

CLAIMS FILING

The claims filing appendix includes the following information:

- Instructions for completing the UB 04 claim form; and
- Samples of a UB 04 claim form for ICF/ID routine billing.

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Instructions for Completing the UB04 for ICF/ID Facility

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/ Identification Number(ID)	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control Number	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	<p>Required. Enter the appropriate 3-digit code as follows:</p> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>First Digit - Type of Facility</u> 2 = Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF technology dependent care) (LOC = SNF infectious disease) (LOC = NF rehab) (LOC = NF complex care)</p> <p>Skilled Nursing/ Intermediate Care (LOC = Case mix)</p> <p><u>Second Digit - Classification</u> 1 = Skilled Nursing -Inpatient</p>	<p>2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by the National Uniform Billing Committee (NUBC).</p> <p>Use 2nd Digit "1" instead.</p>

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Locator #	Description	Instructions	Alerts
4 (cont'd)	Type of Bill (cont'd)	<p>FOR ICF/ID PROVIDERS:</p> <p><u>First digit - type of facility</u> 6 = Intermediate Care (LOC =ICF/ID)</p> <p><u>Second digit - classification</u> 5 = Intermediate Care Level I 6 = Intermediate Care Level II</p> <p>FOR NURSING FACILITY and ICF/ID:</p> <p><u>Third Digit – frequency definition</u> 1 = Admit through discharge claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - first claim. Use this code for the first of an expected series of claims for a course of treatment. 3 = Interim - continuing claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - final claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ replacement of prior claim. Use this code to correct previously submitted and paid claim. 8 = Void/cancel of a prior claim. Use this code to void a previously submitted and paid claim.</p>	
5	Federal Tax Number	Optional.	
6	Statement Covers Period (the from and through dates of the period covered by this bill)	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: last name, first name, middle initial.	

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Locator #	Description	Instructions	Alerts
9a-e	Patient's Address (Street, City, State, Zip)	Required. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	Required. Enter the patient's date of birth using six digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	Required. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	Required for Hospital Services. Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	Leave blank.	
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	

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Locator #	Description	Instructions	Alerts
17	Patient Status	<p>Required. Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6).</p> <p>Valid Codes</p> <p>01 = Discharged to home or self-care (routine discharge)</p> <p>02 = Discharged/transferred to another short-term general hospital for inpatient care</p> <p>03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF)</p> <p>04 = Discharged/transferred to another type of institution for inpatient care</p> <p>06 = Discharged/transferred to home under care of home health services organization</p> <p>07 = Left against medical advice or discontinued care</p> <p>09 = Admitted as inpatient to a hospital</p> <p>20 = Expired/discharged due to death</p> <p>30 = Still a patient</p> <p>61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed</p> <p>62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital</p> <p>63 = Discharged/transferred to a long term care hospital</p>	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	Leave blank.	
35-36	Occurrence Spans (Code and Dates)	Leave blank.	
37	Unlabeled	Leave blank.	
38	Responsible Party Name and Address	Optional.	

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Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p>Required. Enter the appropriate value code.</p> <p>*80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.</p>	<p>Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.</p> <p>Value Codes 81, 82 and 83 are not used for straight Medicaid billing.</p>
42	Revenue Code	<p>Required. Enter the revenue code(s) which identifies the service provided.</p> <p>Bill a level of care (LOC) revenue code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill Louisiana Medicaid:</p> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>Revenue Code & Description</u> <u>(Corresponding Level of Care)</u></p> <p>022 = Skilled Nursing Facility Prospective Payment System (RUGS) (88 = Case Mix -Formerly LOC 20,21, 22)</p> <p>118 = Room and Board-Private Subacute Rehabilitation (31 = NF rehabilitation 20 = SNF/Hospice in nursing facility 21 = ICF I/Hospice in nursing facility 22 = ICF II)</p> <p>193 = Subacute Care Level III (Complex Care) (32 = NF Complex Care)</p> <p>194 = Subacute Care Level IV (28 = SNF technology dependent care)</p> <p>199 = Other Subacute Care (30 = SNF infectious disease)</p>	

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Locator #	Description	Instructions	Alerts
42 (cont'd)	Revenue Code (cont'd)	<p>FOR ICF-ID PROVIDERS:</p> <p><u>Revenue Code & Description</u> <u>(Corresponding Level of Care)</u></p> <p>193 = Pervasive level of care (Inventory for Client and Agency Planning (ICAP) Score 1-19) 192 = Extensive level of care (ICAP Score 20-39) 191 = Limited level of care (ICAP Score 40-69) 190 = Intermittent level of care (ICAP Score 70-99)</p> <p>NOTE: Providers will be paid at the intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file.</p> <p>FOR NURSING FACILITY & ICF/ID:</p> <p><u>Revenue Code & Description Leave of Absence</u></p> <p>183 = Leave of Absence - Subcategory therapeutic (for home leave)</p> <p>185 = Leave of Absence - Subcategory nursing home (for hospitalization)</p>	
43	Revenue Description	Required. Enter the narrative description of the corresponding revenue code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	Leave blank.	

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Locator #	Description	Instructions	Alerts
45	Service Date	<p>Required. Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided.</p> <p>Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the service date should be entered 01-31.</p> <p>Example 2: If the recipient is on hospital leave (Revenue Code 185) from March 06 -12, the service date should be entered 07-12, -- If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).</p> <p>Note: The claim must reflect the total number of days billed at a particular level of care (LOC) corresponding to the revenue code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate revenue code for that LOC and the correct number of days indicated for that LOC for the month of service.</p> <p>Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.</p>	
46	Units of Service	<p>Required. Enter in DAYS the number of units of service for each level of care type on the line adjacent to the level of care revenue code, description, and service date.</p> <p>Example 1: Service date 01-31 should indicate 31 units or days for Revenue Code 194.</p> <p>Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the "from" and "to" days in Form Locator 45.</p> <p>Example 2: (Revenue Code 185), Service date 07-12, service units should be left blank.</p>	
47	Total Charges	Leave Blank.	

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Locator #	Description	Instructions	Alerts
48	Non-Covered Charges	Leave Blank.	
49	Unlabeled Field (National)	Leave Blank.	
50-A,B,C	Payer Name	<p>Situational. Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is required.</p> <p>If the patient is a Medically Needy Spend-Down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. The Medically Needy Spend-Down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.</p>	
51-A,B,C	Health Plan Identification (ID)	<p>Situational. Enter the corresponding health plan ID number for other plans listed in Form Locator 50 A, B, and C.</p> <p>If other insurance companies are listed, then entry of their Health Plan ID numbers is required.</p>	
52- A,B,C	Release of Information	Optional.	
53- A,B,C	Assignment of Benefits Certification Indicator	Optional.	
54- A,B,C	Prior Payments	<p>Situational. Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C.</p> <p>If private insurance was available, but no private insurance payment was made, then enter '0' or '0.00' in this field.</p>	
55- A,B,C	Estimated Amount Due	Optional.	
56	National Provider Identifier (NPI)	Required. Enter the provider's NPI.	The 10-digit NPI must be entered here.

