LOUISIANA DEPARTMENT OF HEALTH

MEDICAL TRANSPORTATION PROVIDER MANUAL

Chapter Ten of the Medicaid Services Manual

Issued November 1, 2010

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

MEDICAL TRANSPORTATION

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OVERVIEW

Non-Emergency Medical Transportation (NEMT) is non-ambulance transportation provided for Medicaid recipients to and from a Medicaid provider. The NEMT Program provides transportation when all other reasonable means of free transportation have been explored and are unavailable to transport a recipient to an appointment for a Medicaid covered service.

NEMT is available without cost to the recipient on a uniform basis throughout the state when recipients request services through the Transportation Dispatch Office via the toll-free telephone number.

COVERED SERVICES

Non-emergency medical transportation (NEMT) shall be authorized for the least costly means of transportation available to the nearest available qualified provider of routine or specialty care within reasonable proximity.

Classification of Providers

NEMT is provided to Medicaid recipients through four classifications of NEMT providers. Scheduling for transportation will be considered in the following order:

- Public providers
- Friends and Family providers
- Non-profit providers
- Profit providers

Public Providers

The Department of Health and Hospitals has contracted with Greyhound Bus Lines and with the New Orleans Regional Transit Authority (RTA) in Orleans Parish to provide public transportation to Medicaid recipients through the NEMT program.

Friends and Family Providers

A recipient's friend or family member who is able to transport the recipient to medical appointments, but requires monetary assistance for this service, may be reimbursed for providing transportation. These individuals must be enrolled with Medicaid as a Friends and Family provider and call the Transportation Dispatch Office (TDO) to obtain prior authorization before transporting the recipient.

Individuals who are enrolled in the Friends and Family program must have completed a Friends and Family Transportation Provider Enrollment Form that was notarized attesting they have:

- A current valid Louisiana Driver's License,
- A current Louisiana State Inspection Sticker on their vehicle, and

- Liability insurance that is at least the minimum insurance required by the State of Louisiana.

A Friends and Family Transportation Provider Enrollment Form can be obtained from Provider Enrollment. (See Appendix G for contact information.)

Non-Profit Providers

Non-profit providers include those providers who are operated by or affiliated with a public organization such as state, federal, parish or city entities, community action agencies or parish Councils on Aging. If a provider qualifies as a non-profit entity according to Internal Revenue Service (IRS) regulations, they may only enroll as non-profit providers.

Profit Providers

Profit providers include corporations, partnerships or individuals who are certified by the Bureau of Health Services Financing (BHSF) to provide non-emergency medical transportation to eligible recipients. Profit providers must comply with all state laws and the regulations of any governing state agency, commission or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid program.

Medical Service Area

Transportation services will be provided to the recipient within the medical service area. If a recipient does not have a choice of at least two providers within the service area, transportation will be authorized to the nearest provider outside the service area. **This determination is made by the TDO.**

Recipient Eligibility for Transportation Services

NEMT services are available to all Medicaid recipients, with the exception of those listed below:

- Recipients who are eligible only for Medicare Supplemental Benefits (Pure Qualified Medicare Beneficiary (QMB)) with "17" in the third and fourth digits of their Medicaid identification number, and

- Foster care children with "15" in the third and fourth digits of their Medicaid identification number.

NEMT for Medicaid applicants is not a covered service. Transportation providers, after being notified by the scheduling service that a Medicaid applicant is in need of transportation, agree to

transport the Medicaid applicant with the understanding that an authorization number will be issued by the TDO only if the applicant becomes Medicaid eligible. **An authorization number will not be issued and payment will not be made if the applicant does not become an eligible Medicaid recipient and determined eligible for the period the services were provided.**

Out-of-State Transportation

All out-of-state transportation must be prior authorized. Transportation for out-of-state medical care **will only be approved:**

- When it is the general practice for residents of a particular locality to use medical resources in an adjoining state, or
- If approval has been obtained to receive medical treatment out-of-state.

Residents of border parishes may seek medical treatment in nearby counties in an adjoining state.

The Shriner's Hospital for Burn Patients in Galveston, Texas provides treatment to recipients at no cost to Medicaid. Therefore, transportation will be approved to this facility if the recipient is not able to arrange other transportation at no cost to him or her.

Exclusions

The following are **not** reimbursable through the NEMT program:

- Transportation to and from a pharmacy.
- Transportation from home to a nursing facility.
- Transportation from one nursing facility to another unless the recipient is transferring to a nursing facility in his medical service area because there were no beds originally available in his/her medical service area.
- Transportation for nursing home residents.
- Transportation for rehabilitation services unless the rehabilitation services have been authorized by the Prior Authorization Unit**. Transportation for the initial visit for an evaluation for the need of rehabilitation services will be approved by the TDO.**
- Transportation to WIC (Women, Infants, & Children) services appointments at Office of Public Health.

Nursing facilities are required to provide medically necessary transportation service to the nearest available provider (within 65 miles) for Medicaid recipients residing in their facilities. Any nursing facility resident needing non-emergency transportation services are the financial responsibility of the nursing facility. Therefore when an ambulance is necessary to transport a nursing home resident for non-emergency services, and does not include the physician's certification, then that trip is not payable by Medicaid. The nursing facility will be billed for services.

Non-Profit and Profit Provider Service Area

Provider service area(s) are the parish(es) in which the provider is authorized to operate. The service area must be approved by the Bureau's Health Standards Section. Request to serve a particular area or to discontinue serving an area are to be directed to the Health Standards Section - NEMT Program Manager. The service area is based on a minimum of one available vehicle per parish in the service area.

Expansion of Provider Service Area

A provider who wishes to expand his/her geographic boundaries must submit a request in writing to the Health Standards Section – NEMT Program Manager and meet all service area criteria. The provider's compliance history and any complaints about their quality of service will be considered in reviewing these requests. Providers requiring corrective action will **not** be approved until the necessary changes have been made. Any new vehicle must be inspected. All drivers must be approved.

Requests for expansion within 60 days of enrollment or the last review, which revealed no problems, will be granted without another review.

SERVICE ACCESS AND AUTHORIZATION

All non-emergency medical transportation must be prior authorized by the Bureau of Health Services Financing (BHSF) or its designee. Requests must be initiated through the BHSF contractor. (See Appendix G for contact information for contractor.)

Requests for transportation may be made by recipients, hemodialysis centers, non-profit transportation providers, or other BHSF-approved sources.

Under no circumstances can profit transportation providers schedule trips on behalf of recipients.

The Transportation Dispatch Office (TDO) will assign transportation on the basis of the least expensive means of transportation available in a geographic area with consideration given to the recipient's choice of provider. **Recipients must take advantage of free transportation and public transportation, if available.**

The provider must be certified to transport within the recipient's parish of origin.

NOTE: BHSF reserves the right to assign recipients who require treatment for life threatening illnesses (e.g., dialysis or cancer treatment) with the least costly provider, regardless of the provider's servicing area, to ensure a recipient's continuity of care.

The prior authorization (PA) number is extremely important in securing reimbursement for any trip provided. The TDO will issue a ten-digit authorization number verifying that the service is approved. This authorization must be used to bill for transportation services. After authorizing a trip for a recipient, the TDO forwards the following information to the fiscal intermediary (FI):

- Recipient name,
- Medicaid ID number,
- Date of Service, procedure code for type of trip,
- The PA number, and
- The amount authorized.

Claims that are sent in for reimbursement must match all the above items to be processed by the claims processing system. Three-digit codes giving the reason(s) for the denial of a claim will be printed on the Remittance Advice (RA) with an explanation. All codes appearing on the RA will

be shown on the second to last page of the RA. The FI should be contacted for assistance in resolving billing problems. The contractor should be contacted for assistance in resolving prior authorization issues.

NOTE: The TDO is authorized by BHSF to void a PA number if the recipient or provider of service complains that the recipient has not been picked up from the provider's office or place of service and other arrangements were made to return the recipient to his/her home or place of residence.

Recipients and medical providers are asked to give at least 48 hours notice when calling to request transportation. When a recipient calls for same day service, the TDO will attempt to schedule the trip.

When a recipient requires a second trip in the same day, either the recipient or the medical provider must call the TDO to obtain authorization. When a scheduled trip cannot be completed, the recipient or provider must immediately notify the TDO. If the provider is unable to arrive at the scheduled destination within 2 hours of the expected time of pick up, it is the provider's responsibility to notify **both** the **TDO** and the **recipient.**

If notified early enough in advance of the appointment, the TDO must attempt to schedule an alternate provider to transport the recipient.

The BHSF requires the TDO to contact the medical provider to verify the recipient kept the appointment and to contact recipients and medical providers regarding their satisfaction with the transportation service. Complaints against transportation providers are forwarded to the state on a monthly basis.

NOTE: If BHSF is notified that a profit transportation provider has been suspended or terminated by a federal, state, or local municipality, the TDO will be notified to immediately cancel all transport authorizations until further notification from BHSF.

Providers who are involved in an incident with a recipient should keep a log documenting the following:

- Nature of the incident,
- Names and contact information of any witnesses to the incident, and
- Any police involvement (citations issued or charges filed, etc).

Determining the Need for an Attendant

The TDO is responsible for determining if an attendant is required. The following conditions require an attendant:

- Sensory deficits, such as blindness or poor vision, deficits in hearing or receptive/expressive language disorder,
- Special needs such as:
  - Convalescence from surgical procedures,
  - General weakness (bed and chair bound),
  - Protection from hazards, e.g., protection from smoking,
  - Decubitus (skin sores), other problems which prohibit sitting for a long period of time where assistance is needed,
  - Incontinence or lack of bowel control (catheterized),
  - Assistance with going to the restroom, and
  - Artificial stoma, colostomy or gastrostomy.
- Need for human assistance for mobility, with or without aids, such as crutches, walkers, wheelchairs or limbs (splinted or in a cast),
- Poor function or in need of supervision (confused, disoriented, hostile, agitated or wanders off),
- Alzheimer's Disease (or some other mental impairment), and/or
- Poor command of the English language.

