THE CERTIFICATION ON THE REVER	10 CLAU 11 CLAU 19 OTH RSE OF THIS FORM AN TAL PROGRAM	IN PAID TO V ER - PLEASE	CERTIFY THAT LA	R M IN COMPLIANCE FOR STATE USE ON	.9		ATTENDING DENTI	THE BEDIATORS
WIVE READ THE CERTIFICATION ON THE REVER REQUEST FOR AUTHORIZATION - SEND TO OFS DEM	10 CLAU 11 CLAU 19 OTH RSE OF THIS FORM AN TAL PROGRAM	IN PAID TO V ER - PLEASE	CERTIFY THAT LA	R M IN COMPLIANCE FOR STATE USE ON	.9			05/20/12