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Locator #	Description	Instructions	Alerts
57	Other Provider Identification (ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58- A,B,C	Insured's Name	<p>Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p>Situational. If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.</p>	
59- A,B,C	Patient's Relationship to Insured	<p>Situational. If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C.</p> <p>Acceptable codes are as follows:</p> <ul style="list-style-type: none"> 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent 	

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Locator #	Description	Instructions	Alerts
60- A,B,C	Insured's Unique Identification (ID)	<p>Required. Enter the recipient's 13-digit Medicaid identification number as it appears on the Medicaid ID card in 60A.</p> <p>Situational. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.</p>	
61- A,B,C	Insured's Group Name (Medicaid not Primary)	<p>Situational. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.</p>	<p>ONLY the 6-digit code should be entered for commercial and Medicare HMOs in this field.</p> <p>DO NOT enter dashes, hyphens or the word TPL in the field.</p> <p>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE.</p>
62- A,B,C	Insured's Group Number (Medicaid not Primary)	<p>Situational If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.</p>	
63-A,B,C	Treatment Authorization Code	Leave blank.	

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Locator #	Description	Instructions	Alerts
64- A,B,C	Document Control Number	<p>Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u></p> <p>01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u></p> <p>10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	
65- A,B,C	Employer Name	<p>Situational. If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.</p>	
66	DX Version Qualifier (Diagnosis and Procedure Code Qualifier)	<p>Required. Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p>	

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Locator #	Description	Instructions	Alerts
67	Principal Diagnosis Codes	Required. Enter the most current ICD diagnosis code.	<p>The most specific diagnosis codes must be used. General codes are not acceptable. A code is invalid if it has not been coded to the full number of digits required for that code.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).</p>
67 A-Q	Other Diagnosis code	<p>Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim.</p> <p>NOTE:</p> <p>ICD-9 Diagnosis Codes beginning with "E" or "M" are not acceptable for any diagnosis code.</p> <p>ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting diagnosis code.	
70	Patient Reason for Visit	Leave blank.	
71	Prospective Payment System (PPS) Code	Leave blank.	
72- A,B,C	ECI (External Cause of Injury)	Leave blank.	

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Locator #	Description	Instructions	Alerts
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a – e	Other Procedure Code / Date		
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and NPI number of the physician ordering the plan of care.	<p>This field must be completed.</p> <p>The attending provider name and NPI <u>cannot</u> be the billing provider.</p> <p>The individual attending provider information must be entered in this field.</p> <p>The attending provider must be enrolled with Louisiana Medicaid.</p>
77	Operating	Leave blank.	

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Locator #	Description	Instructions	Alerts
78	Other	<p>Situational. If applicable, enter the name and NPI of the referring provider or other physician.</p> <p>Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.</p>	<p><u>A referring provider is NOT required on the claim.</u> However, if a referring provider is entered on the claim, the name and NPI number must be entered here with the Qualifier DN indicating referring provider.</p> <p>The referring provider <u>cannot</u> be the billing provider. The individual referring provider information should be entered in this field.</p> <p>If entered, the referring provider must be enrolled with LA Medicaid.</p>
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

SIGNATURE IS NOT REQUIRED ON THE UB-04.

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SAMPLE NURSING FACILITY CLAIM FORM WITH AN ATTENDING PROVIDER ONLY (WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)

1 HAPPY HOME NURSING HOME		2		3a PAT. CMT. # 111111		4 TYPE OF BILL 212	
987 CORN ST.				5 MED. REC. # 111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA d 71111		e	
b		b ANYWHERE		c LA d 71111		e	
10 BIRTHDATE		11 SEX M		12 DATE OF BIRTH 090115		13 ADMISSION 13 HR 14 TYPE 15 SPG 16 DHR 17 STAT 30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38 OCCURRENCE DATE	
39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42 VALUE CODES	
a 80		b 30 30		c 30 30		d 30 30	
b		c		d		e	
c		d		e		f	
d		e		f		g	
e		f		g		h	
f		g		h		i	
g		h		i		j	
h		i		j		k	
i		j		k		l	
j		k		l		m	
k		l		m		n	
l		m		n		o	
m		n		o		p	
n		o		p		q	
o		p		q		r	
p		q		r		s	
q		r		s		t	
r		s		t		u	
s		t		u		v	
t		u		v		w	
u		v		w		x	
v		w		x		y	
w		x		y		z	
x		y		z		aa	
y		z		aa		ab	
z		aa		ab		ac	
aa		ab		ac		ad	
ab		ac		ad		ae	
ac		ad		ae		af	
ad		ae		af		ag	
ae		af		ag		ah	
af		ag		ah		ai	
ag		ah		ai		aj	
ah		ai		aj		ak	
ai		aj		ak		al	
aj		ak		al		am	
ak		al		am		an	
al		am		an		ao	
am		an		ao		ap	
an		ao		ap		aq	
ao		ap		aq		ar	
ap		aq		ar		as	
aq		ar		as		at	
ar		as		at		au	
as		at		au		av	
at		au		av		aw	
au		av		aw		ax	
av		aw		ax		ay	
aw		ax		ay		az	
ax		ay		az		ba	
ay		az		ba		bb	
az		ba		bb		bc	
ba		bb		bc		bd	
bb		bc		bd		be	
bc		bd		be		bf	
bd		be		bf		bg	
be		bf		bg		bh	
bf		bg		bh		bi	
bg		bh		bi		bj	
bh		bi		bj		bk	
bi		bj		bk		bl	
bj		bk		bl		bm	
bk		bl		bm		bn	
bl		bm		bn		bo	
bm		bn		bo		bp	
bn		bo		bp		bq	
bo		bp		bq		br	
bp		bq		br		bs	
bq		br		bs		bt	
br		bs		bt		bu	
bs		bt		bu		bv	
bt		bu		bv		bw	
bu		bv		bw		bx	
bv		bw		bx		by	
bw		bx		by		bz	
bx		by		bz		ca	
by		bz		ca		cb	
bz		ca		cb		cc	
ca		cb		cc		cd	
cb		cc		cd		ce	
cc		cd		ce		cf	
cd		ce		cf		cg	
ce		cf		cg		ch	
cf		cg		ch		ci	
cg		ch		ci		cj	
ch		ci		cj		ck	
ci		cj		ck		cl	
cj		ck		cl		cm	
ck		cl		cm		cn	
cl		cm		cn		co	
cm		cn		co		cp	
cn		co		cp		cq	
co		cp		cq		cr	
cp		cq		cr		cs	
cq		cr		cs		ct	
cr		cs		ct		cu	
cs		ct		cu		cv	
ct		cu		cv		cw	
cu		cv		cw		cx	
cv		cw		cx		cy	
cw		cx		cy		cz	
cx		cy		cz		da	
cy		cz		da		db	
cz		da		db		dc	
da		db		dc		dd	
db		dc		dd		de	
dc		dd		de		df	
dd		de		df		dg	
de		df		dg		dh	
df		dg		dh		di	
dg		dh		di		dj	
dh		di		dj		dk	
di		dj		dk		dl	
dj		dk		dl		dm	
dk		dl		dm		dn	
dl		dm		dn		do	
dm		dn		do		dp	
dn		do		dp		dq	
do		dp		dq		dr	
dp		dq		dr		ds	
dq		dr		ds		dt	
dr		ds		dt		du	
ds		dt		du		dv	
dt		du		dv		dw	
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dv		dw		dx		dy	
dw		dx		dy		dz	
dx		dy		dz		ea	
dy		dz		ea		eb	
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ef		eg		eh		ei	
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el		em		en		eo	
em		en		eo		ep	
en		eo		ep		eq	
eo		ep		eq		er	
ep		eq		er		es	
eq		er		es		et	
er		es		et		eu	
es		et		eu		ev	
et		eu		ev		ew	
eu		ev		ew		ex	
ev		ew		ex		ey	
ew		ex		ey		ez	
ex		ey		ez		fa	
ey		ez		fa		fb	
ez		fa		fb		fc	
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fg		fh		fi		fj	
fh		fi		fj		fk	
fi		fj		fk		fl	
fj		fk		fl		fm	
fk		fl		fm		fn	
fl		fm		fn		fo	
fm		fn		fo		fp	
fn		fo		fp		fq	
fo		fp		fq		fr	
fp		fq		fr		fs	
fq		fr		fs		ft	
fr		fs		ft		fu	
fs		ft		fu		fv	
ft		fu		fv		fw	
fu		fv		fw		fx	
fv		fw		fx		fy	
fw		fx		fy		fz	
fx		fy		fz		ga	
fy		fz		ga		gb	
fz		ga		gb		gc	
ga		gb		gc		gd	
gb		gc		gd		ge	
gc		gd		ge		gf	
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CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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**SAMPLE NURSING FACILITY CLAIM FORM
WITH A REFERRING PROVIDER
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 HAPPY HOME NURSING HOME 987 CORN ST. ANYWHERE, LA 71111										2		3a PAT. ONT. # 1111111 b. MED. REG. # 111111111111 5 FED. TAX NO. 6 STATEMENT COVERS PERIOD FROM 090116 THROUGH 091516										4 TYPE OF BILL 214	
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS a 1235 ANYSTREET													
10 BIRTHDATE b ANYWHERE MMDDYY M 090116 11 SEX 12 DATE 13 HR 14 TYPE 15 SEC 16 DHR 17 STAT 18 19 20 21 22 CONDITION CODES 23 24 25 26 27 28 29 ACOT STATE 30										c LA d 71111 e													
31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE 39 OCCURRENCE DATE 40 CODE 41 OCCURRENCE DATE 42 CODE 43 OCCURRENCE DATE 44 CODE 45 OCCURRENCE DATE 46 CODE 47 OCCURRENCE DATE 48 CODE 49 OCCURRENCE DATE 50 CODE 51 OCCURRENCE DATE 52 CODE 53 OCCURRENCE DATE 54 CODE 55 OCCURRENCE DATE 56 CODE 57 OCCURRENCE DATE 58 CODE 59 OCCURRENCE DATE 60 CODE 61 OCCURRENCE DATE 62 CODE 63 OCCURRENCE DATE 64 CODE 65 OCCURRENCE DATE 66 CODE 67 OCCURRENCE DATE 68 CODE 69 OCCURRENCE DATE 70 CODE 71 OCCURRENCE DATE 72 CODE 73 OCCURRENCE DATE 74 CODE 75 OCCURRENCE DATE 76 CODE 77 OCCURRENCE DATE 78 CODE 79 OCCURRENCE DATE 80 CODE 81 OCCURRENCE DATE 82 CODE 83 OCCURRENCE DATE 84 CODE 85 OCCURRENCE DATE 86 CODE 87 OCCURRENCE DATE 88 CODE 89 OCCURRENCE DATE 90 CODE 91 OCCURRENCE DATE 92 CODE 93 OCCURRENCE DATE 94 CODE 95 OCCURRENCE DATE 96 CODE 97 OCCURRENCE DATE 98 CODE 99 OCCURRENCE DATE 100 CODE 101 OCCURRENCE DATE 102 CODE 103 OCCURRENCE DATE 104 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APPENDIX D: CLAIMS FILING