NOTE: The TDO must inform the provider if a recipient intends to bring along any children.

Medicaid does not pay for the transportation of the attendant. In addition the transportation provider:

- May not charge the recipient or anyone else for the transportation of the attendant,
- May refuse to transport more than one attendant per recipient and may require an attendant for an adult requiring attention during the trip,
- Should be informed by the TDO if a recipient intends to bring along any children,

- Cannot bill for the accompanying children; however, the provider may refuse to transport these children.

A parent, legal guardian, or responsible person must accompany children under the age of 17. If the recipient is under the age of 17 and requires an attendant, the attendant **must:**

- Be age 17 or older,
- Be designated by the parent if the attendant is not the parent or legal guardian,
- Be able to authorize medical treatment and care for the child, and
- Accompany the child to and from the medical appointment.

The attendant **must not:**

- Be a Medicaid provider or employee of a Medicaid provider that is providing services to the recipient being transported, or
- Be a transportation provider or an employee of a transportation provider, or
- Be an employee of a mental health facility.

PROVIDER REQUIREMENTS

Basic tenets of the Non-Emergency Medical Transportation (NEMT) Program include the following:

- Transportation shall be authorized for the least costly means of transportation available.
- Authorization is issued for the nearest available qualified provider of routine or specialty care within reasonable proximity.
- Payment of the attendant to travel with the recipient is not a billable service.
- Payment for non-emergency transportation to regular predicable and continuing medical services such as hemodialysis, chemotherapy or rehabilitation therapy shall be a capitated payment. Ten or more trips a month for the same care to the same provider will be considered capitated.
- When a capitated authorization is not fulfilled, the rate will be divided by 10, and then multiplied by the number of trips the provider has completed. This is to ensure that the total amount of single trips completed does not exceed the capitated payment.
- Scheduled trips in which no transportation of the recipient occurs is not billable. These trips are often referred to as a "dry run".
- Trips in which the recipient is not picked up and returned home can result in a cancellation of the authorization number and therefore prohibit the provider from billing for the service. If there is an instance of a good faith effort to return the patient home and the circumstances are beyond the control of the provider then this should be reported to the Transportation Dispatch Office (TDO) for a determination.
- Any provider who was issued a license to operate by a local governmental municipality that is subsequently revoked, and/or suspended will face administrative sanctions by the Department of Health and Hospitals (DHH) which may include, but not be limited to, suspension and/or exclusion from the Medicaid Program.

NOTE: As a condition of enrollment in the Medicaid program, providers are required to cover the entire parish or parishes for which they enrolled to provide NEMT services. If a provider declines

to accept a trip on a particular day the dispatch personnel will not assign additional trips to that provider for that same day.

Insurance Requirements for Profit and Non-Profit Providers

Profit and non-profit providers are required to have, at minimum, general liability coverage of $300,000 on the business entity, in addition to three months prepaid automobile liability coverage of $100,000 per person and $300,000 per accident or a combined single limit of $300,000. Any provider authorized to transport a recipient out of state must carry at minimum, automobile liability of $1,000,000. This liability policy shall include "owned" autos, hired autos, and non-owned leased autos. Providers are required to have proof of their prepaid premiums. Acceptable proof of prepaid insurance premiums shall at a minimum include a signed and dated statement from the authorized agent or company representative which includes the dates of coverage and dates through which the premium is paid. This statement is in effect through the end date of the payment noted and another statement verifying prepayment for the following three months should be received by the DHH Health Standards Section within 48 hours prior to expiration of coverage.

Proof of insurance coverage in the form of a true and correct copy of the certificate of insurance for automobile and general liability issued by the home office of the insurance company is required. This proof includes verification of the proper limits and types of coverage, policy dates and vehicle identification numbers of the covered vehicles.

The certificate of insurance must state that this coverage is for a Non-Emergency Medical Transportation Vehicle. The policy must have a 30 day cancellation clause issued to the Department of Health and Hospitals. The Health Standards Section must receive a copy of the insurance policy within 45 days of issuance. (See Appendix G for contact information.) A facsimile of the certificate is acceptable proof of coverage for up to 45 days. If a facsimile copy of a certificate from an insurance agency is submitted, the original shall be submitted within 10 working days.

Providers who are terminated because of lapse of coverage may re-enroll in the transportation program and will be subject to all applicable enrollment policies and procedures for new providers.

Lapse of insurance coverage or maintenance of the minimum liability coverage requirements on each vehicle and on the business entity is cause for immediate suspension as a transportation provider. Operation without the minimum liability insurance coverage is a violation of the provider enrollment and participation requirements and all payments made during the period of violation are subject to recoupment. Transportation providers must maintain insurance coverage as a condition of participation in the Medicaid program. The requirement for prepayment of premiums is a continuous one. Therefore, a statement is needed prior to expiration of the current coverage in order to avoid any interruption in participation. Binders are not acceptable proof of insurance coverage. Subcontracting is not allowed in the NEMT Program.

Communication Requirements

Providers must have internet capability as determined by the Medicaid NEMT Program based on the basis of volume of trips authorized to the provider.

Providers must possess a valid e-mail address as the primary method of communication to NEMT providers is through e-mail. It is imperative that providers monitor their e-mail account on a daily basis and report all changes in an e-mail address immediately. (See Appendix G for contact information)

All for profit providers must be accessible by telephone (either conventional or wireless) between the hours of 6:00 a.m. and 10:00 p.m. seven days a week.

Providers must attend all mandated agency trainings, meetings, and conference calls regarding updates on the NEMT Program. Failure to attend mandated trainings will result in a fine of $1000.00. Repeated failure to attend mandated trainings may result in further sanctions including exclusion from the Medicaid Program.

Vehicle Requirements

Each vehicle owned or leased by the provider must continuously meet all vehicle requirements to be authorized for use in the NEMT Program. Providers must own or lease all vehicles and provide proof that the vehicle registration is in the name of the company and must stipulate whether the vehicle is equipped to transport ambulatory or non-ambulatory recipients. Failure to comply with any of the following vehicle inspection requirements is a violation of the provider agreement with the Medicaid Program and all Medicaid payments made during the period of violation are subject to recoupment.

All items not covered under the Louisiana Highway Regulatory Act must function as intended by the vehicle's manufacturer. This includes vehicle heating and air conditioning. Failure to have properly functioning air conditioning or heating during the appropriate season may result in civil money penalties and loss of trip authorizations for any vehicle found out of compliance.

It is the responsibility of the provider to contact the Health Standards Section when a vehicle(s) is no longer operating under the Medicaid Transportation Program or the vehicle(s) capacity has changed. The Health Standards Section will contact the TDO to immediately reduce the provider's vehicle capacity to transport recipients by the total number of recipients the vehicle(s) can accommodate. The TDO will reduce the trips authorization by the total vehicle capacity.

Vehicle Inspection

All vehicles used in the NEMT Program must be inspected by the Health Standards Section before being used to transport Medicaid recipients. Each vehicle that is approved for transporting Medicaid recipients must have a current decal affixed by the inspector.

Inspections will be conducted initially and as deemed necessary by the Health Standards Section thereafter. Vehicles may be inspected more frequently if the provider has a history of non-compliance. Inspection packets are mailed out the month prior to the month in which the inspection is due.

The Louisiana Motor Vehicle Inspector's Handbook, which is based on Louisiana Revised Statute 32 and the Highway Regulatory Act, is used as the standard for inspecting motor vehicles for all relevant issues.

The provider is responsible for having all vehicles inspected and completing the top section of the Transportation Vehicle Inspection Form (MT-9 a) and performing a preliminary inspection of each vehicle to assure that it is in compliance with all items in section II of the form. The provider is also required to maintain clean vehicles, both inside and out.

The form MT-9 a shall be accompanied by a Certificate of Registration from the Louisiana Office of Motor Vehicles and a Certificate of Insurance showing that the vehicle has been added to the provider's commercial automobile policy.

Inspection Requirements for Temporary Use Vehicles

If a situation occurs which necessitates the use of a vehicle temporarily; approval must be given prior to the vehicle being used. The provider must notify the Health Standards Section - NEMT Program Manager to have the vehicle approved, and send a copy of the vehicle registration, insurance certificate, and rental or lease agreement, if applicable. (Refer to Appendix G for Health Standards contact information.) A vehicle used temporarily must be compliant with all rules except signage. The provider will be given an attestation of compliance to sign and return to the Health Standards Section – NEMT Program Manager. A temporary permit will be faxed to the provider to carry in the vehicle for the period of time the vehicle is authorized for use. A temporary permit will not be valid for more than 90 days.

Ride Along Compliance Reviews

As the result of Louisiana's 2010 Center for Medicare and Medicaid Services (CMS) review, the NEMT Program has been mandated to conduct quarterly ride along compliance reviews. During these ride along reviews, all providers will be monitored for vehicle and program compliance which includes, but is not limited to, the examination of the Verification of Medical Transportation (Form MT-3) documents. Non-compliance to any of the aforementioned may result in sanctions,

suspension, and/or exclusion from the Medicaid Program. Providers do not have the right to refuse a ride along review.

If a ride along is performed, and it is determined that the inspected vehicle's capacity is different than what DHH has on file, the provider's vehicle capacity count will immediately be lowered/raised by the total vehicle capacity of the vehicle.

Signage

Each vehicle must have a painted or permanently affixed sign in letters two inches or greater that displays the name and the telephone number of the enrolled provider and the vehicle number. The signs on a car must be placed on the driver and front passenger doors. The signs on a van must be placed on the driver's door, the front passenger door, and the rear door. The signs must not be affixed to the windows where they would interfere with the vision of the driver.

