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.

- **Situationa**l 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

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 must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Required** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**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 (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.	
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
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. In the following circumstance, entering the name of the appropriate physician 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	**Situational –** If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is **required** to be entered.	The PCP's 7-digit referral authorization number must be entered in block 17a.
17b	NPI	**Situational –** If the recipient is linked to a Primary Care Physician, the referring provider's NPI number may be entered.	The referring provider's NPI number must be entered in block 17b.

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 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 **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	**CURRENTLY, FQHC PROVIDERS ARE NOT REQUIRED TO ENTER THIS INFORMATION.** 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. This information must be entered in addition to the procedure code(s).

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	**Situational** – Complete if appropriate or leave blank.	This indicator was formerly entered in block 24I.
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). **Encounter Codes:** • **FQHC encounter visit: T1015** • **FQHC obstetrical service: T1015 w/TH modifier.** • **FQHC KIDMED 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.**	Enter the appropriate encounter procedure on the first line. If both the encounter code and the detail line(s) are not present, the claim will deny.
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	**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.	The revised form accommodates the entry of I.D. Qual.
24J	Rendering Provider I.D. #	**Situational** – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is **required**. Entering the Rendering Provider's NPI in the non-shaded portion of the block is **optional** at this time**.**	
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.	

Locator #	Description	Instructions	Alerts
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	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	The revised form accommodates entry of the Service Location NPI.
32b	Unlabelled	**Situational –** Complete if appropriate or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicating the site number of the Service Location is **required**. 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", "LU002", etc.)	If PCP, enter Site Number and Qualifier of the service location.
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.

Example of CMS-1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): **5632147896325**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Betsey Ross**

3. PATIENT'S BIRTH DATE MM DD YY: **01 05 10** SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **TPL carrier code if applicable**

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. **149 . 0**
2. _____ . _____
3. _____ . _____
4. _____ . _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **Prior auth # if applicable**

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	10	10	01	10	10	72		T1015		1	145 00	1		NPI	1236548 / 1236549875
2	01	10	10	01	10	10	72		99213		1	0 00	1		NPI	1236548 / 1236549875
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ **145 00**

29. AMOUNT PAID $

30. BALANCE DUE $ **145 00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller **2/1/10**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Always Open FQHC
123 Main St.
Any Town, LA 700000

a. **1326547895** b. **1234567**

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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.

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 – If applicable, enter the CommunityCARE authorization number or 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.

26. **REQUIRED** Control Number – Print the correct Control Number as shown on the remittance advice.

27. **REQUIRED** Date of remittance advice that Listed Claim was Paid – Enter MM DD YY from RA form.

28. **REQUIRED** Reasons for Adjustment – Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.

29. **REQUIRED** Reasons for Void – Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.

30. **REQUIRED** Signature of Physician or Supplier – All Adjustment/Void forms must be signed.

31. **REQUIRED** Physician's or Supplier's Name, Address, Zip Code and Telephone Number – Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. *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.

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. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Adalam, Mary
3 PATIENT'S DATE OF BIRTH: 06/11/89
4 MEDICAID ID NUMBER: 1234567891234
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 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 [ ] NO
B. AN AUTO ACCIDENT YES [ ] NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER: CommunityCARE
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): Authorization # (if needed)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 V222
2
3
23 ATTENDING NUMBER: 1234567
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
04	16	10	04	16	10	72	T1015	1	145.00	1		45.00

26 CONTROL NUMBER: 0076156789501
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 05/01/10

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

29 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

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

31 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

UNISYS - 213
5/97

FISCAL AGENT COPY

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

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. A list of codes identifying various carriers may be obtained from the Louisiana Medicaid website, www.lamedicaid.com under the link **Forms/Files**. 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.	
10	Patient's Relationship to Person Named in #5	**Situational.**	

Locator #	Description	Instructions	Alerts
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.	

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. If a tooth number or letter is **required** by Medicaid, do not 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.	

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.	

Locator #	Description	Instructions	Alerts
35	Remarks	**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. 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**.	
39	Number of Enclosures	**Situational** – Enter 00 to 99 in applicable boxes. 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.	
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.	