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**SAMPLE NURSING FACILITY CLAIM FORM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

[illegible]

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APPENDIX D: CLAIMS FILING

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**SAMPLE NURSING FACILITY CLAIM FORM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 HAPPY HOME NURSING HOME		2		3a. PAT. CNTRL. # 1111111		4 TYPE OF BILL 217	
987 CORN ST.				5 MED. REG. # 111111111111			
ANYWHERE, LA 71111				6 STATEMENT COVERS PERIOD FROM 100115		7 THROUGH 102015	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET					
b ANYWHERE				c LA d 71111 e			
10 BIRTHDATE MMDDYY M 090115		11 SEX F		12 DATE OF ADMISSION 101115		13 ICD-10 CODE 01	
14 STAT 01		15 DHR 01		16 CONDITON CODES 22 23 24 25 26 27 28		17 ACOT STATE 30	
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APPENDIX D: CLAIMS FILING

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**SAMPLE ICF/ID FACILITY CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

[illegible]

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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**SAMPLE ICF/ID FACILITY CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CNTRL. # 11111111111111111111		4 TYPE OF BILL 654	
3b MED. REC. # 11111111111111111111		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 100115		7 THROUGH 102015	
8 PATIENT NAME DOE, JOHN		9 PATIENT ADDRESS 1235 ANYSTREET					
10 BIRTHDATE MMDDYY M 080115		11 SEX M		12 DATE 080115		13 ADMISSION 13 ICD-10 TYPE 14 ICD-10 TYPE 15 ICD-10 TYPE 16 ICD-10 TYPE	
17 STAT 01		18		19		20	
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29 ACOT STATE LA		30		31		32	
33 OCCURRENCE DATE		34 CODE		35 OCCURRENCE DATE		36 CODE	
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861							

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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**SAMPLE ICF/ID FACILITY CLAIM FORM
WITH A REFERRING PROVIDER
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 BLOMMINGICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111										2										3a PAT. DATE # 111111 3b MED. REG. # 111111111111 3c FED. TAX NO.										4 TYPE OF BILL 654																																																																					
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS a 1235 ANYSTREET										c LA d 71111																																																																															
10 BIRTH DATE MMDDYY M 080116										11 SEX F										12 DATE OF ADMISSION 12 HR 14 TYPE 15 SNG 16 DHR 20										17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30																																																																					
31 OCCURRENCE DATE										32 CODE										33 OCCURRENCE DATE										34 CODE										35 OCCURRENCE DATE										36 CODE										37 OCCURRENCE DATE										38 CODE																													
39 CODE										40 VALUE CODES AMOUNT										41 CODE										42 VALUE CODES AMOUNT										43 CODE										44 VALUE CODES AMOUNT																																																	
45 REV. CD. 193										46 DESCRIPTION CASE MIX										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE 01-05										46 SERV. UNITS 5										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																													
PAGE 1 OF 1										CREATION DATE 110515										TOTALS																																																																															
50 PRIOR NAME MEDICAID										51 HEALTH PLAN ID										52 RFL INFO										53 ADL BIL										54 PRIOR PAYMENTS TPL ...										55 EST. AMOUNT DUE										56 NPI 1234567890																																							
																																								57 OTHER PAYMENT IF APPLICABLE										58 NPI 1234567																																																	
59 INSURED'S NAME DOE, JOHN										60 INSURED'S UNIQUE ID 1234567890123										61 GROUP NAME TPL CARRIER										62 INSURANCE GROUP NO.																																																																					
																														CODE IF APPLICABLE																																																																					
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																																															
66 F71										67 A B C D E F G H										68																																																																															
69 ADMIT DATE										70 PATIENT REASON DX										71 PRIOR CODE										72 ECI										73																																																											
74 PRINCIPAL PROCEDURE CODE										a OTHER PROCEDURE CODE										b OTHER PROCEDURE CODE										c OTHER PROCEDURE CODE										d OTHER PROCEDURE CODE										e OTHER PROCEDURE CODE										f OTHER PROCEDURE CODE																																							
80 REMARKS										81 CC a b c d										76 ATTENDING NPI 1298765432										77 OPERATING NPI										78 OTHER DN NPI 1589999999										79 OTHER NPI										80																																							
																				LAST ADAMS										FIRST JANE										LAST										FIRST										LAST DOE										FIRST APRIL																													