Vehicles funded by the Louisiana Department of Transportation and Development (DOTD) are required to have the DOTD transit logo displayed on them. These vehicles will be accepted as appropriate identification for enrollment in the NEMT program.

Providers in Orleans Parish must use their Orleans Parish Certificate of Public Necessity and Convenience (CPNC) number as their unit number. The CPNC number must meet Orleans Parish regulations for size, contrast of color and location.

License Plate Requirements

Each Non-Emergency, Non-Ambulance Medical Transportation vehicle must have a "For Hire," a public or a handicapped license plate. To obtain a "For Hire" license plate from the Louisiana Office of Motor Vehicles, a "For Hire" waiver from the Louisiana Public Service Commission must be obtained. A waiver is obtained by sending a completed and notarized MT-10 to the Louisiana Public Service Commission. (See Appendix G for contact information.) Once the waiver has been received from the Louisiana Public Service Commission, it must be taken with all other required vehicle documentation and appropriate fees to the Office of Motor Vehicles. The vehicle must be licensed in the provider's business name when obtaining the license plate. The waiver is for the business entity and should be retained for future vehicle purchases.

Adding or Deleting Vehicles

Providers must send a NEMT Request for Inspection form (HSS MT-15) to the Health Standards Section – NEMT Program Manager when requesting to add or delete a vehicle from their fleet. (See Appendix H for information on how to obtain a copy of this form) The NEMT Request for Inspection form must be accompanied by a Certificate of Registration, Certificate of Insurance, and the completed Section I of the Transportation Vehicle Inspection Form (MT-9 a). Providers

from the cities of New Orleans and Shreveport and providers from Jefferson Parish must also submit copies of their appropriate municipal or parochial permits.

When a vehicle is deleted from the fleet, the decal must be removed from the vehicle.

Office Relocation Requirements

Any change in geographic location of the main office must be reported and approved by the Health Standards Section – NEMT Program Manager prior to the change.

Advertising

Providers may only advertise via television, radio and newspapers. The following guidelines must be followed:

- Advertisements may not include the terms "free ride," "at no cost to you," "at no direct cost to you," or any such reference to indicate that the ride is "free."
- Under no circumstances shall the TDO telephone number be included in any advertisement.
- Providers must not solicit from door to door nor pass out or post handbills.
- Telephone solicitation is prohibited.
- Providers may give business cards to recipients riding with them but only one card per recipient. Recipients may not give out or pass out business cards for providers.
- Transportation providers must not solicit business for medical providers and medical providers must not solicit business for transportation providers.
- **The recipient is entitled to freedom of choice**. A medical provider cannot decide which transportation provider a recipient will use or make arrangements to use one transportation company exclusively.
- Providers are prohibited from offering inducements to recipients in order to obtain or solicit business or continue business. Examples of prohibited inducements include:
    - Sending birthday, sympathy, Christmas or greeting cards,
    - Offering raffle tickets with each ride,
    - Carrying “free refreshments” in the vehicle,

- Providing "free" breakfasts, lunch, dinner or snacks,
- Transporting (even in a provider's personal vehicle) recipient to the cleaners, grocery store or other destinations that are not Medicaid covered services, and
- Providing a monetary payment for using the provider's service.

PROVIDER RESPONSIBILITIES

Providers are responsible for picking up recipients to ensure that they arrive at their appointments on time and are returned home within a reasonable amount of time. If the provider determines that he is unable to provide the requested transport, the provider must reassign the trip to the Transportation Dispatch Office (TDO) within the following timeframes:

- **For-Profit Providers -** Trips must be reassigned by 11:59 p.m. on the day of receipt of the assignment

- **Non-Profit Providers -** Trips must reassigned by 11:59 a.m. on the next business day of receipt of the assignment

Providers are responsible for sending via e-mail a list of cancellations, dry runs, and rate corrections to the TDO daily. The TDO will e-mail the provider notification of the trip(s) to be canceled. The provider will be notified of cancellations initiated by the recipient or the medical personnel in advance of the appointment. The provider should be notified at least one hour prior to the appointment if possible. (Longer distance trips will be given reasonable and appropriate considerations.)

Providers may not file a claim for a trip that has been canceled by the scheduling office. It is the provider's responsibility to be able to receive cancellations between 8:00 a.m. and 5:00 p.m. Monday through Friday.

Providers must transport as many recipients as the vehicles allow when there are individuals going to the same medical service area during the same time frame. The number of recipients allowed in a vehicle depends on the number of seat belts in the transportation vehicle. For example, if three recipients from the same locale are all going to medical providers in the same area, with appointments at approximately the same time, they should be transported together. For recipients with excessive wait time, a provider should return the recipients back home whose services are completed and return or send another vehicle to pick up those who are not finished.

Recipients must be picked up in a reasonable time frame and returned to their home. If the driver returns to pick up the recipient and cannot locate him/her the driver must determine if the recipient left the premises. If the recipient cannot be found, the driver must contact his office immediately. Every attempt must be made to locate the recipient. If the recipient cannot be located, contact the TDO. Failure on the part of the provider to act responsibly may result in administrative sanctions imposed against him/her (including suspension from the program).

Vehicle Operation Requirements, Safety and Professionalism

Drivers should project responsible, professional and courteous behavior. Drivers must **exercise the utmost safety** in caring for recipients while transporting them and guard against becoming insensitive to their physical and emotional condition(s). Exercising a high quality of care and concern in the provision of services reflects positively on the Non-Emergency Medical Transportation (NEMT) Program.

Drivers must ensure:

- The equipment and vehicle used is kept clean and serviceable at all times,
- All laws of the State of Louisiana are observed while transporting a vehicle with passengers, and
- The vehicle is safe and in excellent operating condition.

  NOTE: A vehicle must not be driven unless the driver determines that the following parts and accessories are in good working order: vehicle brakes, parking brakes, steering mechanism, lighting devices and reflectors, tires, horn, windshield wipers and rear-view mirrors.

Drivers must:

- Not consume or be under the influence of intoxicating liquor, narcotic drugs or amphetamines within four hours of going on duty or while operating a motor vehicle.
- Assure that any vehicle they drive with “for hire,” “handicapped” or “public” license plates comes to a complete stop as required by state law. This includes all railroad crossings.
- Exercise extreme caution in the operation of a vehicle when hazardous conditions such as those caused by snow, ice, sleet, fog, mist, rain, dust or smoke adversely affect visibility or traction. Speed must be reduced when such conditions exist. If conditions become sufficiently dangerous, the operation of the vehicle must be discontinued or operated to the nearest point at which the safety of the passengers is assured.
- Use turn signals not less than 100 feet in advance of and during the turning movement of the vehicle. Turn signals must be flashed to indicate the direction of vehicle movement in traffic lanes.

- Have been instructed in the proper procedures required to move recipients into and out of the vehicle equipped to transport non-ambulatory, wheelchair recipients.
- Ensure all passengers are wearing seatbelts or are otherwise secured.
- Ensure that no smoking, eating, or drinking occurs in the vehicle as in accordance with current Occupational, Safety and Health Administration (OSHA) regulations.
- Always turn the engine off when fueling a motor vehicle, and never fuel the vehicle where there is smoke or an open flame.

Vehicles are never to be towed or pushed with passengers on board. All vehicles must contain a basic first aid kit and a fire extinguisher, and all drivers must ensure that **no smoking** occurs in vehicles.

Children less than six years of age must be placed in a National Highway Traffic Safety Administration (NHTRA) approved child safety restraint system (infant or child seat) regardless of where the child is placed in the vehicle.

Age of Child	Weight of Child	Seat Specifications
Under 1 year of age **OR**	Less than 20 pounds	Rear-facing child safety seat
Between 1 and 4 years of age **OR**	Between 20 and 40 pounds	Forward-facing restraint seat
At least 4 years of age, but less than 6 years of age	Between 40 and 60 pounds	Restrained in a child booster seat
6 years of age or older **OR**	60 pounds or more	Restrained in an appropriate child booster seat or the vehicle's safety belt

Providers are only required to provide one infant or child seat. If there is more than one child on board the vehicle, or the child does not fit in the provider's child seat, then the provider is to require the parent to furnish the appropriate child seat. The TDO is responsible for notifying all parents of this requirement when authorizing the trip.

All child safety seats shall be installed in the vehicle according to the manufacturer's recommendation, and all drivers shall be instructed in the proper installation and use of the seats.

Van type vehicles which handle wheelchairs must have a wheelchair restraint and the appropriate wheelchair lift or a ramp 28" wide with toe cleats. The lift may be manual or hydraulic.

Emergency Action Procedure

If an emergency arises while transporting a recipient, the driver must immediately assess the situation and if possible assist the recipient and his/her attendant with the emergency. In some cases it may be necessary to transport the recipient to the hospital emergency room or the doctor's office.

If the driver is transporting the recipient with no assistant when an emergency arises, the driver should assess the situation and determine whether to:

- Stop the vehicle and assist with the emergency,
- Proceed immediately to the nearest medical facility, or
- Call 911 for emergency medical assistance.

If the recipient is taken to the emergency medical facility, the driver must immediately notify the Health Standards Section – NEMT Program Manager, the TDO and a member of the recipient's family. When driving to the emergency medical facility, the driver should remain calm and alert and drive as quickly as conditions permit for safe vehicle operation.

Accident Reporting Requirements

All motor vehicle accidents must be reported to the law enforcement agency of competent jurisdiction in accordance with Louisiana Revised Statute 32:398.

