



***REINSTATEMENT
And
IMPLEMENTATION
Of
LAHIPP
THIRD PARTY LIABILITY (TPL)
CLAIMS PAYMENT***

April 7, 2017

**LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING**

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THIRD PARTY LIABILITY OVERVIEW

Federal regulations and applicable state laws require that third-party resources be used before Medicaid is billed. **Third-party** refers to those payment resources available from other liable sources, including but not limited to both private and public health insurance, which can be applied toward the Medicaid recipient's medical and health expenses.

It is the responsibility of each provider to verify the recipient's eligibility prior to providing services. Information concerning other insurance coverage is presented in the eligibility response if it appears on that recipient's Medicaid file.

All insurance companies appearing on the Medicaid Resource file are assigned a TPL Carrier Code for billing purposes. When other insurance is present on the eligibility response, providers should obtain the TPL carrier code(s) for the name of the third-party insurance carrier from the TPL Carrier Code listing. The TPL carrier code listing is located on the LA Medicaid website at www.lamedicaid.com under "Forms/Files/User Guides".

If the insurance information provided in the eligibility response is not correct, the provider should:

- (1) Instruct the recipient to contact his/her parish worker to correct the file to either add or terminate the coverage if the insurance has been canceled; OR
- (2) Submit a request to the Medicaid Program to have the recipient's resource file updated.

Claims submitted for recipients with primary insurance will deny unless the applicable instructions are followed to indicate the insurance coverage information correctly on the claim.

In most cases it is the provider's responsibility to bill the third-party carrier prior to billing Medicaid. In those situations where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient. Reimbursement must be made immediately to comply with federal regulations.

NOTE: The absence of other coverage on the eligibility response does not negate the provider's responsibility to ask the recipient if he/she has other insurance coverage.

NOTE: Once a recipient is accepted as a Medicaid recipient, the provider MAY NOT pick and choose the services he will bill to Medicaid, regardless of TPL payment/coverage or any other criteria. All Medicaid covered services must be billed to Medicaid.

ELIGIBILITY DETERMINATION

It is the provider's responsibility to always verify recipient eligibility prior to providing services.

All recipients enrolled in Louisiana's Medicaid Program are issued permanent **Plastic Identification Cards**. These permanent identification cards contain a card control number (CCN) which can be used by the provider to verify Medicaid eligibility. The Louisiana Department of Health (LDH) offers several options to assist providers with verification of current eligibility. Use of these options will require provider verification. The following eligibility verification options are available:

1. e-MEVS, a web application accessed through www.lamedicaid.com
2. Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.
3. Recipient Eligibility Verification System (REVS), an automated telephonic eligibility verification system
4. Pharmacy Point of Sale (POS).

These eligibility verification systems provide confirmation of the following:

- Recipient eligibility
- Managed Care linkages
- Third Party (Insurance) Resources
- Service limits and restrictions
- Lock-In

The eligibility response will not only confirm the recipient's eligibility and whether the recipient has other insurance, but it will also indicate any special information related to the recipient's enrollment.

LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (LAHIPP)

The focus of this training packet relates to the payment of TPL claims for recipients enrolled through the Louisiana Health Insurance Premium Payment Program (LAHIPP).

LAHIPP provides help for a Medicaid-eligible member of a household to be covered by the family's employer-sponsored private insurance policy. The program **may** pay some or all of the health insurance premiums for an employee and their family if they have insurance available through their jobs and someone in the family has Medicaid. Those getting Medicaid will also be able to have health insurance. *

Under Section 1906 of the CMS regulations, LA Medicaid is required to pay the patient responsibility (co-pays, co-insurances, and deductibles) on TPL claims for these recipients.

LAHIPP eligibles will be identified by the response, **"This recipient is enrolled in LAHIPP"**. This information will allow you to determine the payment methodology used to process and pay TPL claims.

MEVS response screen formats may vary based on application used, vendors, etc. However, the response description for LAHIPP recipients will be presented as indicated above.

A sample response screen follows:

Louisiana Medicaid

For Technical Support, call toll-free 1-877-598-8753.

Provider Logout

Warning: Unauthorized use of this site or the information contained herein is prohibited by the Louisiana Department of Health and Hospitals

Member ID Number	1234567890000
Date of Birth	01/01/1974
Sex	Male

Health Benefit Plan Coverage

Benefit	Coverage Level	Insurance Type	Plan Coverage Description
Active Coverage	Individual	Medicaid	Eligible for Medicaid on Date of Service.
Benefit Description	Individual	Medicaid	This Recipient is Enrolled in LAHIPP.
Benefit Description	Individual	Medicaid	Recipient has Private Insurance.
Benefit Description	Individual	Medicaid	Preferred Language: English.