Locator #	Description	Instructions	Alerts
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	**Required** – Enter the signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider's assistant.	
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.**	

Locator #	Description	Instructions	Alerts
57	Signature	**Required** – Enter the signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider's assistant.	
58	NPI	**Optional** – Enter the 10-digit NPI of the treating (attending) dental provider	

Example of ADA Claim Form

ADA Dental Claim Form

MSA 07-02
Attachment 1

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[X] EPSDT/Title XIX

2. Predetermination/Preauthorization Number: 123456789

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

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

13. Date of Birth (MM/DD/CCYY): 08/14/2004
14. Gender: [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#): 1234567890123

16. Plan/Group Number
17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender: [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number: TPL Carrier Code
10. Patient's Relationship to Person Named in #5: [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Student Status: [ ] FTS [ ] PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender: [ ] M [ ] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	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	10/4/10					D0999	Encounter - All Inclusive	100 00
2	10/4/10	10				D4341	Periodontal Scaling and Root Planing	110 00
3	10/4/10			13		D2954	Post & Core	94 00
4	10/4/10			15		D2931	Stainless Steel Crown	140 00
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
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		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	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: [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other
39. Number of Enclosures (00 to 99): Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from: [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
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 700000

49. NPI: 1987654321
50. License Number
51. SSN or TIN
52. Phone Number: (222)999-4444
52A. Additional Provider ID: 1234567

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 11/5/10
Signed (Treating Dentist) Date

54. NPI: 1234567890
55. License Number: 99999
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number ( ) –
58. Additional Provider ID: 1987654

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.

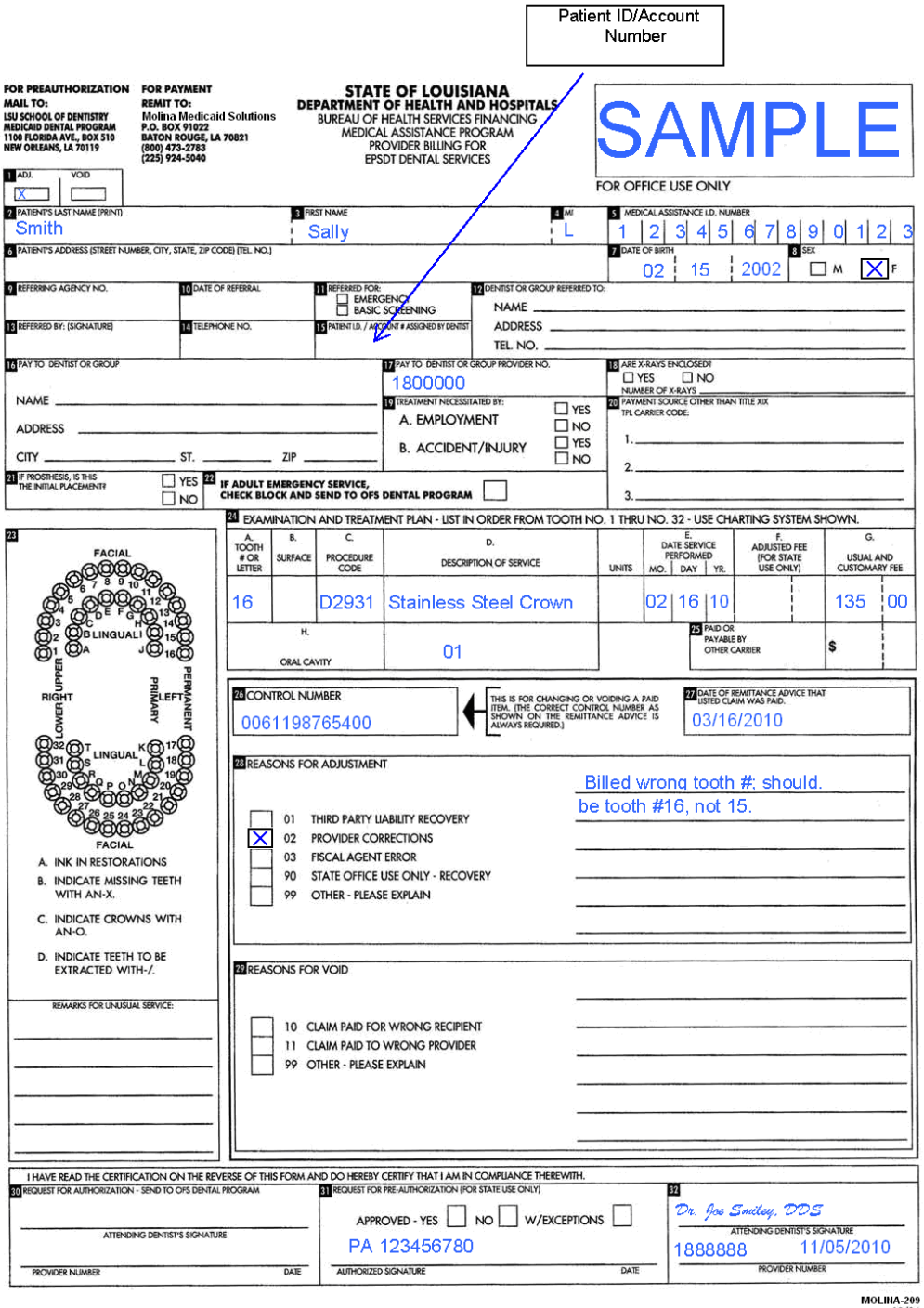
Instructions for Completing 209 Adjustment/Void Form (EPSDT)

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.	