Providers must report the following to the Health Standards – NEMT Program Manager:

Reporting Requirements	Reporting Period
All motor vehicle accidents	Within 72 hours of the accident
Copy of the Louisiana Uniform Motor Vehicle Accident Report	Within 10 working days of the accident
Written report of all incidents when a Medicaid recipient is killed or injured while in the provider's care, regardless of the cause	Within 72 hours of the incident

STAFFING AND TRAINING

Driver Requirements

Each provider is responsible to assure that all drivers continuously meet the following minimum requirements in order to transport Medicaid recipients:

- Be 25 years of age or older and possess a current driver's license (class D or CDL). Proof of the driver's age and license classification must be documented in the driver's personnel file at all times. A copy of the driver's license should be submitted to the inspector with the MT-8 form.

- Have successfully completed a defensive driving course accredited by the National Safety Council or a course equivalent to the course approved by the Health Standards Section – NEMT Program Manager. Proof of successful completion must be documented in the driver's personnel file. A copy of the certificate verifying completion of the course must be submitted with each MT-8. Online courses are not acceptable.

- Have an Official Driving Record from the Office of Public Safety with the MT-8 with no more than two driving violations and no Driving While Intoxicated (DWI) violations within the past three years.

In accordance with Louisiana Revised Statute 40:1300.51-56, providers must obtain a criminal history check on all new drivers hired. The criminal history check must be from, or an agency authorized by the Louisiana State Police. Providers must provide the Health Standards Section with the results of the criminal history check. Appropriate documentation includes a copy of the Criminal History Check Request Form and a copy of the money order used to pay for the history check.

Providers must report all driver changes to the inspector within five working days on the Form MT-8-C (Driver Change Form) including terminations and reasons for terminations.

Providers must report within five working days to the Transportation Manager at Health Standards when a new driver is hired or when there is a driver change. Information regarding new drivers must be reported on the Driver Information Form (Form MT-8) and include an updated Official Driving Record. Driver changes must be reported on the Driver's Change Form (Form MT-8-C) and include terminations and reason(s) for terminations. (See Appendix H for information on obtaining a copy of these forms and Appendix G for contact information.)

RECORD KEEPING

Transportation providers must maintain sufficient documentation to identify the recipients transported, trips made, locations traveled, driver qualifications, vehicle capabilities and safety information.

Daily Trip Log

A daily trip log must be maintained to document the specific date, time and destination of a recipient's transport. The daily trip log must be written in ink, maintained in a chronological order, and include the following information:

- Recipient's name,
- Recipient's Medicaid number,
- Recipient's address,
- Destination,
- Departure date and time,
- Arrival time,
- Driver's name,
- Vehicle number, if the provider has more than one vehicle, and
- Any other comments regarding the trip.

NOTE: A sample "Non-Emergency Medical Transportation Log" is included in Appendix H for the provider's use.

Verification of Medical Transportation

The "Verification of Medical Transportation" (Form MT-3) must be maintained on each recipient transported. The Form MT-3 can be written in ink or electronically produced, and must include the following information:

- Appointment date,

- Appointment time,
- Transportation provider name,
- Recipient's name,
- Recipient's Medicaid number,
- Recipient's address,
- Address of the scheduled medical appointment,
- Recipient's signature and date,
- Driver's signature and date,
- Medical facility/physicians' signature and date, and
- Medical facility's stamp (Optional)

NOTE: Failure to complete and execute the Form MT-3 will result in a fine equal to the cost of the trip. Continued failure to complete the Form MT-3 will result in other administrative sanctions including, but not limited to, exclusion from the Medicaid Program. (See Appendix H for information on obtaining a copy and instructions for completing the Form MT-3).

Providers who transport recipients to recurring appointments (e.g., hemodialysis, chemotherapy and behavioral health) during a given week must ensure the Form MT-3 is signed by the recipient, a representative from the medical facility and the driver on the last date service was provided for that week. Only one Form MT-3 is required per week for capitated trips.

All documentation must be made available to the Department of Health and Hospitals, the Office of Attorney General and other state and federal entities under which the scope of regulating this program falls.

All documentation must be maintained for five years from the date the claim is paid.

REIMBURSEMENT

Friends and Family

Friends and Family providers are paid a flat fee per trip**.** A capitated rate is paid for 10 or more trips per month to the same medical facility. This reimbursement is intended to cover all persons in the car at the time of the trip. The Friends and Family provider is also eligible for a negotiated rate.

Non Profit Providers

Payment for non-profit providers is set at a flat rate per trip. Non-profit providers are eligible for negotiated rates.

Profit Providers

Reimbursement for Profit Providers is set on a base of a round trip of up to 65 miles. . In addition to the basic procedure used to reimburse the trip, there are provisions to pay, when necessary, on a capitated basis and on a negotiated basis.

NOTE: See Appendix B for rates and codes to be used.

COMPLAINT PROCEDURES

Complaint procedures are designed for use by interested parties to bring problems encountered with Non-Emergency Medical Transportation providers to the attention of the Department of Health and Hospitals. Any person having knowledge that the quality of service provided by a transportation provider is substandard and potentially detrimental to the well being of Medicaid recipients or that freedom of choice of the recipient is being violated, may make a written or verbal complaint to Health Standards, the Bureau of Health Services Financing (BHSF) Non-Emergency Medical Transportation (NEMT) Program Section or the Transportation Dispatch Office (TDO). (See Appendix G for contact information.)

OVERVIEW

Participation in the Medicaid program is governed for ambulance providers by meeting the requirements of R.S.40.1235.2 (Licensure for Ground Ambulances). Licensing by the Health Standards Section of the Bureau of the Health Services Financing (BHSF) is also required.

Ambulance services must be medically necessary. Medical necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated. Ambulance services are not covered when another means of transportation could be utilized without endangering the individual's health, whether or not such transportation is actually available. Determination of medical necessity of the means of transport is made by the physician or nurse at the treating facility. The physician must complete the appropriate form required by the Department of Health and Hospitals (DHH) in order for the ambulance provider's claim to be considered valid. No other form, other than those approved by DHH, will be considered valid documentation for the mode of transportation.

Transportation for routine medical appointments for non-ambulatory individuals is provided through the Non-Emergency Medical Transportation program. When wheelchair van transportation for a non-ambulatory individual is not available, Medicaid will approve ambulance transportation to be provided and billed at the non-emergency rates.

EMERGENCY MEDICAL TRANSPORTATION

Emergency ambulance transportation is provided for an unforeseen combination of circumstances that apparently demand immediate attention at a medical facility to prevent serious impairment or loss of life. The following are examples of this criteria:

- A recipient who has a medical condition such as a possible heart attack; stroke or altered mental status,
- A recipient who presents with a hemorrhage, altered mental status, or a possible spinal injury,
- A recipient requiring the administration of IV fluids and/or medications when the recipient would be susceptible to injury if other methods of transportation were utilized,
- A recipient who is unmanageable or needs restraint,
- A recipient who appears to be in a psychiatric crisis as indicated by unmanageable or threatening behavior.

Emergency ambulance service is ambulance services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the recipient's health in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Loss of life, limb or sight.

An ambulance trip that does not meet at least one of these criteria would be considered a non-emergency service and must be coded and billed as such.

Emergency ambulance transportation is approved when the treating physician or nurse at the receiving hospital certifies on the Molina Form 105 that the recipient was in his/her judgment in need of emergency care and an ambulance was the only means by which this recipient could have been brought safely to the emergency room.

Absence of this documentation, which is maintained on file at the ambulance provider's office, will result in the claim being classified as not valid.

NON-EMERGENCY AMBULANCE TRANSPORTATION

Non-emergency ambulance transportation is provided to a Medicaid recipient to and/or from a provider of medical services for a covered medical service when no other means of transportation is available and/or the recipient is unable to ride in any other type of vehicle (i.e., auto or stretcher van) due to medical reasons. The nature of the trip is not an emergency, but the recipient requires the use of an ambulance.

Non-emergency ambulance transportation would include, but would not be limited to, all scheduled runs regardless of origin and destination, as well as transports to nursing homes or the recipient's residence. Non-emergency ambulance transportation will be provided at the non-emergency ambulance rates to recipients who are non-ambulatory, in need of transportation to a routine medical appointment and there is no wheelchair van provider available.

The services must be provided in accordance with state law and regulations governing the administration of these services. Additionally, certification is required for the medical technicians and other ambulance personnel by the Department of Health and Hospitals, Bureau of Emergency Medical Services. The ambulance service provider must notify the Bureau of Health Services Financing's Health Standards Section prior to licensing of the level of care that they wish to provide to the public: basic, intermediate or paramedic. The ambulance service will be required to equip and provide staff according to the level they have chosen.

In all cases, the recipient's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must indicate on the Certification of Ambulance Transportation Form (Molina 105 Attachment) that either:

- The transport was of an emergency nature, or
- The transport was of a non-emergency nature but an ambulance was required.

This form must be attached to all hardcopy claims, and a copy must be maintained on file for a period of five years (whether the claim was filed electronically or hardcopy).

AMBULANCE – MISCELLANEOUS POLICIES

Nursing Home Ambulance Transportation

Nursing facilities are required to provide medically necessary transportation services for Medicaid recipients residing in their facility. Any nursing home recipient needing non-emergency transportation services are the financial responsibility of the nursing facility. This means that any ambulance transportation provided to a nursing home recipient for a non-emergency service that does ***not include the physician's certification that an ambulance was required***, is not payable by Louisiana Medicaid; therefore, the nursing facility should be billed for such services.

Limits and Overrides

An override gives approval to perform a service that exceeds the given limitations. An override cannot be requested until the service has been performed.

Service Limits for Emergency Services

Payment will be made, without Medicaid approval, for one emergency trip per day to a hospital. Payment may also be made for a same day, second trip, when it is necessary for the recipient to be transferred from that hospital to another in order to receive the appropriate level of care.

When billing for additional emergency services, the provider must submit a hard copy claim with the Certification of Ambulance Transportation Form (105 Attachment) to the fiscal intermediary for consideration of an override of the service limit.

Services Limits for Non-Emergency Ambulance Services

Payment will be made for a maximum of two trips for one recipient on the same date of service. Additional services will require state office review and approval prior to reimbursement being made.