LB-04 CMS-1450

APPROVED OMB NO. 0908-0097

NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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APPENDIX D: CLAIMS FILING

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**SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111		2		3a PAT. ONTL. # 1111111 3b MED. REC. # 1111111111111111 5 FED. TAX NO.		4 TYPE OF BILL 657	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA d 71111 e			
10 BIRTHDATE MMDDYY M 080115		11 SEX M		12 DATE OF ADMISSION 13 HR 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21		CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE 30	
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE		38 CODE	
39 VALUE CODES AMOUNT		40 CODE		41 VALUE CODES AMOUNT		42 CODE	
a 80		19.30					
b							
c							
d							
43 REV. CO.		44 DESCRIPTION		45 HCPCS / RATE / HIPPS CODE		46 SERV. DATE	
193		CASE MIX				01-20	
185		HOSPITAL LEAVE				04-07	
183		HOME LEAVE				10-13	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
PAGE 1 OF 1		CREATION DATE 122815		TOTALS			
50 PRVYR NAME MEDICAID		51 HEALTH PLAN ID		52 PRIOR PAYMENTS TPL ..		53 EST. AMOUNT DUE	
54 PAYMENT IF APPLICABLE		55 NPI 1234567890		56 S7 1234567		57 OTHER PRV ID	
58 INSURED'S NAME DOE, JOHN		59 INSURED'S UNIQUE ID 1234567890123		60 GROUP NAME TPL CARRIER		61 INSURANCE GROUP NO.	
62 TREATMENT AUTHORIZATION CODES		63 DOCUMENT CONTROL NUMBER A 5309198798700 02		64 EMPLOYER NAME			
65 ATTENDING NPI 1298765432		66 QUAL		67 FIRST JANE		68 LAST ADAMS	
69 OPERATING NPI		69 QUAL		69 FIRST		69 LAST	
70 OTHER NPI		70 QUAL		70 FIRST		70 LAST	
71 OTHER NPI		71 QUAL		71 FIRST		71 LAST	
72 OTHER NPI		72 QUAL		72 FIRST		72 LAST	
73 OTHER NPI		73 QUAL		73 FIRST		73 LAST	
74 OTHER NPI		74 QUAL		74 FIRST		74 LAST	
75 OTHER NPI		75 QUAL		75 FIRST		75 LAST	
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97 OTHER NPI		97 QUAL		97 FIRST		97 LAST	
98 OTHER NPI		98 QUAL		98 FIRST		98 LAST	
99 OTHER NPI		99 QUAL		99 FIRST		99 LAST	
100 OTHER NPI		100 QUAL		100 FIRST		100 LAST	

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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Instructions for Completing the UB04 for ICF/ID Facility

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone Number	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/ Identification Number(ID)	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control Number	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record Number	Optional. Enter patient's medical record number (up to 24 characters).	
4	Type of Bill	<p>Required. Enter the appropriate 3-digit code as follows:</p> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>First Digit - Type of Facility</u> 2 = Skilled Nursing (LOC = ICF I) (LOC = ICF II) (LOC = SNF) (LOC = SNF technology dependent care) (LOC = SNF infectious disease) (LOC = NF rehab) (LOC = NF complex care)</p> <p>Skilled Nursing/ Intermediate Care (LOC = Case mix)</p> <p><u>Second Digit - Classification</u> 1 = Skilled Nursing -Inpatient</p>	<p>2nd Digit "7" when used with 1st Digit "2" is reserved for assignment by the National Uniform Billing Committee (NUBC).</p> <p>Use 2nd Digit "1" instead.</p>

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
4 (cont'd)	Type of Bill (cont'd)	<p>FOR ICF/ID PROVIDERS:</p> <p><u>First digit - type of facility</u> 6 = Intermediate Care (LOC =ICF/ID)</p> <p><u>Second digit - classification</u> 5 = Intermediate Care Level I 6 = Intermediate Care Level II</p> <p>FOR NURSING FACILITY and ICF/ID:</p> <p><u>Third Digit – frequency definition</u> 1 = Admit through discharge claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - first claim. Use this code for the first of an expected series of claims for a course of treatment. 3 = Interim - continuing claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - final claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ replacement of prior claim. Use this code to correct previously submitted and paid claim. 8 = Void/cancel of a prior claim. Use this code to void a previously submitted and paid claim.</p>	
5	Federal Tax Number	Optional.	
6	Statement Covers Period (the from and through dates of the period covered by this bill)	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: last name, first name, middle initial.	

CHAPTER 26: ICF/DD SERVICES**APPENDIX D: CLAIMS FILING****PAGE(S) 25**

Locator #	Description	Instructions	Alerts
9a-e	Patient's Address (Street, City, State, Zip)	Required. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	Required. Enter the patient's date of birth using six digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	Required. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	Required for Hospital Services. Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	Leave blank.	
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
17	Patient Status	<p>Required. Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6).</p> <p>Valid Codes</p> <p>01 = Discharged to home or self-care (routine discharge)</p> <p>02 = Discharged/transferred to another short-term general hospital for inpatient care</p> <p>03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF)</p> <p>04 = Discharged/transferred to another type of institution for inpatient care</p> <p>06 = Discharged/transferred to home under care of home health services organization</p> <p>07 = Left against medical advice or discontinued care</p> <p>09 = Admitted as inpatient to a hospital</p> <p>20 = Expired/discharged due to death</p> <p>30 = Still a patient</p> <p>61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed</p> <p>62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital</p> <p>63 = Discharged/transferred to a long term care hospital</p>	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	Leave blank.	
35-36	Occurrence Spans (Code and Dates)	Leave blank.	
37	Unlabeled	Leave blank.	
38	Responsible Party Name and Address	Optional.	

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APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p>Required. Enter the appropriate value code.</p> <p>*80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.</p>	<p>Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04.</p> <p>Value Codes 81, 82 and 83 are not used for straight Medicaid billing.</p>
42	Revenue Code	<p>Required. Enter the revenue code(s) which identifies the service provided.</p> <p>Bill a level of care (LOC) revenue code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill Louisiana Medicaid:</p> <p>FOR NURSING FACILITY PROVIDERS:</p> <p><u>Revenue Code & Description</u> <u>(Corresponding Level of Care)</u></p> <p>022 = Skilled Nursing Facility Prospective Payment System (RUGS) (88 = Case Mix -Formerly LOC 20,21, 22)</p> <p>118 = Room and Board-Private Subacute Rehabilitation (31 = NF rehabilitation 20 = SNF/Hospice in nursing facility 21 = ICF I/Hospice in nursing facility 22 = ICF II)</p> <p>193 = Subacute Care Level III (Complex Care) (32 = NF Complex Care)</p> <p>194 = Subacute Care Level IV (28 = SNF technology dependent care)</p> <p>199 = Other Subacute Care (30 = SNF infectious disease)</p>	

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
42 (cont'd)	Revenue Code (cont'd)	<p>FOR ICF-ID PROVIDERS:</p> <p><u>Revenue Code & Description</u> <u>(Corresponding Level of Care)</u></p> <p>193 = Pervasive level of care (Inventory for Client and Agency Planning (ICAP) Score 1-19) 192 = Extensive level of care (ICAP Score 20-39) 191 = Limited level of care (ICAP Score 40-69) 190 = Intermittent level of care (ICAP Score 70-99)</p> <p>NOTE: Providers will be paid at the intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file.</p> <p>FOR NURSING FACILITY & ICF/ID:</p> <p><u>Revenue Code & Description Leave of Absence</u></p> <p>183 = Leave of Absence - Subcategory therapeutic (for home leave)</p> <p>185 = Leave of Absence - Subcategory nursing home (for hospitalization)</p>	
43	Revenue Description	Required. Enter the narrative description of the corresponding revenue code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	Leave blank.	