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	All adjustment forms must be signed, and **the provider number must be entered**.	

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.

Example of 209 Adjustment/Void Form (EPSDT)



Patient ID/Account Number

FOR PREAUTHORIZATION
MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID 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
(800) 473-2783
(225) 924-5040

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

SAMPLE

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

2 PATIENT'S LAST NAME (PRINT): Smith
3 FIRST NAME: Sally
4 MI: L
5 MEDICAL ASSISTANCE I.D. NUMBER: 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: 02 15 2002
8 SEX: [ ] M [X] F
9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11 REFERRED FOR: [ ] EMERGENCY [ ] BASIC SCREENING
12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST
16 PAY TO DENTIST OR GROUP: NAME / ADDRESS / CITY ____ ST. ____ ZIP ____
17 PAY TO DENTIST OR GROUP PROVIDER NO.: 1800000
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO — NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY: A. EMPLOYMENT [ ] YES [ ] NO; B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX — TPL CARRIER CODE: 1. 2. 3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO
22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM [ ]

24 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	UNITS	E. DATE SERVICE PERFORMED MO.	DAY	YR.	F. ADJUSTED FEE (FOR STATE USE ONLY)	G. USUAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown		02	16	10		135 00
H. ORAL CAVITY			01					25 PAID OR PAYABLE BY OTHER CARRIER	$

23 FACIAL / LINGUAL / FACIAL — RIGHT, LEFT, UPPER, LOWER, PRIMARY, PERMANENT
A. INK IN RESTORATIONS
B. INDICATE MISSING TEETH WITH AN-X.
C. INDICATE CROWNS WITH AN-O.
D. INDICATE TEETH TO BE EXTRACTED WITH-/.

REMARKS FOR UNUSUAL SERVICE:

26 CONTROL NUMBER: 0061198765400
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.: 03/16/2010

28 REASONS FOR ADJUSTMENT
Billed wrong tooth #; should be tooth #16, not 15.
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[X] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN

29 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.

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)
APPROVED - YES [ ] NO [ ] W/EXCEPTIONS [ ]
PA 123456780
AUTHORIZED SIGNATURE DATE

32 Dr. Joe Smiley, DDS
ATTENDING DENTIST'S SIGNATURE
1888888 11/05/2010
PROVIDER NUMBER

MOLINA-209
10/04

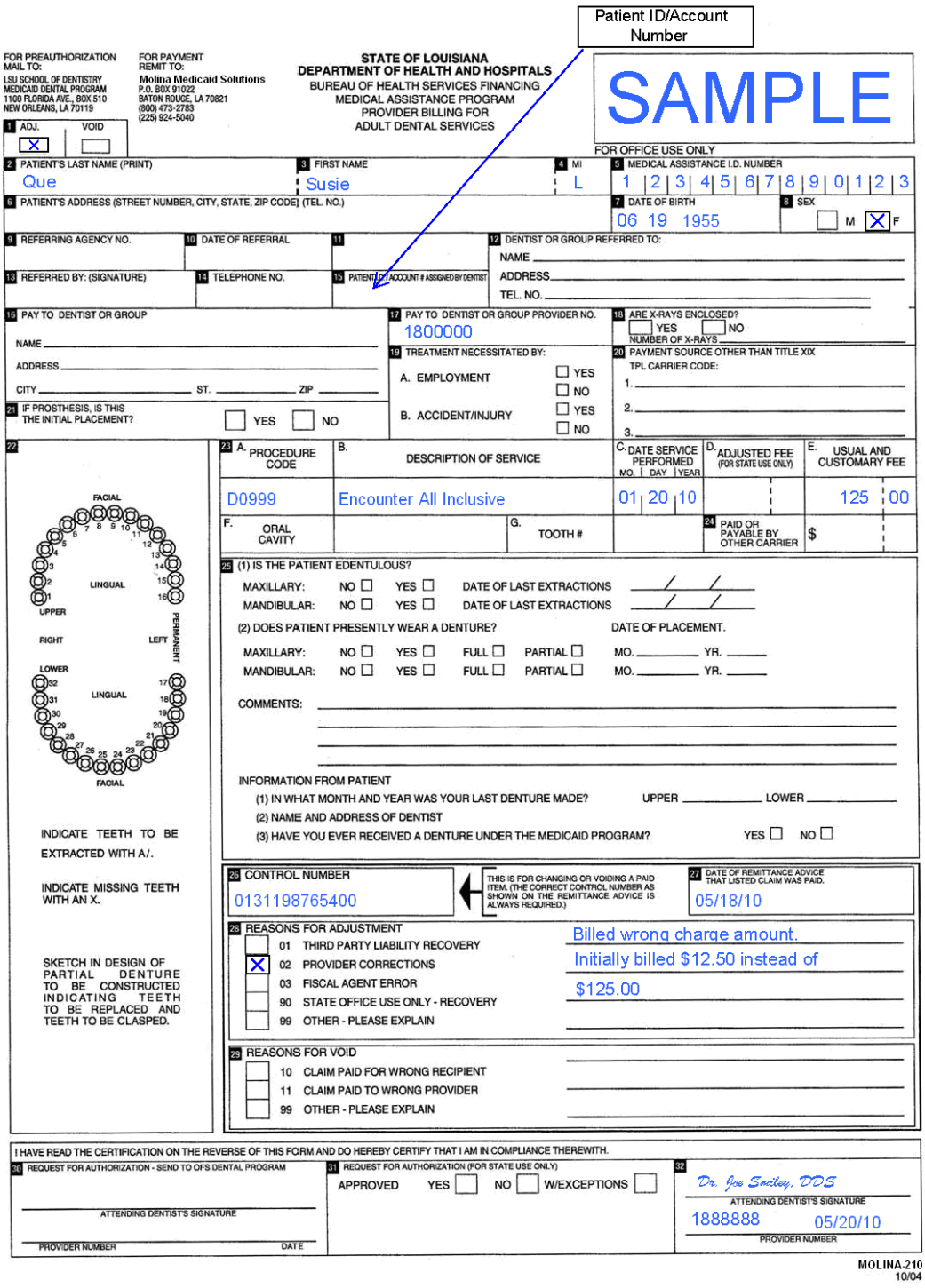
Instructions for Completing 210 Adjustment/Void Form (Adult)