When billing for additional non-emergency services, the provider must submit a hard copy claim with the Certification of Ambulance Transportation Form (105 Attachment) stating that the transport was of a non-emergency nature, but an ambulance was required.

Medicaid /Medicare Service Limits

Medicaid allows two trips on the same day. In certain situations, an override will be necessary in order to process the claims.

If Medicare pays on the second trip, same day, the Medicaid claim should be filed with the same procedure code as the Medicare claim, along with the Medicare Explanation of Benefit (EOB).

Providers may send the claims and the Medicare EOB to the fiscal intermediary's Correspondence Unit for forwarding to the Bureau of Health Services Financing (BHSF).

If Medicare denies the service as "not covered" (for example, hemodialysis transportation, a trip to the doctor's office, etc) and Medicaid will cover the service, the BHSF has given the fiscal intermediary the authority to override the 275 edit. ***Note that the Medicare EOB must be filed (attached) with the Medicaid claim.*** These requests should be sent to the fiscal intermediary. (See Appendix G for contact information.)

Medicaid and Medicare Part B

Services for Medicare Part B recipients should be billed to the Medicare carrier on the Medicare claim form. Medicare will make payment and cross the claim over to the fiscal intermediary for Title XIX payment. If the recipient has private insurance, the provider should bill the fiscal intermediary after the private insurer has been billed and has either paid or denied the claim.

Medicaid will not make payment on any claim denied by Medicare as not being medically necessary. Qualified Medicare Beneficiary (QMB) claims are included in this policy.

For trips that are not covered by Medicare but are covered by Medicaid, payment will not be made unless the claim is filed hardcopy with the Medicare EOB attached stating the reason for denial by Medicare.

For claims that fail to cross over via tape, a hard copy claim along with Certification of Ambulance Transportation Form (105 Attachment) may be filed up to six months after the date of the Medicare EOB, provided they were filed with Medicare within a year of the date of service.

Medicaid does a cost comparison of cross over claims to determine if Medicare paid more than Medicaid for the claim. If this occurs and Medicare has paid more than Medicaid pays for the service, the claim will be "zero" paid and the ambulance provider will be considered paid in full. No balance may be collected from the recipient.

AIR TRANSPORTATION

Participation in the Medicaid program "is governed by the licensing law La. R.S 40:1236.2" (Licensure for helicopters and fixed winged aircraft). The participation requirement also includes certification by the Bureau of Health Services Financing's Health Standards Section.

Prior Authorization of Services

Prior authorization of services is required and this function is performed by the Prior Authorization Unit of the fiscal intermediary, which must review air ambulance claims and either approve or disapprove these services based on the following requirements:

- Emergency air transportation is covered only if speedy admission of the recipient is essential, and

- The point of pick up is inaccessible by land vehicle or great distances or other obstacles are involved in getting the recipient to the nearest hospital with appropriate facilities.

Commercial Air Transportation for Out of State Care

Transportation on commercial airlines is approved for out of state trips when no comparable services can be provided in Louisiana and the risk to the patient's health is grave. All out of state medical care must be prior authorized by the Prior Authorization Unit of the fiscal intermediary and approved by the Medicaid Director or his/her designee. Transportation may be included in the prior authorization for medical services. The health and safety of the recipient must be confirmed by the treating physician, and the patient's ability to tolerate this form of travel must be considered.

HOSPITAL-BASED AMBULANCES

Hospital-based ambulances are designed to transport patients to their own facility only. The fact that a hospital has an ambulance must be disclosed to the Provider Enrollment Unit. The hospital will need to mail or fax the Provider Enrollment Unit a copy of their ambulance license along with a cover letter requesting that this additional service be added to their provider file.

If a hospital performs general ambulance services to the community, i.e. transporting recipients, the services would be considered that of an ambulance service provider. Therefore, enrollment as an ambulance provider is necessary.

Claiming these costs on the hospital cost report is **erroneous**. Only ambulance services performed by the hospital that transports patients back to its own hospital may be claimed on the cost report.

AMBULANCE MEMBERSHIPS

Ambulance companies that are enrolled in Medicaid may not **solicit** Medicaid recipients for membership fees for a subscription plan. Solicitation of such fees is a violation of Section 1916 of the Social Security Act and regulations at 42 CFR 447.15 and 447.53. If such membership fees are collected, the Medicaid recipient must be refunded in full, or the ambulance provider will be terminated from the program.

It is **not** a violation of the regulations when a Medicaid-enrolled ambulance company accepts membership fees if the Medicaid recipient voluntarily subscribes to the plan.

If a Medicaid-enrolled ambulance company's subscription plan operates as an insurance policy, and the Medicaid recipient pays the fee, the fee is treated as an insurance premium and is not in violation of Medicaid regulations.

RETURN TRIPS AND TRANSFERS

Return Trips

When a recipient is transported to a hospital by ambulance on an emergency basis and is not admitted, and the hospital can find no other means of returning the recipient home or the recipient is not ambulatory, the ambulance provider may be paid for a non-emergency return trip.

The non-emergency return trip should be billed on the Form 105. Appropriate hospital emergency room personnel (registered nurse, licensed practical nurse, emergency room clerk) must indicate on the bottom line of Block 17 that either they were unable to locate any other means of returning the recipient home, or due to the condition of the recipient, the ambulance transportation was medically necessary.

When billing for such a service, the trip should be included in Block 17 on the same claim form submitted for the emergency ambulance service.

Transfers

An ambulance transfer is the transport of a recipient by ambulance from one hospital to another. It must be medically necessary for the recipient to be transported by ambulance. The recipient must be transported to the most appropriate hospital. It is not appropriate to take the recipient to a hospital that does not meet his/her needs and then have to perform a transfer to another hospital.

If the physician(s) make the decision that the level of care required by the recipient cannot be provided by the hospital, and the recipient has to be transported to another hospital, the provider may be paid for both transfers.

REIMBURSEMENT

Mileage

Ambulance providers may bill for covered medically necessary mileage for ambulance transport to the nearest appropriate facility.

Mileage can only be billed when the patient is in the vehicle (loaded miles).

Mileage must be billed in accordance with the type of service indicated by the licensed medical professional on the Certification of Ambulance Transportation Form (Molina 105 Attachment).

The amount of Medicaid reimbursement for mileage will vary depending on whether the transport is due to a life threatening emergency which requires transportation by ambulance, a non-emergency requiring transportation by ambulance, or a non-emergency not requiring transportation by ambulance.

Emergency Ambulance

Medicaid will pay a base rate plus mileage according to the established state fee schedule (based on Medicare rates). Separate reimbursement for oxygen and disposable supplies will be made.

Emergency Air

Payment for air mileage will be limited to actual air mileage from point of pick up to point of delivery. Payment for round trip transportation on the same day between two hospitals is the base rate plus the round trip mileage. If a land ambulance must be used as part of the transport, the land ambulance provider will be reimbursed separately according to rules and regulations for ground ambulance.

Non-Emergency Ambulance

Medicaid will pay base rate plus mileage.

Procedure Code A0226

Medicaid no longer covers "Ambulance 911-Non-emergency" services, previously covered by procedure code **A0226**. If a nurse or physician refuses to sign the 105 Attachment form stating that ambulance transportation was necessary, the service may be considered a non-covered service by Medicaid. Providers are allowed to bill recipients for services not covered by Medicaid.

FRIENDS AND FAMILY TRANSPORTATION PROVIDER ENROLLMENT FORM

This section is for UNISYS PE use only:

Driver Parish Code: _____ Begin Date: ___/___/___ Rep: _____

Provider #: _____ End Date: ___/___/___ Extension: _____

This Friends & Family Enrollment Form is for: ☐ New Enrollment ☐ Recertification ☐ Add-On

Please fill out the entire form below. Incomplete forms will be rejected which will delay the enrollment date. Please print.

Driver Information ☐ Mr. ☐ Mrs. ☐ Ms.

Full Name of Driver: _____
Last First Middle Initial Maiden (if applicable)

Mailing Address of Driver: _____
Street or P.O. Box City State ZIP Code

_____ ( ) - - -
Parish of Driver Telephone Number of Driver Social Security Number of Driver

I will transport the following people (limited to a total of 5 individuals):

Medicaid Recipient Name	Date of Birth (mm/dd/yyyy)	Medicaid Plastic Card Control Number (16 digit CCN Number on Medicaid Card)
1.	/ /	
2.	/ /	
3.	/ /	
4.	/ /	
5.	/ /	

Check off the boxes and fill in the information below:

A. I have a current Louisiana Driver's license that is not suspended or revoked. ☐ Yes ☐ No Driver's License Number: _____

B. I have a current Louisiana State inspection sticker on my car. ☐ Yes ☐ No Car License Plate Number: _____

C. I carry liability insurance on my car and it is at least the minimum insurance required by the state of Louisiana. ☐ Yes ☐ No Name of Insurance Company: _____

I promise/attest that all the above information is true and accurate. I understand that false statements regarding this information can result in fines, penalties, and/or imprisonment. Signature must be witnessed by two individuals who are not family members and are 18 years of age or older.