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APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
45	Service Date	<p>Required. Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided.</p> <p>Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the service date should be entered 01-31.</p> <p>Example 2: If the recipient is on hospital leave (Revenue Code 185) from March 06 -12, the service date should be entered 07-12, -- If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11).</p> <p>Note: The claim must reflect the total number of days billed at a particular level of care (LOC) corresponding to the revenue code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate revenue code for that LOC and the correct number of days indicated for that LOC for the month of service.</p> <p>Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.</p>	
46	Units of Service	<p>Required. Enter in DAYS the number of units of service for each level of care type on the line adjacent to the level of care revenue code, description, and service date.</p> <p>Example 1: Service date 01-31 should indicate 31 units or days for Revenue Code 194.</p> <p>Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the "from" and "to" days in Form Locator 45.</p> <p>Example 2: (Revenue Code 185), Service date 07-12, service units should be left blank.</p>	
47	Total Charges	Leave Blank.	

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Locator #	Description	Instructions	Alerts
48	Non-Covered Charges	Leave Blank.	
49	Unlabeled Field (National)	Leave Blank.	
50-A,B,C	Payer Name	<p>Situational. Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is required.</p> <p>If the patient is a Medically Needy Spend-Down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. The Medically Needy Spend-Down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.</p>	
51-A,B,C	Health Plan Identification (ID)	<p>Situational. Enter the corresponding health plan ID number for other plans listed in Form Locator 50 A, B, and C.</p> <p>If other insurance companies are listed, then entry of their Health Plan ID numbers is required.</p>	
52- A,B,C	Release of Information	Optional.	
53- A,B,C	Assignment of Benefits Certification Indicator	Optional.	
54- A,B,C	Prior Payments	<p>Situational. Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C.</p> <p>If private insurance was available, but no private insurance payment was made, then enter '0' or '0.00' in this field.</p>	
55- A,B,C	Estimated Amount Due	Optional.	
56	National Provider Identifier (NPI)	Required. Enter the provider's NPI.	The 10-digit NPI must be entered here.

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Locator #	Description	Instructions	Alerts
57	Other Provider Identification (ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58- A,B,C	Insured's Name	<p>Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p>Situational. If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.</p>	
59- A,B,C	Patient's Relationship to Insured	<p>Situational. If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C.</p> <p>Acceptable codes are as follows:</p> <ul style="list-style-type: none"> 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent 	

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APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
60- A,B,C	Insured's Unique Identification (ID)	<p>Required. Enter the recipient's 13-digit Medicaid identification number as it appears on the Medicaid ID card in 60A.</p> <p>Situational. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.</p>	
61- A,B,C	Insured's Group Name (Medicaid not Primary)	<p>Situational. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.</p>	<p>ONLY the 6-digit code should be entered for commercial and Medicare HMOs in this field.</p> <p>DO NOT enter dashes, hyphens or the word TPL in the field.</p> <p>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE.</p>
62- A,B,C	Insured's Group Number (Medicaid not Primary)	<p>Situational If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.</p>	
63-A,B,C	Treatment Authorization Code	Leave blank.	

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APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
64- A,B,C	Document Control Number	<p>Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u></p> <p>01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u></p> <p>10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	
65- A,B,C	Employer Name	<p>Situational. If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.</p>	
66	DX Version Qualifier (Diagnosis and Procedure Code Qualifier)	<p>Required. Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p>	

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APPENDIX D: CLAIMS FILING

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Locator #	Description	Instructions	Alerts
67	Principal Diagnosis Codes	Required. Enter the most current ICD diagnosis code.	<p>The most specific diagnosis codes must be used. General codes are not acceptable. A code is invalid if it has not been coded to the full number of digits required for that code.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).</p>
67 A-Q	Other Diagnosis code	<p>Situational. Enter the ICD code or codes for all other applicable diagnoses for this claim.</p> <p>NOTE:</p> <p>ICD-9 Diagnosis Codes beginning with "E" or "M" are not acceptable for any diagnosis code.</p> <p>ICD-10-CM "V", "W", "X", & "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting diagnosis code.	
70	Patient Reason for Visit	Leave blank.	
71	Prospective Payment System (PPS) Code	Leave blank.	
72- A,B,C	ECI (External Cause of Injury)	Leave blank.	

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Locator #	Description	Instructions	Alerts
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a – e	Other Procedure Code / Date		
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and NPI number of the physician ordering the plan of care.	<p>This field must be completed.</p> <p>The attending provider name and NPI <u>cannot</u> be the billing provider.</p> <p>The individual attending provider information must be entered in this field.</p> <p>The attending provider must be enrolled with Louisiana Medicaid.</p>
77	Operating	Leave blank.	

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Locator #	Description	Instructions	Alerts
78	Other	<p>Situational. If applicable, enter the name and NPI of the referring provider or other physician.</p> <p>Note: If a referring provider is entered on the claim, the information must be entered in FL 78 with Qualifier DN.</p>	<p><u>A referring provider is NOT required on the claim.</u> However, if a referring provider is entered on the claim, the name and NPI number must be entered here with the Qualifier DN indicating referring provider.</p> <p>The referring provider <u>cannot</u> be the billing provider. The individual referring provider information should be entered in this field.</p> <p>If entered, the referring provider must be enrolled with LA Medicaid.</p>
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

SIGNATURE IS NOT REQUIRED ON THE UB-04.

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APPENDIX D: CLAIMS FILING

PAGE(S) 25

**SAMPLE NURSING FACILITY CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

1 HAPPY HOME NURSING HOME 987 CORN ST. ANYWHERE, LA 71111		2		3a INT. ONTL. # b. MED. REG. # 1111111111		4 TYPE OF BILL 212	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS b ANYWHERE		c LA d 71111		e	
10 BIRTH DATE MMDDYY M 090115		11 SEX M		12 DATE 090115		13 HR. 14 TYPE 15 SPC 30	
16 OCCURRENCE DATE 31		17 OCCURRENCE DATE 32		18 OCCURRENCE DATE 33		19 OCCURRENCE DATE 34	
20 OCCURRENCE DATE 35		21 OCCURRENCE DATE 36		22 OCCURRENCE DATE 37		23 OCCURRENCE DATE 38	
24		25		26		27	
28		29		30		31	
32		33		34		35	
36		37		38		39	
40		41		42		43	
44		45		46		47	
48		49		50		51	
52		53		54		55	
56		57		58		59	
60		61		62		63	
64		65		66		67	
68		69		70		71	
72		73		74		75	
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84		85		86		87	
88		89		90		91	
92		93		94		95	
96		97		98		99	

SAMPLE

EXAMPLE OF ICD 09
WITH AN ATTENDING PROVIDER ONLY

50 PRYER NAME A MEDICAID		51 HEALTH PLAN ID		52 PRIOR PAYMENTS TPL PAYMENT IF APPLICABLE		53 EST. AMOUNT DUE 1234567890		54 NON-COVERED CHARGES 1234567	
55 INSURED'S NAME A DOE, JOHN		56 INSURER'S UNIQUE ID 1234567890123		57 GROUP NAME TPL CARRIER CODE IF APPLICABLE		58 INSURANCE GROUP NO.		59	
60 TREATMENT AUTHORIZATION CODES		61 DOCUMENT CONTROL NUMBER		62 EMPLOYER NAME		63		64	
65		66		67		68		69	
70		71		72		73		74	
75		76		77		78		79	
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85		86		87		88		89	
90		91		92		93		94	
95		96		97		98		99	