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.	

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	All adjustment forms must be signed, and the provider number must be entered.	

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.

Example of 210 Adjustment/Void Form (Adult)



Patient ID/Account Number

SAMPLE

FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID 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
(800) 473-2783
(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

1 ADJ. [X] VOID [ ]

FOR OFFICE USE ONLY

2 PATIENT'S LAST NAME (PRINT): Que
3 FIRST NAME: Susie
4 MI: L
5 MEDICAL ASSISTANCE I.D. NUMBER: 1 2 3 4 5 6 7 8 9 0 1 2 3
6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)
7 DATE OF BIRTH: 06 19 1955
8 SEX: [ ] M [X] F
9 REFERRING AGENCY NO.
10 DATE OF REFERRAL
11
12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.
13 REFERRED BY: (SIGNATURE)
14 TELEPHONE NO.
15 PATIENT ID/ACCOUNT # ASSIGNED BY DENTIST
16 PAY TO DENTIST OR GROUP: NAME / ADDRESS / CITY / ST. / ZIP
17 PAY TO DENTIST OR GROUP PROVIDER NO.: 1800000
18 ARE X-RAYS ENCLOSED? [ ] YES [ ] NO — NUMBER OF X-RAYS
19 TREATMENT NECESSITATED BY: A. EMPLOYMENT [ ] YES [ ] NO; B. ACCIDENT/INJURY [ ] YES [ ] NO
20 PAYMENT SOURCE OTHER THAN TITLE XIX — TPL CARRIER CODE: 1. 2. 3.
21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? [ ] YES [ ] NO

22

INDICATE TEETH TO BE EXTRACTED WITH A/.

INDICATE MISSING TEETH WITH AN X.

SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND TEETH TO BE CLASPED.

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
D0999	Encounter All Inclusive	01 20 10		125 00
F. ORAL CAVITY		G. TOOTH #	24 PAID OR PAYABLE BY OTHER CARRIER	$

25 (1) IS THE PATIENT EDENTULOUS?
MAXILLARY: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
MANDIBULAR: NO [ ] YES [ ] DATE OF LAST EXTRACTIONS ___/___/___
(2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT.
MAXILLARY: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. ____ YR. ____
MANDIBULAR: NO [ ] YES [ ] FULL [ ] PARTIAL [ ] MO. ____ YR. ____
COMMENTS:
INFORMATION FROM PATIENT
(1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER ____ LOWER ____
(2) NAME AND ADDRESS OF DENTIST
(3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES [ ] NO [ ]

26 CONTROL NUMBER: 0131198765400
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.: 05/18/10

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

29 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.

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY)
APPROVED YES [ ] NO [ ] W/EXCEPTIONS [ ]

32 Dr. Joe Smiley, DDS
ATTENDING DENTIST'S SIGNATURE
1888888 05/20/10
PROVIDER NUMBER

MOLINA-210
10/04