Other or Additional Payor

Coverage Level	Individual
Service Type	Medical Care

* **Note:** Non-Medicaid-eligible family members are eligible only to have group health plan premiums paid on their behalf if necessary to obtain access for the Medicaid enrollee. They are liable for any patient responsibility on their claims.

<p style="text-align: center;">LAHIPP FEE FOR SERVICE – MEDICAL MANAGED CARE – BEHAVIORAL HEALTH</p>

LAHIPP recipients will receive their medical services and emergency ambulance services through Fee-For-Service Medicaid and claims will be processed through Molina.

LAHIPP recipients will receive their specialized behavioral health services (i.e. services provided by a specialized behavioral health provider) and NEMT services, including non-emergency ambulance services, through the Healthy Louisiana managed care organization (MCO) to which they are linked on the date of service. Claims for these services should be submitted to the MCO.

Providers can identify the MCO through the MEVS eligibility inquiry.

This training packet is related to the claims paid Fee-For-Service by Molina.

LAHIPP VS. NON-LAHIPP PRIVATE TPL PAYMENT METHODOLOGY

PAYMENT OF LAHIPP SECONDARY CLAIMS

For recipients enrolled in LAHIPP, once the claim has been processed and paid by the primary carrier, LA Medicaid processes and pays the full patient responsibility (co-pay, co-insurance, and/or deductible) - regardless of Medicaid's allowed amount, billed charges, or TPL payment amount. However, **recipients must follow the policies of the primary plan, and only in certain circumstances will Medicaid consider payment of claims that are denied by the primary payer.**

PAYMENT OF NON-LAHIPP SECONDARY CLAIMS

Medicaid uses a cost comparison methodology to pay TPL claims for Non-LAHIPP recipients with primary insurance. TPL claims are processed as they were processed by the primary payer, and TPL payment amount is applied just as the primary payer indicates on the EOB. **If there is only a total TPL amount on the EOB, a "spend down" methodology is used to calculate payment and process the claim.**

The payment will be made based on the lesser of (1) Medicaid allowed amount minus TPL payment, OR (2) total patient responsibility amount (co-pay, co-insurance, and/or deductible).

NOTE: For all TPL claims, Medicaid will never pay more than the total co-pay, co-insurance and/or deductible. If co-pay, co-insurance and/or deductible are not owed, Medicaid will zero pay the claim.

TPL CLAIMS SUBMISSION

ELECTRONIC CLAIMS (EDI)

Louisiana Medicaid accepts and processes TPL claims submitted electronically. **Providers must enter the appropriate and accurate information from the primary payor EOB for transmission electronically to Louisiana Medicaid for processing and payment. Post-payment reviews will be conducted to ensure that accurate information is being submitted by providers.**

Detailed information concerning correct entry of TPL data in the 837 electronic specifications may be found in the Companion Guide(s) located on the Louisiana Medicaid web site, www.lamedicaid.com, link "HIPAA Billing Instructions and Companion Guides". Choose the appropriate 5010v Companion Guide applicable to the 837 transaction to be submitted.

Questions concerning EDI transmissions may be directed to the Molina EDI Department at (225) 216-6303.

HARD COPY CLAIMS

Electronic claims submission is the preferable means of submitting Medicaid claims, but providers may continue to submit paper claims if necessary. With paper submissions, **providers must:**

- Submit the claim hard copy
- Attach a copy of the EOB, making sure any remarks/comments/edit descriptions from the other insurance company are legible and attached.
- Enter the correct six-digit carrier code assigned by Medicaid for the private insurance carrier in the correct block on the claim form.
- The dates of service, procedure codes and total charges on the primary EOB **must match** the claim submitted to Medicaid or the claim will be rejected.
- All Medicaid requirements such as prior authorization **must** be met before payment will be considered.

IMPORTANT NOTE: Providers must ensure that the correct, accurate EOB is attached to each TPL claim form; that EOB copies are clear, complete, and readable; and that the description of EOB edits is attached.

EXAMPLES OF LAHIPP AND NON-LAHIPP PAYMENTS

An example of the difference between LAHIPP and Non-LAHIPP recipient payments follows.

EXAMPLE OF CLAIM PAYMENTS FOR LAHIPP VS. NON-LAHIPP RECIPIENTS

Procedure Code -	99213
Provider Billed Amount -	\$ 70.00
Private Insurance Allowable -	\$ 50.00
Private Insurance Payment -	\$ 40.00
Patient Responsibility (Co-Pay) -	\$ 10.00

LAHIPP Recipient

Medicaid Allowable	\$ 36.13
TPL Payment	<u>-40.00</u>
	- 3.87

Medicaid Payment	\$ 10.00
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(Because this is a LAHIPP recipient, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.)