_____ _____ _____
Print Name of Driver Signature of Driver Date of Signature

_____ _____ _____
Print Name of Witness #1 Signature of Witness #2 Date of Signature

_____ _____ _____
Print Name of Witness #2 Signature of Witness #2 Date of Signature

Mail completed form to: Molina – Provider Enrollment, P.O. Box 80159, Baton Rouge, LA 70898-0159

NEMT RATES-AS OF DECEMBER 1, 2010

Procedure Code	Service Description	Rate
Z9498	Non- Profit Flat Rate	$14.25
Z5177	Profit Flat Rate (0-65 miles round trip)	$18.32
Z5178	Profit Negotiated Rate	Negotiated
Z5187	Non- Profit Flat W/C Rate	$24.43
Z5186	Profit-Flat W/C Rate	$30.53
Z5179	3-Day a Week Flat Cap Rate (0-65 miles round trip)	$183.16
Z5180	3-Day a Week Negotiated Cap Rate (66 miles plus round trip)	$244.23
Z5185	3-Day a Week Flat W/C Cap Rate (0-65 miles round trip)	$219.79
Z5184	3-Day a Week Negotiated W/C Cap Rate (66 miles plus round trip)	$305.27
Z5188	4-Day a Week Flat Cap Rate (0-65 miles round trip)	$232.59
Z5188	4-Day a Week Negotiated Cap Rate (66 miles plus round trip)	$259.13
Z5183	5-Day a Week Flat Cap Rate (0-65 miles round trip)	$366.33
Z5182	5-Day a Week Negotiated Cap Rate (66 miles plus round trip)	$386.68
Z9486	Friends & Family Flat Rate	$7.13
Z5181	Friends & Family Negotiated Rate Cap	Negotiated
Z9494	Friends & Family Flat Rate Cap	$71.25

Negotiated rates are determined by round trip miles.

0-65	$18.32	366-395	$102.77	696-725	$183.16
66-95	$22.89	396-425	$106.84	726-755	$190.80
96-125	$30.53	426-455	$114.48	756-785	$198.43
126-155	$38.16	456-485	$122.11	786-815	$206.05
156-185	$45.80	486-515	$129.73	816-845	$213.70
186-215	$53.43	516-545	$137.37	846-875	$221.32
216-245	$61.05	546-575	$145.01		
246-275	$68.69	576-605	$152.64		
276-305	$76.32	606-635	$160.27		
306-335	$83.95	636-665	$167.90		
336-365	$91.59	666-695	$175.54		

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

DATE

MEMORANDUM

TO: NAME, Medicaid Provider Enrollment Manager @ Molina Medicaid Solutions

FROM: NAME, Medicaid Program Manager, Health Standards, NEMT

RE: NAME OF TRANSPORTATION COMPANY

On DATE the above referenced provider passed initial survey for the Medicaid, Non-Emergency Medical Transportation Program, and has completed all requirements to operate as a PROFIT/NON-PROFIT provider in NAME OF parish.

The provider has one vehicle in NAME OF PARISH with a capacity of # OF ambulatory clients, for a total daily capacity of # OF ambulatory clients. It is based at COMPLETE PHYSICAL ADDRESS.

The contact person is NAME and his/her telephone number is NUMBER. The business and mailing address are the same as above.

No changes have been made since the inspection was conducted.

Please write in the provider number in the space provided below and return a copy of this letter to this office.

If you have any further questions, please contact me at 225-342-9404.

Cc: Provide file
Enclosures PE-50 Disclosure of Ownership
IRS Verification of Taxpayer Identification Number
Electronic Funds Transfer Authorization; Voided check

Provider Number: _____ Effective Date:_____

By: _____
id Provider Enrollment Manager @ Molina Medicaid Solutions

AMBULANCE TRANSPORTATION CODES

EMERGENCY AMBULANCE

A0382	Basic Support, Routine Support
A0394*	ALS Special Service Disposable Supplies IV
A0398	ALS Routine Disposable Supplies
A0422	Ambulance (ALS or BLS) Oxygenated Oxygen Supplies, Life Sustaining
A0425	Ground Mileage
A0427	ALS Emergency Transport
A0429	BLS Emergency Transport
A0433	ALS 2
A0434	Specialty Care Transport

***A0394 – This code is payable only when Medicare determines it medically necessary.**

EMERGENCY AIR

A0430	Fixed wing air
A0431	Rotary wing air
A0435	Air mileage; fixed wing
A0436	Air mileage; rotary wing

NON-EMERGENCY AMBULANCE

A0360	Base rate, BLS, first trip
A0364	Base rate, no specialized ALS services, first trip
A0366	Base rate, specialized ALS services, first trip
A0380	Loaded miles, BLS, first trip
A0390	Loaded miles, ALS, First trip
A0426	ALS Non-emergency transport
A0428	BLS Non-emergency transport

These are current national codes recognized by Centers for Medicare and Medicaid Services (CMS) along with changes approved by the Louisiana Department of Health and Hospitals.

AMBULANCE TRANSPORTATION MODIFIERS

When billing for Procedure Codes A0425 – A0429 and A0433 - A0434 for Ambulance Transportation services in field 17C of the Unisys 105 Form, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code. **Effective with the date of service October 1, 2003, spaces will not be recognized as a valid modifier for those procedures requiring a modifier.** The following table identifies the valid modifiers.

Ambulance Transportation Claims -
Valid Modifiers

Modifier	Description
DD	Trip from DX/Therapeutic Site to another DX/Therapeutic Site
DE	Trip from DX/Therapeutic Site to Residential, Domiciliary, Custodial Facility
DH	Trip from DX/Therapeutic Site to Hospital
DI	Diagnostic-Therapeutic Site/Transfer Airport Heli Pad
DP	Trip from DX/Therapeutic Site to Physician's Office
DR	Trip from DX/Therapeutic Site to Home
DX	Trip from DX/Therapeutic Site to MD to Hospital
ED	Trip from an RDC or Nursing home to DX/Therapeutic Site
EH	Trip from an RDC or Nursing home to Hospital
EG	Trip from an RDC or Nursing home to Dialysis Facility (Hospital based)
EI	Residential Domicile Custody Facility/Transfer Airport Heli Pad
EJ	Trip from an RDC or Nursing home to Dialysis Facility (non-Hospital based)
EN	Trip from an RDC or Nursing home to SNF
EP	Trip from an RDC or Nursing home to Physician's Office
ER	Trip from an RDC or Nursing home to Physician's Office
EX	Trip from RDC to MD to Hospital
GE	Trip from HB Dialysis Facility to an RDC or Nursing Home
GG	Trip from HB Dialysis Facility to Dialysis Facility (Hospital Based)
GH	Trip from HB Dialysis Facility to Hospital
GI	HB Dialysis Facility/Transfer Airport Heli Pad
GJ	Trip from HB Dialysis Facility to Dialysis Facility (non-Hospital Based)
GN	Trip from HB Dialysis Facility to SNF

Modifier	Description
GP	Trip from HB Dialysis Facility to Physician's Office
GR	Trip from HB Dialysis Facility to Patient's Residence
GX	Trip from HB Dialysis Facility to MD to Hospital
HD	Trip from Hospital to DX/Therapeutic Site
HE	Trip from Hospital to an RDC or Nursing Home
HG	Trip from Hospital to Dialysis Facility (Hospital Based)
HH	Trip from One Hospital to Another Hospital
HI	Hospital/Transfer Airport Heli Pad
HJ	Trip from Hospital to Dialysis Facility
HN	Trip from Hospital SNF
HP	Trip from Hospital to Physician's Office
HR	Trip from Hospital to Patient's Residence
IH	Transfer Airport Heli Pad/Hospital
JE	Trip from NHB Dialysis Facility to RDC or Nursing Home
JG	Trip from NHB Dialysis Facility to Dialysis Facility (Hospital Based)
JH	Trip from NHB Dialysis Facility to Hospital
JI	NHB Dialysis Facility/Transfer Airport Heli Pad
JN	Trip from NHB Dialysis Facility to SNF
JP	Trip from NHB Dialysis Facility to Physician's Office
JR	Trip from NHB Dialysis Facility to Patient's Residence
JX	Trip from NHB Dialysis Facility to MD to Hospital
ND	Trip from SNF to DX/Therapeutic Site
NE	Trip from SNF to an RDC or Nursing Home
NG	Trip from SNF to Dialysis Facility (Hospital based)
NH	Trip from SNF to Hospital
NI	Skilled Nursing Facility/Transfer Airport Heli Pad
NJ	Trip from SNF to Dialysis Facility (non-Hospital based)
NN	Trip from SNF to SNF
NP	Trip from SNF to Physician's Office

Modifier	Description
NR	Trip from SNF to Patient's Residence
NX	Trip from SNF to MD to Hospital
PD	Trip from a Physician's Office to DX/Therapeutic Site
PE	Trip from a Physician's Office to an RDC or Nursing Home
PG	Trip from a Physician's Office to Dialysis Facility (Hospital based)
PH	Trip from a Physician's Office to a Hospital
PI	Physician's Office/Transfer Airport Heli Pad
PJ	Trip from a Physician's Office to Dialysis Facility (non-Hospital based)
PN	Ambulance trip from the Physician's Office to Skilled Nursing Facility
PP	Ambulance trip from Physician to Physician's Office
PR	Trip from Physician's Office to Patient's Residence
RD	Trip from the Patient's Residence to DX/Therapeutic Site
RE	Trip from the Patient's Residence to an RDC or Nursing Home
RG	Trip from the Patient's Residence to Dialysis Facility (Hospital based)
RH	Trip from the Patient's Residence to a Hospital
RI	Residence/Transfer Airport Heli Pad
RJ	Trip from the Patient's Residence to Dialysis Facility (non-Hospital based)
RN	Trip from the Patient's Residence to Skilled Nursing Facility
RP	Trip from the Patient's Residence to a Physician's Office
RX	Trip from Patient's Residence to MD to Hospital
SH	Trip from the Scene of an Accident to a Hospital
SI	Accident Scene, Acute Event/Transfer Airport, Heli Pad

NOTE: Adding a modifier to procedure codes for Fixed Wing Mileage (A0435) and Helicopter Air Mileage (A0436) is not required.

MEDICARE NON-COVERED TRANSPORT MODIFIER CODES

The following modifiers should be used when billing for transports that are non-covered services by Medicare. These modifiers **may be used ONLY with procedure codes A0425-A0429 and A0433-A0434** to allow the claim to bypass the Medicare edit and process as a Medicaid claim.