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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SAMPLE NURSING FACILITY CLAIM FORM WITH AN ATTENDING PROVIDER ONLY (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)

1 HAPPY HOME NURSING HOME		2		3a PAT. CHL. # 1111111		4 TYPE OF BILL 214	
987 CORN ST.				b. MED. REG. # 1111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET					
b. ANYWHERE				c. LA		d. 71111	
10 BIRTHDATE MMDDYY M 090115		11 SEX 1		12 DATE OF ADMISSION 15 SEP 16		13 TYPE 01	
14 DHR 01		15 STAT 18		16 19		17 20	
18 21		19 22		20 23		21 24	
22 25		23 26		24 27		25 28	
26 29		27 30		28 31		29 32	
30 33		31 34		32 35		33 36	
34 37		35 38		36 39		37 40	
38 41		39 42		40 43		41 44	
42 45		43 46		44 47		45 48	
46 49		47 50		48 51		49 52	
50 53		51 54		52 55		53 56	
54 57		55 58		56 59		57 60	
60 61		61 62		62 63		63 64	
64 65		65 66		66 67		67 68	
68 69		69 70		70 71		71 72	
72 73		73 74		74 75		75 76	
76 77		77 78		78 79		79 80	
80 81		81 82		82 83		83 84	
84 85		85 86		86 87		87 88	
88 89		89 90		90 91		91 92	
92 93		93 94		94 95		95 96	
96 97		97 98		98 99		99 100	
100 101		101 102		102 103		103 104	
104 105		105 106		106 107		107 108	
108 109		109 110		110 111		111 112	
112 113		113 114		114 115		115 116	
116 117		117 118		118 119		119 120	
120 121		121 122		122 123		123 124	
124 125		125 126		126 127		127 128	
128 129		129 130		130 131		131 132	
132 133		133 134		134 135		135 136	
136 137		137 138		138 139		139 140	
140 141		141 142		142 143		143 144	
144 145		145 146		146 147		147 148	
148 149		149 150		150 151		151 152	
152 153		153 154		154 155		155 156	
156 157		157 158		158 159		159 160	
160 161		161 162		162 163		163 164	
164 165		165 166		166 167		167 168	
168 169		169 170		170 171		171 172	
172 173		173 174		174 175		175 176	
176 177		177 178		178 179		179 180	
180 181		181 182		182 183		183 184	
184 185		185 186		186 187		187 188	
188 189		189 190		190 191		191 192	
192 193		193 194		194 195		195 196	
196 197		197 198		198 199		199 200	
200 201		201 202		202 203		203 204	
204 205		205 206		206 207		207 208	
208 209		209 210		210 211		211 212	
212 213		213 214		214 215		215 216	
216 217		217 218		218 219		219 220	
220 221		221 222		222 223		223 224	
224 225		225 226		226 227		227 228	
228 229		229 230		230 231		231 232	
232 233		233 234		234 235		235 236	
236 237		237 238		238 239		239 240	
240 241		241 242		242 243		243 244	
244 245		245 246		246 247		247 248	
248 249		249 250		250 251		251 252	
252 253		253 254		254 255		255 256	
256 257		257 258		258 259		259 260	
260 261		261 262		262 263		263 264	
264 265		265 266		266 267		267 268	
268 269		269 270		270 271		271 272	
272 273		273 274		274 275		275 276	
276 277		277 278		278 279		279 280	
280 281		281 282		282 283		283 284	
284 285		285 286		286 287		287 288	
288 289		289 290		290 291		291 292	
292 293		293 294		294 295		295 296	
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300 301		301 302		302 303		303 304	
304 305		305 306		306 307		307 308	
308 309		309 310		310 311		311 312	
312 313		313 314		314 315		315 316	
316 317		317 318		318 319		319 320	
320 321		321 322		322 323		323 324	
324 325		325 326		326 327		327 328	
328 329		329 330		330 331		331 332	
332 333		333 334		334 335		335 336	
336 337		337 338		338 339		339 340	
340 341		341 342		342 343		343 344	
344 345		345 346		346 347		347 348	
348 349		349 350		350 351		351 352	
352 353		353 354		354 355		355 356	
356 357		357 358		358 359		359 360	
360 361		361 362		362 363		363 364	
364 365		365 366		366 367		367 368	
368 369		369 370		370 371		371 372	
372 373		373 374		374 375		375 376	
376 377		377 378		378 379		379 380	
380 381		381 382		382 383		383 384	
384 385		385 386		386 387		387 388	
388 389		389 390		390 391		391 392	
392 393		393 394		394 395		395 396	
396 397		397 398		398 399		399 400	
400 401		401 402		402 403		403 404	
404 405		405 406		406 407		407 408	
408 409		409 410		410 411		411 412	
412 413		413 414		414 415		415 416	
416 417		417 418		418 419		419 420	
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424 425		425 426		426 427		427 428	
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432 433		433 434		434 435		435 436	
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440 441		441 442		442 443		443 444	
444 445		445 446		446 447		447 448	
448 449		449 450		450 451		451 452	
452 453		453 454		454 455		455 456	
456 457		457 458		458 459		459 460	
460 461		461 462		462 463		463 464	
464 465		465 466		466 467		467 468	
468 469		469 470		470 471		471 472	
472 473		473 474		474 475		475 476	
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480 481		481 482		482 483		483 484	
484 485		485 486		486 487		487 488	
488 489		489 490		490 491		491 492	
492 493		493 494		494 495		495 496	
496 497		497 498		498 499		499 500	
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508 509		509 510		510 511		511 512	
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516 517		517 518		518 519		519 520	
520 521		521 522		522 523		523 524	
524 525		525 526		526 527		527 528	
528 529		529 530		530 531		531 532	
532 533		533 534		534 535		535 536	
536 537		537 538		538 539		539 540	
540 541		541 542		542 543		543 544	
544 545		545 546		546 547		547 548	
548 549		549 550		550 551		551 552	
552 553		553 554		554 555		555 556	
556 557		557 558		558 559		559 560	
560 561		561 562		562 563		563 564	
564 565		565 566		566 567		567 568	
568 569		569 570		570 571		571 572	
572 573		573 574		574 575		575 576	
576 577		577 578		578 579		579 580	
580 581		581 582		582 583		583 584	
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596 597		597 598		598 599		599 600	
600 601		601 602		602 603		603 604	
604 605		605 606		606 607		607 608	
608 609		609 610		610 611		611 612	
612 613		613 614		614 615		615 616	
616 617		617 618		618 619		619 620	
620 621		621 622		622 623		623 624	
624 625		625 626		626 627		627 628	
628 629		629 630		630 631		631 632	
632 633		633 634		634 635		635 636	
636 637		637 638		638 639		639 640	
640 641		641 642		642 643		643 644	
644 645		645 646		646 647		647 648	
648 649		649 650		650 651		651 652	
652 653		653 654		654 655		655 656	
656 657		657 658		658 659		659 660	
660 661		661 662		662 663		663 664	
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668 669		669 670		670 671		671 672	
672 673		673 674		6			