Non-LAHIPP Recipient

Cost Comparison – The LESSER of:

Medicaid Allowable	\$36.13
TPL Payment	<u>- 40.00</u>
	- 3.87

OR

Patient Responsibility (Co-Pay)	\$10.00
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EQUALS

Medicaid Payment -	\$ 0.00
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(Medicaid “zero pays” the claim. When cost-compared, the private insurance paid more than Medicaid's allowable for the procedure. When cost compared, the lesser of the Medicaid allowable minus the TPL payment OR the patient co-pay is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

NOTE: Providers must remember that the same procedure/service may be paid differently based on whether the recipient is LAHIPP or non-LAHIPP.

Please note that all information below, including the patient responsibility, can be found on the TPL EOB.

Professional Example #1

See Professional Example 1 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
99212	55.00	0	24.10	36.00 (Ded)	36.00
83655-QW	30.00	0	11.37	28.20 (Ded)	28.20
Totals	85.00	0	35.47	64.20 (Ded)	64.20

(Medicaid is required to pay the co-pay, co-insurance, and/or deductible for Medicaid covered services for LAHIPP recipients, regardless of Medicaid's allowable, billed charges, or TPL payment amount.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
99212	55.00	0	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0	11.37	28.20 (Ded)	11.37
Totals	85.00	0	35.47	64.20 (Ded)	35.47

(Medicaid pays the allowed amount minus TPL payment OR total patient responsibility amount (co-pay, co-insurance, and/or deductible) for Non-LAHIPP recipients. The Medicaid allowed amount minus the TPL paid amount is LESS THAN the Patient Responsibility; thus, the Medicaid allowed amount is the payment.)

Professional Example #2

See Professional Example #2 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
99436	250.00	49.50	0 (non-covered)	33.00 (Coins)	0
99433	65.00	20.46	0 (non-covered)	13.64 (Coins)	0
99433	65.00	20.46	0 (non-covered)	13.64 (Coins)	0
99238	115.00	44.88	28.80	29.92 (Coins)	29.92
Totals	495.00	135.30	28.80	90.20 (Coins)	29.92

(At this time, procedure codes 99436 and 99433 are not covered by LA Medicaid. Thus, Medicaid will pay nothing on those procedures even though this recipient is LAHIPP. The co-insurance is paid for procedure 99238 because this is a LAHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
99436	250.00	49.50	0 (non-covered)	33.00 (Coins)	0
99433	65.00	20.46	0 (non-covered)	13.64 (Coins)	0
99433	65.00	20.46	0 (non-covered)	13.64 (Coins)	0
99238	115.00	44.88	28.80	29.92 (Coins)	0
Totals	495.00	135.30	28.80	90.20 (Coins)	0

(At this time, procedure codes 99436 and 99433 are not covered by LA Medicaid. Thus, Medicaid will pay nothing on those procedures. Procedure 99238 is paid at zero because the Medicaid Allowed Amount minus the TPL payment is -16.08, which is less than the co-insurance amount of 29.92.)

Outpatient Example #1

See Outpatient Example #1 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR270	99.25	74.44	22.04	0	0
HR450	316.25	137.19	70.24	100.00	100.00
Totals	415.50	211.63	92.28	100.00	100.00

(The 100.00 deductible for this claim is paid because this is a LAHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR270	99.25	74.44	22.04	0	0
HR450	316.25	137.19	70.24	100.00	0
Totals	415.50	211.63	92.28	100.00	0

(This claim is paid at zero because the Medicaid Allowed Amount minus the TPL payment is LESS THAN the deductible.)

Outpatient Example #2

See Outpatient Example #2 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR259	1.10	0.33	0.33	1.10	1.10
HR450	291.39	87.71	87.71	22.11	22.11
HR450	99.22	4.88	29.87	0.00	0.00
Totals	391.71	92.92		23.21	23.21

(In this example, the claim lines were bundled by the primary carrier and processed as one total. Therefore, Medicaid “spends down” the total payment and patient responsibility. The total payment is “spent down” (or applied) against the Medicaid allowed amount, and the total patient responsibility is “spent down” (or applied) against the billed charges. The 23.21 co-insurance for the total claim is paid because this is a LAHIPP recipient. It is paid by “spending it down” on each claim line until the entire 23.21 is paid. The last claim line is paid at “0” because the entire patient responsibility (co-insurance) is paid on the prior claim lines when processed by Medicaid.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
HR259	1.10	0.33	0.33	1.10	0.00
HR450	291.39	87.71	87.71	22.11	0.00
HR450	99.22	4.88	29.87	0.00	0.00
Totals	391.71	92.92		23.21	0.00