Modifier	Description
DD	Clinic/Free-standing Facility to Clinic/Free-standing Facility
DE	Clinic/Free-standing Facility to Nursing Home
DP	Clinic/Free-standing Facility to Physician
DR	Clinic/Free-standing Facility to Residence
ED	Nursing Home to Clinic/Free-standing Facility
EP	Nursing Home to Physician *
ER	Nursing Home to Residence
HP	Hospital to Physician
NP	Skilled Nursing Facility to Physician *
PD	Physician to Clinic/Free-standing Facility
PE	Physician to Nursing Home
PN	Physician to Skilled Nursing Facility
PP	Physician to Physician
PR	Physician to Residence
RD	Residence to Clinic/Free-standing Facility
RE	Residence to Nursing Home
RP	Residence to Physician *

* **These modifiers will bypass the Medicare edit for non-emergency transports ONLY.**

CONTACT INFORMATION

Office Name	Contact Information
Health Standards	Health Standards P. O. Box 3767 Baton Rouge, LA 70802 Phone #: (225) 342-9405 Fax #: (225) 342-0157 EMS home page: http://new.dhh.louisiana.gov/index.cfm/directory/detail/714 NEMT home page: http://new.dhh.louisiana.gov/index.cfm/directory/detail/732
Transportation Dispatch Office (TDO)	Phone #: 1-866-272-5501 or (337) 684-2041 Fax #: 1-800-864-5226
Molina Provider Enrollment Unit	Molina Medicaid Solutions Provider Enrollment Unit P. O. Box 80159 Baton Rouge, LA 70898-0159 Phone #: (225) 216-6370 Fax #: (225) 216-6392
Public Service Commission	Public Service Commission P. O. Box 91154 Baton Rouge, LA 70821 Phone #: (225) 342-4404
Non-Emergency Medical Transportation	Bureau of Health Services Financing Attn: NEMT Program P. O. Box 91030 Baton Rouge, LA 70821 Phone #: (225) 342-2604 or (225) 342-6227 Fax #: (225) 376-4648 or (225) 242-0406

Office Name	Contact Information
Molina Provider Relations Unit	Molina Medicaid Solutions P. O. 91024 Baton Rouge, LA 70821 Phone #: 1-800-473-2783
First Transit, Inc. (to report provider's e-mail address change)	carl.marceaux@firstgroup.com

FORMS

This appendix includes information about how to access the forms that are referenced in the Medical Transportaion manual chapter and where they can be obtained.

The following forms can be found in this appendix:

- **Certification of Ambulance Transportation** – Molina 105 Attachment
- **Certification of Ambulance Transportation** – Molina 105 Attachment Instructions
- **Non-Emergency Medical Transportation Log**

The following NEMT forms are available at http://new.dhh.louisiana.gov/index.cfm/page/1544:

- **NEMT Program Driver Information Form** – MT-8
- **Transportation Vehicle Inspection Form** – MT-9 a
- **NEMT Request for Inspection (Fleet Addition)** – MT-15
- **Instructions for Completing NEMT Request for Inspection (Fleet Addition) – MT-15**

The following NEMT form is available at http://new.dhh.louisiana.gov/index.cfm/page/1543:

- **NEMT Program Driver's Change Form** – MT-8-C

The following NEMT forms are available at http://www.lamedicaid.com/provweb1/Forms/forms.htm#web:

- **Non-Emergency Medical Transportation Log**
- **Verification of Medical Transportation** – Form MT-3

The following EMS forms are available at http://new.dhh.louisiana.gov/index.cfm/page/1539:

- **Request for Inspection – (Ambulance – Sprint – Air Ambulance)** – ET-05
- **Instructions for Completing EMS Request for Inspection (Fleet Addition) Form ET-05**
- **Medical Response Emergency Vehicle Survey – Ambulances – Minimum Equipment & Supply Needs**
- **Medical Response Emergency Vehicle Survey – Sprint Report – Minimum Equipment & Supply Needs**

Molina 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name	Origin of Services
ID # of Recipient	Destination
Date of transport	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:
Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable and is not likely to require the attendance of an EMT. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: Patient will require transportation ____ (number) times a week during the month's ____, ____ (month(s). (year)) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months).
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en Route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:
Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other *(describe):*

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above. Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

I have read the above certification and I have read and understand the instructions on the reverse side of this form.	
	I **agree** with the determination.
	I **disagree** with the determination, for the following reasons:

Signature of MD/PA/NP/CNS/RN/DON
X _____ _____ _____
Printed Name **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form. Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Molina Form 105. Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services. If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate.

Molina 105 ATTACHMENT-INSTRUCTIONS

CERTIFICATION OF AMBULANCE TRANSPORTATION

Purpose
Molina 105 Attachment is initiated to support medical necessity for ambulance transportation for those recipients residing in nursing facilities or those recipients receiving dialysis, radiology and physical therapy services. Facility reviewers will review this form to determine whether the facility is properly requesting ambulance transportation services. Ambulance transportation reviewers will review this information to determine the patient's condition meets the need for ambulance transportation.

Preparation
Identifying Information: Recipient name, Medicaid ID number, date of transport, origin of service, destination, and destination address shall be completed by either the ambulance transportation provider or the facility. Every item is to be completed.

Certification of Ambulance Transportation Necessity (Section I): Effective with date of service July 1, 2003, the Department of Health and Hospitals has revised the certification form (Form 105 Attachment). The new form shall replace the Form 105 Attachment 1 currently in use by the ambulance industry. Also, the certification shall require the attending physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse (all applicable sate licensure or certification requirement must be met) or nursing facility director of nursing for LTC residents to certify that the patient's condition meets the need for ambulance transportation services. Ambulance transportation was necessary because other means of transportation would endanger the life or health of the patient. In addition, signed certification statements from physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), registered nurses (RN), or nursing facility director of nursing for LTC residents are also acceptable when professional services are furnished by the same.

Type of Ambulance Transportation Necessary:
There are three types of medical transport available:

1. Emergency ambulance transport is appropriate in case of accidents or sudden medical emergency.
2. Non-emergency ambulance transport is to be utilized when the condition of the patient requires or may require medical care en route. Examples of conditions which could reasonably be expected to require non-emergency ambulance transport are: (1) unstable diabetes; (2) chronic pulmonary diseases requiring use of oxygen during transport; (3) unstable ventilator assistance; (4) IV therapy. Prior scheduling is to be utilized.
3. Non-emergency, non-ambulance transport is appropriate for routine non-emergency transport of wheelchair or ambulatory patients. Prior scheduling is to be utilized.

Medical Professional Statement (To Be Completed by MD/PA/NP/CNS/RN/DON)-(Section II): The Medical Professional Statement section is to be completed only if the recipient's physician has not issued written orders requiring ambulance transportation. Such written orders, if used in lieu of the Medical Professional Statement on this form, must specify the medical condition which requires travel by ambulance, the length of time for which ambulance transport will be necessary, and must be signed and dated by the physician. A copy of the written orders, if pertinent, must be attached to the form.

If no written orders have been issued, the Medical Professional Statement shall be completed by the treating medical doctor, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or the nursing facility director of nursing. (The physician may be the physician treating the patient, the physician who instructed the patient to travel to the medical facility, or the medical director of the facility which received the patient.) The medical professional shall check the appropriate block indicating agreement with the facility statements or indicating disagreement and the reason for disagreement.

Ambulance Driver and Attendant Designation and Signature: The names of the ambulance driver and attendant and their national EMT numbers shall be printed or typed legibly by the transportation provider. The form MUST be signed and dated by the driver and the attendant.

Disposition
The facility may file a copy of the form in the patient's record when transport is provided. In cases involving nursing facilities, this copy shall be completed, signed, and dated by the nursing facility Director of Nursing, the ambulance driver, and the ambulance attendant. The Medical Professional Statement shall also be completed unless the medical professional at the medical destination is to complete this section.

Ambulance transportation providers who submit paper claims or bill electronically shall retain the original of the form in the office available for review for a period of five (5) years from the date of service. Every claim shall have either a copy of the physician's written orders attached or the Medical Professional Statement on the form completed, signed, and dated by the appropriate medical professional.

NOTE: When the Medical Professional Statement disagrees with the certification of medical necessity, non-emergency ambulance transport shall be reimbursed at a rate not to exceed the non-emergency, non-ambulance rate.

CLAIMS FILING

Non-Emergency Medical Transportation Billing Overview

Non-Emergency Medical Transportation claims are filed on the Molina Medicaid Solutions Form 106.

These forms may be obtained from Molina Medicaid Solutions by call Provider Relations at (800) 473-2783 or (225) 924-5040

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Completed claims should be mailed to:

Molina Medicaid Solutions
P. O. Box 91022
Baton Rouge, LA 70821

Form 106 Billing Instructions for Non-Emergency Medical Transportation

Locator #	Description	Instructions	Alerts
1	Last Name	Required -Enter recipient's last name.	
2	First Name	Required – Enter recipient's first name.	
3	MI	Required - Enter recipient's middle initial.	
4	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Date of Birth	Required - Enter the recipient's date of birth	
7	Sex	Required - Enter the recipient's sex.	
8	Medical Appointment Time	Optional - Enter the time, month, day, and year of the recipient's medical appointment.	
9	Origin of Service	Required - Enter the origin of service.	
10	Destination of Service	Required - Enter the destination of service.	
11	Prior Authorization	Required - Enter the 10-digit alphanumeric prior authorization number assigned by the dispatch office.	
12	Transportation authorized is:	Required - Check the appropriate block to indicate whether the scheduled service was one-way or two-way transport.	
13	EPSDT Referral	Leave blank.	
14		This item serves as a reminder that all non-emergency medical transportation must be prior authorized by the dispatch office.	
15	Signature of DHHR Worker, Title, Parish, Date	Leave blank.	
16	Provider Name and Address	Required - Enter the name and address of the transportation provider providing the service.	
17	Provider Number	Required - Enter the provider's 7-digit Medicaid provider number.	
18	Treating Practitioner's Name	Required - Enter the name of the medical provider treating the patient.	
19	Medical Record Number	Optional - Enter the recipient's medical record number assigned by the provider.	