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APPENDIX D: CLAIMS FILING

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SAMPLE NURSING FACILITY CLAIM FORM
WITH A REFERRING PROVIDER
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)

1 HAPPY HOME NURSING HOME 987 CORN ST. ANYWHERE, LA 71111		2		3a PAT. OUTL. # 11111111 b. MED. REG. # 111111111111 c. STATEMENT COVERS PERIOD FROM 090116 THROUGH 091516		4 TYPE OF BILL 214	
8 PATIENT NAME a. DOE, JOHN		9 PATIENT ADDRESS a. 1235 ANYSTREET		c. LA d. 71111		e.	
10 BIRTHDATE MMDDYY M 090116		11 SEX M		12 DATE OF ADMISSION 15 SEP 14 TYPE 1		13 DHR 20	
14 STAT 18		19		20		21	
22		23		24		25	
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34		35		36		37	
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522		523		524		525	
526		527		528		529	
530		531		532		533	
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974		975		976		977	
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APPENDIX D: CLAIMS FILING

PAGE(S) 25

**SAMPLE NURSING FACILITY CLAIM FORM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

[illegible]

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APPENDIX D: CLAIMS FILING

PAGE(S) 25

**SAMPLE NURSING FACILITY CLAIM FORM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

HAPPY HOME NURSING HOME 987 CORN ST. ANYWHERE, LA 71111										2		3a PRG. CNTL. # 1111111 b. MED. REC. # 11111111111 5 FED. TAX NO.										4 TYPE OF BILL 217																	
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS a 1235 ANYSTREET										6 STATEMENT COVERS PERIOD FROM 100115 TO 102015																			
b ANYWHERE										c LA										d 71111																			
10 BIRTH DATE MMDDYY M 090115										11 SEX 12 DATE 13 HR 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21										CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE 30																			
31 OCCURRENCE DATE 32 CODE 33 OCCURRENCE DATE 34 CODE 35 OCCURRENCE DATE 36 CODE 37 OCCURRENCE DATE 38 CODE										39 CODE 40 VALUE CODES AMOUNT 41 CODE 42 VALUE CODES AMOUNT 43 CODE 44 VALUE CODES AMOUNT																													
39 CODE 40 VALUE CODES AMOUNT 41 CODE 42 VALUE CODES AMOUNT 43 CODE 44 VALUE CODES AMOUNT										45 CODE 46 VALUE CODES AMOUNT 47 CODE 48 VALUE CODES AMOUNT 49 CODE 50 VALUE CODES AMOUNT																													
42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HIPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49																																							
022 CASE MIX										01-20										19																			
185 HOSPITAL LEAVE										05-08																													
183 HOME LEAVE										17-19																													
<div style="font-size: 2em; font-weight: bold; color: blue;">SAMPLE</div> <div style="font-size: 1.2em; font-weight: bold; color: blue;">EXAMPLE OF ICD 10 WITH AN ATTENDING PROVIDER ONLY</div>																																							
PAGE 1 OF 1										CREATION DATE 122815										TOTALS																			
50 PRVYR NAME MEDICAID										51 HEALTH PLAN ID										52 PRIOR PAYMENTS TPL : PAYMENT IF APPLICABLE										53 EST. AMOUNT DUE 1234567890									
58 INSURED'S NAME DOE, JOHN										59 INSURED'S UNIQUE ID 1234567890123										60 GROUP NAME TPL CARRIER CODE IF APPLICABLE										61 INSURANCE GROUP NO. 1234567									
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER A 5278198798700 02										65 EMPLOYER NAME																			
66 Z471 F0281										67 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z										68																			
69 ADMIT CODE 70 PATIENT REASON FOR										71 PRG. CODE 72 ECI										73																			
74 PRINCIPAL PROCEDURE CODE DATE OTHER PROCEDURE CODE DATE										75 OTHER PROCEDURE CODE DATE										76 ATTENDING NP1 1298765432 QUAL FIRST JANE																			
77 OPERATING NP1 QUAL FIRST										78 OTHER NP1 QUAL FIRST										79 OTHER NP1 QUAL FIRST																			
80 REMARKS										81 CC a b c d										82																			

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

PAGE(S) 25

**SAMPLE ICF/ID FACILITY CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

[illegible]

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

PAGE(S) 25

**SAMPLE ICF/ID FACILITY CLAIM FORM
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111		2		3a PAT. CNTRL. # 11111111111111111111		4 TYPE OF BILL 654	
5 PATIENT NAME DOE, JOHN		6 PATIENT ADDRESS 1235 ANYSTREET		7 STATEMENT COVERS PERIOD FROM 100115		8 THROUGH 102015	
9 PATIENT NAME DOE, JOHN		10 PATIENT ADDRESS ANYWHERE		11 LA		12 71111	
13 BIRTHDATE MMDDYY 080115		14 SEX M		15 DATE 080115		16 DHR	
17 STAT 01		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACOT STATE		30		31		32	
33 OCCURRENCE DATE		34 CODE		35 OCCURRENCE DATE		36 CODE	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
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113		114		115		116	
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225		226		227		228	
229		230		231		232	
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257		258		259		260	
261		262		263		264	
265		266		267		268	
269		270		271		272	
273		274		275		276	
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717		718		719		720	
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APPENDIX D: CLAIMS FILING

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**SAMPLE ICF/ID FACILITY CLAIM FORM
WITH A REFERRING PROVIDER
(WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)**

1 BLOMMINGICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111										2										3a PAT. CNTR. # 1111111 3b MED. REG. # 111111111111 3c FED. TAX NO.										4 TYPE OF BILL 654																																																	
8 PATIENT NAME a DOE, JOHN										9 PATIENT ADDRESS a 1235 ANYSTREET										c LA d 71111 e																																																											
10 BIRTH DATE MMDDYY M 080116										11 SEX M										12 DATE OF ADMISSION 12 HR 14 TYPE 15 SNG 16 DHR 20										17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30																																																	
31 OCCURRENCE CODE										32 OCCURRENCE DATE										33 OCCURRENCE CODE										34 OCCURRENCE DATE										35 OCCURRENCE SPAN FROM THROUGH										36 OCCURRENCE SPAN FROM THROUGH										37																			
38										39 VALUE CODES AMOUNT a 80										40 VALUE CODES AMOUNT b 5.00										41 VALUE CODES AMOUNT c										42																																							
43 REV. CD. 193										44 DESCRIPTION CASE MIX										45 HCPCS / RATE / HIPPS CODE										46 SERV. DATE 01-05										47 SERV. UNITS 5										48 TOTAL CHARGES										49 NON-COVERED CHARGES										50									
PAGE 1 OF 1										CREATION DATE 110515										TOTALS																																																											
51 PRIOR NAME MEDICAID										52 HEALTH PLAN ID										53 PRIOR PAYMENTS TPL ...										54 EST. AMOUNT DUE										55 NPI 1234567890										56 NPI 1234567																													
58 INSURED'S NAME DOE, JOHN										59 PRIOR 60 INSURED'S UNIQUE ID 1234567890123										61 GROUP NAME TPL CARRIER										62 INSURANCE GROUP NO.										63																																							
64 TREATMENT AUTHORIZATION CODES										65 DOCUMENT CONTROL NUMBER										66 EMPLOYER NAME																																																											
67 F71										68										69 ADMIT DATE										70 PATIENT REASON DX										71 PRIOR CODE										72 ECI										73																			
74 PRINCIPAL PROCEDURE CODE										75 OTHER PROCEDURE CODE										76 ATTENDING NPI 1298765432										77 OPERATING NPI										78 OTHER DN NPI 1589999999										79 OTHER NPI										80																			
81 REMARKS										82										83										84										85										86										87																			

CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

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**SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT
WITH AN ATTENDING PROVIDER ONLY
(WITH ICD-9 DIAGNOSIS CODE DATES BEFORE 10/1/15)**

1 BLOMMING ICF-DD FACILITY		2		3a PAT. CNTRL. # 1111111		4 TYPE OF BILL 657	
1800 CORN ST.				5 MED. REC. # 111111111111			
ANYWHERE, LA 71111				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET					
b ANYWHERE		c LA		d 71111		e *	
10 BIRTHDATE MMDDYY M 080115		11 SEX		12 DATE OF BIRTH		13 ADMISSION 13 HR. 14 TYPE 15 SPC 16 DHR 17 STAT 18 19 20 21	
22 CONDITION CODES 23 24 25 26 27 28		29 ACOT STATE 30					
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE		38 CODE	
39 OCCURRENCE DATE		40 CODE		41 OCCURRENCE DATE		42 CODE	
43 OCCURRENCE DATE		44 CODE		45 OCCURRENCE DATE		46 CODE	
47 OCCURRENCE DATE		48 CODE		49 OCCURRENCE DATE		50 CODE	
51 OCCURRENCE DATE		52 CODE		53 OCCURRENCE DATE		54 CODE	
55 OCCURRENCE DATE		56 CODE		57 OCCURRENCE DATE		58 CODE	
59 OCCURRENCE DATE		60 CODE		61 OCCURRENCE DATE		62 CODE	
63 OCCURRENCE DATE		64 CODE		65 OCCURRENCE DATE		66 CODE	
67 OCCURRENCE DATE		68 CODE		69 OCCURRENCE DATE		70 CODE	
71 OCCURRENCE DATE		72 CODE		73 OCCURRENCE DATE		74 CODE	
75 OCCURRENCE DATE		76 CODE		77 OCCURRENCE DATE		78 CODE	
79 OCCURRENCE DATE		80 CODE		81 OCCURRENCE DATE		82 CODE	
83 OCCURRENCE DATE		84 CODE		85 OCCURRENCE DATE		86 CODE	
87 OCCURRENCE DATE		88 CODE		89 OCCURRENCE DATE		90 CODE	
91 OCCURRENCE DATE		92 CODE		93 OCCURRENCE DATE		94 CODE	
95 OCCURRENCE DATE		96 CODE		97 OCCURRENCE DATE		98 CODE	
99 OCCURRENCE DATE		100 CODE		101 OCCURRENCE DATE		102 CODE	
103 OCCURRENCE DATE		104 CODE		105 OCCURRENCE DATE		106 CODE	
107 OCCURRENCE DATE		108 CODE		109 OCCURRENCE DATE		110 CODE	
111 OCCURRENCE DATE		112 CODE		113 OCCURRENCE DATE		114 CODE	
115 OCCURRENCE DATE		116 CODE		117 OCCURRENCE DATE		118 CODE	
119 OCCURRENCE DATE		120 CODE		121 OCCURRENCE DATE		122 CODE	
123 OCCURRENCE DATE		124 CODE		125 OCCURRENCE DATE		126 CODE	
127 OCCURRENCE DATE		128 CODE		129 OCCURRENCE DATE		130 CODE	
131 OCCURRENCE DATE		132 CODE		133 OCCURRENCE DATE		134 CODE	
135 OCCURRENCE DATE		136 CODE		137 OCCURRENCE DATE		138 CODE	
139 OCCURRENCE DATE		140 CODE		141 OCCURRENCE DATE		142 CODE	
143 OCCURRENCE DATE		144 CODE		145 OCCURRENCE DATE		146 CODE	
147 OCCURRENCE DATE		148 CODE		149 OCCURRENCE DATE		150 CODE	
151 OCCURRENCE DATE		152 CODE		153 OCCURRENCE DATE		154 CODE	
155 OCCURRENCE DATE		156 CODE		157 OCCURRENCE DATE		158 CODE	
159 OCCURRENCE DATE		160 CODE		161 OCCURRENCE DATE		162 CODE	
163 OCCURRENCE DATE		164 CODE		165 OCCURRENCE DATE		166 CODE	
167 OCCURRENCE DATE		168 CODE		169 OCCURRENCE DATE		170 CODE	
171 OCCURRENCE DATE		172 CODE		173 OCCURRENCE DATE		174 CODE	
175 OCCURRENCE DATE		176 CODE		177 OCCURRENCE DATE		178 CODE	
179 OCCURRENCE DATE		180 CODE		181 OCCURRENCE DATE		182 CODE	
183 OCCURRENCE DATE		184 CODE		185 OCCURRENCE DATE		186 CODE	
187 OCCURRENCE DATE		188 CODE		189 OCCURRENCE DATE		190 CODE	
191 OCCURRENCE DATE		192 CODE		193 OCCURRENCE DATE		194 CODE	
195 OCCURRENCE DATE		196 CODE		197 OCCURRENCE DATE		198 CODE	
199 OCCURRENCE DATE		200 CODE		201 OCCURRENCE DATE		202 CODE	
203 OCCURRENCE DATE		204 CODE		205 OCCURRENCE DATE		206 CODE	
207 OCCURRENCE DATE		208 CODE		209 OCCURRENCE DATE		210 CODE	
211 OCCURRENCE DATE		212 CODE		213 OCCURRENCE DATE		214 CODE	
215 OCCURRENCE DATE		216 CODE		217 OCCURRENCE DATE		218 CODE	
219 OCCURRENCE DATE		220 CODE		221 OCCURRENCE DATE		222 CODE	
223 OCCURRENCE DATE		224 CODE		225 OCCURRENCE DATE		226 CODE	
227 OCCURRENCE DATE		228 CODE		229 OCCURRENCE DATE		230 CODE	
231 OCCURRENCE DATE		232 CODE		233 OCCURRENCE DATE		234 CODE	
235 OCCURRENCE DATE		236 CODE		237 OCCURRENCE DATE		238 CODE	
239 OCCURRENCE DATE		240 CODE		241 OCCURRENCE DATE		242 CODE	
243 OCCURRENCE DATE		244 CODE		245 OCCURRENCE DATE		246 CODE	
247 OCCURRENCE DATE		248 CODE		249 OCCURRENCE DATE		250 CODE	
251 OCCURRENCE DATE		252 CODE		253 OCCURRENCE DATE		254 CODE	
255 OCCURRENCE DATE		256 CODE		257 OCCURRENCE DATE		258 CODE	
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CHAPTER 26: ICF/DD SERVICES

APPENDIX D: CLAIMS FILING

PAGE(S) 25

SAMPLE ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH AN ATTENDING PROVIDER ONLY (WITH ICD-10 DIAGNOSIS CODE DATES ON OR AFTER 10/1/15)

1 BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111		2		3a PAT. ONT. # 1111111 3b MED. REC. # 1111111111111111 5 FED. TAX NO.		4 TYPE OF BILL 657	
8 PATIENT NAME a DOE, JOHN		9 PATIENT ADDRESS a 1235 ANYSTREET		c LA d 71111 e			
10 BIRTHDATE MMDDYY M 080115		11 SEX M		12 DATE OF ADMISSION 13 HR 14 TYPE 15 SFC 16 DHR 17 STAT 18 19 20 21		CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE 30	
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