(This is a non-LAHIPP recipient. In this example, the claim lines were bundled by the primary carrier and processed as one total. Therefore, Medicaid “spends down” the total payment and patient responsibility. The total payment is “spent down” (or applied) against the Medicaid allowed amount, and the total patient responsibility is “spent down” (or applied) against the billed charges. On line one, the TPL Paid Amount applied is the 0.33 Medicaid Allowed Amount, and the patient responsibility applied is the 1.10 billed charges. The line is paid at zero because the Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility. On line two, 87.71 of the TPL Paid Amount is applied and equals the Medicaid Allowed Amount. The remaining 22.11 of the patient responsibility is applied as it is less than the billed charges. The claim line is paid at 0.00 because the Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility. On line three, the remaining TPL Paid Amount of 4.88 is “spent down.” The claim line is paid at 0.00 because no patient responsibility remains.)

Inpatient Example #1

See Inpatient Example #1 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	34,359.32	9,015.00	4,646.90	250.00	250.00

(The 250.00 patient deductible is paid for this LaHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	34,359.32	9,015.00	4,646.90	250.00	0

(The claim is paid at zero because the Medicaid Allowable of 4646.90 minus the TPL payment of 9015.00 is less than the 250.00 patient deductible.)

Inpatient Example #2

See Inpatient Example #2 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR HR 110 R & B	12,253.00	2,450.00	5,052.30	300.00 (co-pay)	300.00

(The co-pay is paid because this is a LAHIPP recipient and the services are a covered Medicaid service.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00 (co-pay)	300.00

(This is a Non-LAHIPP recipient. The Medicaid Allowed Amount minus the TPL payment is GREATER THAN the co-pay; thus, the co-pay is paid on this covered service.)

Inpatient Example #3

See Inpatient Example #3 of Appendix A for the corresponding claim example and accompanying EOB.

LAHIPP Recipient:

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	14,788.37	10,255.07	4,593.00	478.93	478.93

(The deductible is paid for this LAHIPP recipient.)

Non-LAHIPP Recipient

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility	Medicaid Payment
Multiple HR R & B	14,788.37	10,255.07	4,593.00	478.93	0

(This is a Non-LAHIPP recipient. The Medicaid Allowed Amount minus the TPL Payment Amount is LESS THAN zero; thus, the payment is "0".)

TPL CLAIM EDITS

The following claim edits appear on TPL claims processed.

Edit 928 – Paid Patient Responsibility Amount per the EOB

This edit will appear when the claim is paid by the Primary Carrier and Medicaid payment is the amount of the patient responsibility.

Edit 929 – Paid Medicaid Amount TPL Denied Claim

This edit will appear in circumstances when the claim is denied by the primary carrier and Medicaid pays as primary.

Edit 931 – Denied Per the TPL EOB Information

This edit will appear when the claim is denied by the primary carrier and Medicaid will not consider payment as primary.

It may be possible for providers to contact the primary carrier and resubmit to them with corrected information in order to have the claim reconsidered.

IMPORTANT REMINDERS CONCERNING TPL CLAIMS PROCESSING AND PAYMENT

- For claims submitted electronically, providers must ensure that the appropriate and accurate information from the primary payer's EOB is entered correctly in the 837 transaction.
- For TPL paper claims, providers must ensure that the correct, accurate EOB is attached to each TPL claim form and that EOBs are clear, complete, readable, and include descriptions of EOB edits. Other forms of incomplete documentation (payment registers, electronic reports, etc.) are not acceptable and will be rejected back to the provider.
- Services that are not covered by LA Medicaid will not be considered for payment.
- Recipients must follow the policies of the primary plan, and only in certain circumstances will Medicaid consider payment of claims that are denied by the primary payer.
- Medicaid will never pay more than the total co-pay, co-insurance and/or deductible. If the TPL carrier pays the claim, and co-pay, co-insurance and/or deductible are not owed on a service covered by Medicaid, Medicaid will zero pay the claim.
- The same procedure/service may be paid differently based on whether the recipient is LAHIPP or non-LAHIPP.
- Providers must verify recipient eligibility to ensure that the recipient is eligible on the date of service and to determine if TPL applies and how the recipient is enrolled.

IMPORTANT REMINDERS CONCERNING MEDICAID COVERAGE

REMINDER 1:

Louisiana Medicaid continues to use the “pay and chase” method of payment for **prenatal and preventive care** for individuals with health insurance coverage. This means that most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. Pay and Chase is not applicable to hospital claims. Additional information can be found in the General Information and Administration Provider Manual found online at www.lamedicaid.com, directory link Provider Manuals.

The Bureau of Health Services Financing seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

REMINDER 2:

Louisiana Medicaid has adopted the following policy concerning Medicaid coverage based on CMS (Centers for Medicare and Medicaid Services) clarification.

When a recipient has other insurance, the recipient must follow any and all requirements of that insurance since it is primary.

- The recipient must seek services from an in-network provider.
- If the claim is denied because the recipient sought medical care outside of the network and without authorization, Medicaid will deny the claim.
- If the recipient does not follow their private insurance rules and regulations, Medicaid will not be responsible for considering payment of those services. The recipient is responsible for the payment of the services.
- Recipients must be informed prior to the service that they will be responsible for the payment if they choose to obtain the services of an out-of-network provider or services that are not authorized where authorization is required.
- Providers must determine prior to providing services, to which plan the recipient belongs and if the provider of service is a part of the network of that particular plan.
- If the private insurance denies the service because the service is not a covered service offered under the plan, the claim will be handled as a straight Medicaid claim and processed based on Medicaid policy and pricing.

NOTE: If the provider of the service plans to file a claim with Medicaid, copayments or any other payment cannot be accepted from the Medicaid recipient.

TPL INFORMATION UPDATES

Requests to add or remove TPL coverage must be submitted to HMS via one of the following methods:

Fax: 877-204-1325

Email: latpr@hms.com

Phone: 877-204-1324

HMS Hours of Operation: Monday thru Friday, 8am - 5pm Central Time.
Louisiana state holidays are excluded.

Private Third Party Liability (TPL) Update Request Change Forms can be found here:

http://www.lamedicaid.com/ProvWeb1/ProviderTraining/Packets/2008ProviderTrainingMaterials/Recipient_Insurance_Update.pdf

Questions concerning HMS updates should be addressed to HMS at 1-877-204-1324.

APPENDIX A – CLAIM FORM EXAMPLES

**CLAIM
FORM
EXAMPLES**

PROFESSIONAL EXAMPLE #1



HEALTH INSURANCE CLAIM FORM

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

☐ PICA

PICA ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BKG (UNG) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Adalam, Mary		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Adalam, Mary	
5. PATIENT'S ADDRESS (No., Street) 123 Any Street		7. INSURED'S ADDRESS (No., Street) 123 Any Street	
CITY Anytown STATE LA		CITY Anytown STATE LA	
ZIP CODE 70000 TELEPHONE (Include Area Code) (225) 555-5555		ZIP CODE 70000 TELEPHONE (Include Area Code) (225) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N/A		11. INSURED'S POLICY GROUP OR FECA NUMBER 100000	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 010101		a. INSURED'S DATE OF BIRTH MM DD YY SEX 06 11 89 M F <input checked="" type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME Humana	
d. INSURANCE PLAN NAME OR PROGRAM NAME LA Medicaid		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 07 06 16 07 06 16 11		15. OTHER DATE MM DD YY QUAL 07 06 16 07 06 16 11	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK John Doe, MD		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 07 06 16 07 06 16 11	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. L700 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ANESTHESIA I. ID. QUAL J. RENDERING PROVIDER ID.#	
1 07 06 16 07 06 16 11 99212 A 55.00 NPI 1234567		25. FEDERAL TAX I.D. NUMBER SSN/EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For doctors, see 24d) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Resd for NUCC Use	
2 07 06 16 07 06 16 11 83655 QW A 30.00 NPI 1234567		H0000 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ 85.00 \$ 0.00	
3		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)) John Doe, MD	
4		32. SERVICE FACILITY LOCATION INFORMATION	
5		33. BILLING PROVIDER INFO & PH# (264) 555-0000 Angel Giggles, LLC 123 Smiley St. Sunny, LA 70000	
6		a. 1357901357 b. 1999999	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0938-1197 FORM 1500 (02-12)

HUMANA AUTOMATED REMITTANCE ADVICE

ANY QUESTIONS - PLEASE CONTACT

HUMANA CLAIMS OFFICE
PO BOX 14801
LEXINGTON, KY 40512-4801

OR CALL 1-888-357-6767
OR VISIT WWW.HUMANA.COM

BENEFITS PAID TO THE FOLLOWING

MEDICAL CENTER DR
ALEXANDRIA, LA 71301

PROVIDER ID: [REDACTED]
FEDERAL TAX ID: [REDACTED]
REMITTANCE ID: [REDACTED]
CHECK NUMBER: [REDACTED]

HUMANA.

PAGE 1 OF 3
DATE 06/17/11

LINE #	DATE OF SERVICE FROM	DATE OF SERVICE TO	SERVICE CODE	CHARGE	EXCLUDED AMOUNT	DISCOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAY	COINSUR	BENEFIT AMOUNT
PROVIDER NAME: [REDACTED]				HQR ID: [REDACTED]				CLAIM NUMBER: [REDACTED]			
PATIENT NAME: [REDACTED]				PAT DOB: [REDACTED]				PAT ACCT: [REDACTED]			
SUBSCRIBER NAME: [REDACTED]				REL CD: [REDACTED]				GROUP: [REDACTED]			
001	07/06/11	07/06/11	89212	55.00	19.00	0.00	36.00	36.00	0.00	0.00	0.00
002	07/06/11	07/06/11	83655	30.00	1.80	0.00	28.20	28.20	0.00	0.00	0.00
CLAIM TOTALS				85.00	20.80	0.00	64.20	64.20	0.00	0.00	0.00
REMARK CODES HIPAA/HUMANA											
001 45 /SBO				EST-HQR RESPONSIBILITY				85.00 TOTAL PAID			
002 45 /SBO								0.00			

PROFESSIONAL EXAMPLE #2



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA												<input type="checkbox"/> PICA											
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (TRICARE #) CHAMPVA <input type="checkbox"/> (Number ID #) GROUP HEALTH PLAN <input type="checkbox"/> (ID #) FECA BENEFIT <input type="checkbox"/> (ID #) OTHER <input type="checkbox"/> (ID #)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567891234											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Adalam, Mary												3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX 06/11/89 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
5. PATIENT'S ADDRESS (No., Street) 123 Any Street												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
CITY Anytown												CITY Anytown											
STATE LA												STATE LA											
ZIP CODE 70000												ZIP CODE 70000											
TELEPHONE (Include Area Code) (225) 555-5555												TELEPHONE (Include Area Code) (225) 555-5555											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N/A												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO											
11. INSURED'S POLICY OR GROUP NUMBER 010101												12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX 06/11/89 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
13. RESERVED FOR NUCC USE												14. OTHER CLAIM ID (Designated by NUCC)											
15. RESERVED FOR NUCC USE												16. INSURANCE PLAN NAME OR PROGRAM NAME LA Medicaid											
17. CLAIM CODES (Designated by NUCC)												18. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																							
19. 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 _____												20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
21. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM/DD/YY QUAL 07/24/16												22. OTHER DATE QUAL MM/DD/YY 1234567											
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK John Doe, MD												24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY 07/24/16 07/25/16											
25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												26. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (24E) (ICD Ind.) A. Z0000 B. R0989 C. P599 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												28. RESUBMISSION CODE ORIGINAL REF. NO. _____											
29. PRIOR AUTHORIZATION NUMBER _____												30. F. CHARGES G. DAYS OR UNITS H. SPOT FEE/PLR I. ID. QUAL J. RENDERING PROVIDER ID. # 250.00 65.00 65.00 115.00 0987654321											
31. FEDERAL TAX I.D. NUMBER SSN EIN _____												32. PATIENT'S ACCOUNT NO. H0000											
33. ACCEPT ASSIGNMENT? (For govt claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												34. TOTAL CHARGE \$ 495.00											
35. 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.) John Doe, MD												36. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____											
37. BILLING PROVIDER INFO & PH# Angel Giggles, LLC 123 Smiley St. Sunny, LA 70000												38. AMOUNT PAID 136.30											
39. SIGNED 7/10/16												40. SIGNED 1357901357 1999999											

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

11

UnitedHealthcare
A UnitedHealth Group Company

**PROVIDER
EXPLANATION
OF BENEFITS**

PATIENT DETAIL

PRODUCT	MECH. ID	PATIENT NAME	PAT REL	PATIENT ACCOUNT	MEMBER NAME	CONTROL NUMBER	DATE RECEIVED	PROVIDER OF SERVICE
CHCPC	A-0000000000	0000000000	CHC	0000000000	0000000000	0100000000-00	08/13/00	0000000000
CHCPC	A-0000000000	0000000000	CHC	0000000000	0000000000	0100000000-00	08/13/00	0000000000
CHCPC	A-0000000000	0000000000	CHC	0000000000	0000000000	0100000000-01	08/08/00	0000000000

SERVICE DETAIL

PATIENT NAME	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT/ COPAY	PLAN CON	PAID TO PROVIDER	BKFC CD	PATIENT RESP.
	07/24/01	89438	250.00	167.50	167.50	82.50		BOK	49.50	IT	01/03/01
	07/25/01	89433	65.00	30.50	30.50	34.50		BOK	20.48	IT	01/03/01
	07/26/01	89433	65.00	30.50	30.50	34.50		BOK	20.48	IT	01/03/01
	07/27/01	89228	115.00	40.20	40.20	74.80		BOK	44.88	IT	01/03/01
		SUBTOTAL	495.00	268.50	268.50	225.50			135.36		01/03/01

TOTAL PAID TO PROVIDER

\$195.30

REMARKS

(W2) THESE EXPENSES HAVE BEEN APPLIED TO THE PATIENT'S ANNUAL DEDUCTIBLE. THE PATIENT IS RESPONSIBLE FOR PAYING THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL ALL CHARGES THAT ARE APPLIED TO THE ANNUAL DEDUCTIBLE PLEASE FORWARD THIS PAYMENT TO YOUR PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

[illegible]

HUMANA AUTOMATED REMITTANCE ADVISE

ANY QUESTIONS - PLEASE CONTACT: HUMANA CLAIMS OFFICE PO BOX 14601 LEXINGTON, KY 40512-4601 OR CALL 1-888-357-8787 OR VISIT WWW.HUMANA.COM	BENEFITS PAID TO THE FOLLOWING: [REDACTED] [REDACTED] HAMMOND, LA [REDACTED] PROVIDER ID: [REDACTED] FEDERAL TAX ID: [REDACTED] REMITTANCE ID: [REDACTED] CHECK NUMBER: [REDACTED]	HUMANA. PAGE 16 OF 30 DATE 08/10/11
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PROVIDER NAME: [REDACTED] MBR ID: [REDACTED] CLAIM NUMBER: [REDACTED]
 PATIENT NAME: [REDACTED] PAT DOB: [REDACTED] PAT ACCT: [REDACTED]
 SUBSCRIBER NAME: [REDACTED] REL CO: EMPLOYEE GROUP: [REDACTED]

LINE	DATE OF SERVICE	SERVICE CODE	CHARGE	EXCLUDED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAY	COINSUR	BENEFIT AMOUNT	
001	08/03/11	08/03/11	270	89.25	0.00	24.81	74.44	0.00	0.00	74.44
002	08/03/11	08/03/11	450	316.25	0.00	79.06	237.19	0.00	100.00	137.19
CLAIM TOTALS				415.50	0.00	103.87	211.63	0.00	100.00	211.63
REMARK CODES H1PAA/HUMANA										
001 131/SNO										
002 131/SNO										
01111111138542										

2000002783

HUMANA AUTOMATED REMITTANCE ADVISE

ANY QUESTIONS - PLEASE CONTACT: HUMANA CLAIMS OFFICE PO BOX 14601 LEXINGTON, KY 40512-4601 OR CALL 1-888-357-8787 OR VISIT WWW.HUMANA.COM	BENEFITS PAID TO THE FOLLOWING: [REDACTED] PO BOX [REDACTED] HAMMOND, LA [REDACTED] PROVIDER ID: [REDACTED] FEDERAL TAX ID: [REDACTED] REMITTANCE ID: [REDACTED] CHECK NUMBER: [REDACTED]	HUMANA. PAGE 17 OF 30 DATE 08/10/11
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LINE #	DATE OF SERVICE FROM TO	SERVICE CODE	CHARGE	EXCLUDED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAY	COINSUR	BENEFIT AMOUNT
					EST MBR RESPONSIBILITY	100.00	TOTAL PAID	211.63	

[illegible]

DELTA DIVISION LA		REMITTANCE RECEIVED DETAIL REPORT PROVIDER NUMBER: [REDACTED]				PRINTED 11/12/XX TIME 15:52:59 PAY DATE 11/12/XX			
0000 BLUE CROSS BLUE SHIELD OF LA									
PATIENT NAME	HEALTH	COVERAGE DATES		TOTAL	DEDUCTIBLE	CO INS	NON-COVERED	CONTRACT	PROVIDER
PATIENT ACCT	INSURANCE NO	FROM	THRU	CHARGES	AMOUNT	AMOUNT	CHARGES	ADJUSTMENT	PAYMENT
NUMBER	INTERNAL			DENIED				PRIMARY	
	CONTROL NO			CHARGES				PAY AMOUNT	
[REDACTED]	[REDACTED]	10/15/XX	10/15/XX	391.71	0.00	23.21	0.00	275.58	92.92
				0.00				0.00	
STATUS CD: 1		MESSAGE:							
PATIENT LIB AMT:		23.21							

1 ABC Hospital P.O. Box 1234 Anytown, LA 70809										2										3a PAT. CHLT. # 2323232323 b. MED. REG. # 123456789 5 FED. TAX NO.										4 TYPE OF BILL 111																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
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INPATIENT HOSPITAL EXAMPLE #2

1 ABC Hospital P.O. Box 1234 Anytown, LA 70809		2		3a PAT. CNTL. # 2323232323 b. MED. REG. # 123456789 5 FED. TAX NO.		4 TYPE OF BILL 111	
8 PATIENT NAME a		9 PATIENT ADDRESS a 123 Any Street		c LA d 70000		e	
b Adalam, Mary		b Anytown		c LA d 70000		e	
10 BIRTHDATE 06/11/89		11 SEX F		12 DATE OF ADMISSION 042417		13 TYPE 2	
14 SPC 1		15 DHR 13		16 STAT 01		17 C1	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38 Mary Adalam 123 Any Street Anytown, LA 70000		39 CODE 80		40 VALUE CODES AMOUNT 5.00		41	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 100		Room-Board/PVT		769.00		5	
2 250		Pharmacy				104	
3 258		IV Solutions				9	
4 270		General Supplies				7	
5 272		Sterile Supply				7	
6 300		Lab				3	
7 302		Lab/Immunology				4	
8 305		Lab/Hemotology				4	
9 360		OR Services				2	
10 370		Anesthesia				2	
11 636		Drugs/Detail				1	
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
PAGE 1 OF 1		CREATION DATE 05/30/17		TOTALS		12253.00	
50 PAYER NAME Best Care Inc		51 HEALTH PLAN ID 90000		52 PRIOR PAYMENTS 2450.00		53 EST. AMOUNT DUE 1777778	
54 INSURED'S NAME Adalam, Mary		55 REL 60 INSURED'S UNIQUE ID 1234567890123		61 GROUP NAME 010101		62 INSURANCE GROUP NO. D00000	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 O3421 Y Z370 Y O6989X0 Y		67		68		69	
70 ADMIT DX O3421		71 PATIENT REASON DX a		72 PRS CODE b		73	
74 PRINCIPAL PROCEDURE CODE 10D00Z1		75 OTHER PROCEDURE CODE 042517		76 ATTENDING NPI 5115115110		77 QUAL 13222222	
78 LAST Doe		79 FIRST Dave		80 LAST		81 FIRST	
82 OTHER NPI		83 QUAL		84 LAST		85 FIRST	
86 OTHER NPI		87 QUAL		88 LAST		89 FIRST	
90 REMARKS		91 B1CC a		92 b		93 c	
		94 d		95		96	

UB-04 CMS-1450

APPROVED OMB NO. 0908-0997

NUBC

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

Before 1980

Date: 05/15/2000

TIN: [REDACTED]

RS BEST CARE DISCOUNT APPLIED

To obtain a review of benefits determination, submit your request in writing to this office. Your request should include the employer name, your name and other identifying information. You may review documents pertinent to your claim free of charge. Written request for a review must be mailed or delivered within 180 days following receipt of this explanation. Ordinarily, you will receive notice of the final determination within 60 days following receipt of your request. If special circumstances require an extension of time, you will be notified of such an extension during the 60 days following receipt of your request and you will receive a final written response within 120 days following receipt of your request.

INPATIENT HOSPITAL EXAMPLE #3

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4	CENTRAL GROUP		BULATPARK RECEIPTABLE AFFAIRS DU GRAND ME F		FILE NO. MESSAGE				
50	DELTA DIVISION		REMITTANCE RECEIVED DETAIL REPORT		PRINTED 11/05/XX				
18	LA		PROVIDER NUMBER: [REDACTED]		TIME 15:37:16				
	00637 BLUE CROSS BLUE SHIELD OF LA				PAY DATE 11/05/XX				
	PATIENT NAME	HEALTH INSURANCE NO	COVERAGE DATES FROM THRU	TOTAL CHARGES	DEDUCTIBLE AMOUNT	CO INS AMOUNT	NON-COVERED CHARGES	CONTRACT ADJUSTMENT PRIMARY	PROVIDER PAYMENT
	PATIENT ADDRESS NUMBER	INTERNAL CONTROL NO		DENIED CHARGES				PAY AMOUNT	
	[REDACTED]	[REDACTED]	10/04/XX 10/10/XX	14788.37	478.93	0.00	0.00	4054.37	10255.07
				0.00				0.00	
	STATUS CD: 1	MESSAGE: 6							
	COVERED DATE:								
	PATIENT LTR AMT:	478.93							