Locator #	Description	Instructions	Alerts
20	Payment source other then title XIX	Leave blank	
21A	Date of Service	Required - Enter the date the transportation service was rendered.	
21B	Origin Code	Required - Enter the correct origin code from those listed on the form to show where the trip began.	
21C	Destination Code	Required - Enter the correct destination code from those listed on the form to show where the trip ended.	
21D	Procedure Code	Required - Enter the five-digit procedure code prior authorized by the dispatch office. Only one trip may be billed per claim form.	
21E	Additional Mileage	Leave blank.	
21F	Total Charge	Required - Enter the monetary charge for the procedure code.	
21G	Third Party Payment	Leave blank.	
22	Signature of Provider Date Signed	Required - The provider or the provider's authorized representative must sign and date the claim form. Stamped or computer-generated signatures will be accepted only if they are initialed by the provider or the provider's representative.	
Remarks: The "remarks" section should be used to explain any unusual occurrences (i.e., the recipient or the medical provider refused to sign the MT-3 form).			

Example of a 106 Claim Form

MAIL TO:
MOLINA MEDICAID SOLUTIONS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 LAST NAME	2 FIRST NAME	3 MI	4 MEDICAL ASSISTANCE I.D. NUMBER
Valentine	John	C	1 2 3 4 5 6 7 8 9 0 1 2 3

5 PATIENT'S ADDRESS	6 DATE OF BIRTH	7 SEX	8 MEDICAL APPOINTMENT TIME
123 Hollow Lane, Turkey Day, LA 70000	02 14 63	[X] M [ ] F	HOUR MO. DAY YEAR

9 ORIGIN OF SERVICE	10 DESTINATION OF SERVICE
John C Valentine (NAME)	Hemo of Louisiana (NAME)
123 Hollow Lane (STREET)	859 Independence Street (STREET)
Turkey Day, LA 70000 (CITY)	Spooky, LA 79000 (CITY)

11	12 TRANSPORTATION AUTHORIZED IS	13 EPSDT REFERRAL
Z123456789	[ ] ONE WAY [X] TWO WAY	[ ] YES [ ] NO

14 PRIOR AUTHORIZATION

I HEREBY CERTIFY THAT TRANSPORTATION FOR THIS RECIPIENT WAS MADE FOR A TITLE XIX COVERED SERVICE AND THAT ALL OTHER REASONABLE MODES OF TRANSPORTATION HAVE BEEN EXPLORED AND FOUND UNAVAILABLE.

15 SIGNATURE OF DHHR WORKER	TITLE	PARISH	DATE

TO BE COMPLETED BY TRANSPORTATION PROVIDER

16 PROVIDER NAME AND ADDRESS	17 PROVIDER NUMBER	18 TREATING PRACTITIONER'S NAME AND NUMBER
EZ Transports 620 June Drive March Town, LA 78000	1234567	John Wise MD
	19 MEDICAL RECORD NUMBER	20 PAYMENT SOURCE OTHER THAN TITLE XIX [ ] YES [ ] NO TPL CARRIER CODES 1. 2. 3.

ORIGIN AND DESTINATION CODES

(1) INPATIENT HOSPITAL
(2) INTERMEDIATE CARE FACILITY
(3) OFFICE
(4) EMERGENCY ROOM
(5) CLINIC
(6) OUTPATIENT HOSPITAL
(7) HOME
(8) OTHER

21	A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
0	08 02 10	7	8	Z5177		30 00	
1							
2							
3							
	REMARKS:			TOTALS		$ 30 00	$

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

22 SIGNATURE OF PROVIDER	DATE SIGNED
IMA BILLER	09/01/2010

Molina 106
7/91

FISCAL AGENT COPY

Voids

The Molina Medicaid Solutions 206 Form is used to void incorrect payments of claims originally filed on the Molina Medicaid Solutions 106 Form.

These forms may be obtained from Molina Medicaid Solutions by call Provider Relations at (800) 473-2783 or (225) 924-5040

Non–Emergency, Non-Ambulance Medical Transportation claims cannot be adjusted, only voided.

If a claim was paid incorrectly, the payment must first be voided and then a correct 106 Form should be submitted to Molina for payment consideration.

Only a **paid** claim can be voided. Denied claims must be corrected and resubmitted—not voided.

Instructions and an example of a completed 206 Form are shown on the following pages.
The completed Molina Medicaid Solutions 206 Form should be mailed to:

Molina Medicaid Solutions
P. O. Box 91022
Baton Rouge, LA 70821

Form 206 Billing Instructions for Completing a Void

Locator #	Description	Instructions	Alerts
1	Adjustment/Void	Required - Check "Void" box.	
2	Last Name	Required -Enter recipient's last name.	
3	First Name	Required – Enter recipient's first name.	
4	MI	Required - Enter recipient's middle initial.	
5	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
6	Patient's Address	Optional – Print the recipient's permanent address.	
7	Date of Birth	Required - Enter the recipient's date of birth	
8	Sex	Required - Enter the recipient's sex.	
9	Medical Appointment Time	Optional - Enter the time, month, day, and year of the recipient's medical appointment.	
10	Origin of Service	Required - Enter the origin of service.	
11	Destination of Service	Required - Enter the destination of service.	
12	Transportation authorized is:	Required - Check the appropriate block to indicate whether the scheduled service was one-way or two-way transport.	
13	EPSDT Referral	Leave blank.	
14	Provider Name and Address	Required - Enter the name and address of the transportation provider providing the service.	
15	Provider Number	Required - Enter the provider's 7-digit Medicaid number.	
16	Treating Practitioner's Name	Required - Enter the name of the medical provider.	
17	Medical Record Number	Optional - Enter the recipient's medical record number assigned by the provider.	
18	Payment source other then title XIX	Leave blank	
19A	Date of Service	Required - Enter the date the transportation service was rendered. Enter the information exactly as it appeared on the original claim form.	

Locator #	Description	Instructions	Alerts
19B	Origin Code	Required - Enter the correct origin code from those listed on the form to show where the trip began. Enter the information exactly as it appeared on the original claim form.	
19C	Destination Code	Required - Enter the correct destination code from those listed on the form to show where the trip ended. Enter the information exactly as it appeared on the original claim form.	
19D	Procedure Code	Required - Enter the five-digit procedure code prior authorized by the dispatch office. Enter the information exactly as it appeared on the original claim form.	
19E	Additional Mileage	Leave blank.	
19F	Total Charge	Required - Enter the monetary charge for the procedure code. Enter the information exactly as it appeared on the original claim form.	
19G	Third Party Payment	Leave blank.	
20	Remarks	The "remarks" section should be used to explain any unusual occurrences (i.e., the recipient or the medical provider refused to sign the MT-3 form).	
21	Control Number	Required - Enter the control number exactly as it appeared on the RA.	
22	Date of Remittance Advice	Required - Enter the date of the Remittance Advice the claim paid.	
23	Reason for Adjustment	Leave blank.	
24	Reason for Void	Required - Check the appropriate box and write a brief narrative explaining the reason.	
25	Signature of Provider	Required - The provider or the provider's representative must sign and date the claim form. Stamped or computer-generated signatures will be accepted only if they are initialed by the provider or the provider's representative.	
26	Date Signed	Enter the date signed.	

Example of a 206 Void Form

MAIL TO:
MOLINA MEDICAID SOLUTIONS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
NON-AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 ADJ [ ] VOID [X]

2 LAST NAME	3 FIRST NAME	4 MI	5 MEDICAL ASSISTANCE I.D. NUMBER
Valentine	John	C	1 2 3 4 5 6 7 8 9 0 1 2 3

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE)	7 DATE OF BIRTH	8 SEX	9 MEDICAL APPOINTMENT TIME
123 Hollow Lane, Turkey Day, LA 70000	02 14 63	[X] M [ ] F	HOUR MO. DAY YR.

10 ORIGIN OF SERVICE	11 DESTINATION OF SERVICE
John C. Valentine 123 Hollow Lane Turkey Day, LA 70000	Hemo of Louisiana 859 Independence Street Spooky, LA 79000

12 TRANSPORTATION AUTHORIZED IS [ ] ONE WAY [X] TWO WAY
13 EPSDT REFERRAL [ ] YES [ ] NO

TO BE COMPLETED BY TRANSPORTATION PROVIDER

14 PROVIDER NAME AND ADDRESS	15 PROVIDER NUMBER	16 TREATING PRACTITIONER'S NAME AND NUMBER
EZ Transports (NAME) 620 June Drive (STREET) March Town, LA 78000 (CITY STATE ZIP)	1234567	John Wise MD
	17 MEDICAL RECORD NUMBER	18 PAYMENT SOURCE OTHER THAN TITLE XIX [ ] YES [ ] NO A. CARRIER B. POLICY NUMBER

ORIGIN OF DESTINATION
(01) INPATIENT HOSPITAL (03) OFFICE (05) CLINIC (07) HOME
(02) INTERMEDIATE CARE FACILITY (04) EMERGENCY ROOM (06) OUTPATIENT HOSPITAL (08) OTHER

19

A. DATE OF SERVICE	B. ORIGIN CODE	C. DESTINATION CODE	D. PROCEDURE CODES	E. ADDITIONAL MILEAGE	F. TOTAL CHARGE	G. THIRD PARTY PAYMENT
08/02/2010	7	8	Z5177		30 00	
			TOTALS		$ 30 00	$

20 REMARKS:

21 CONTROL NUMBER 0258098765400
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
22 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID. 09/21/10

23 REASONS FOR ADJUSTMENT
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[ ] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

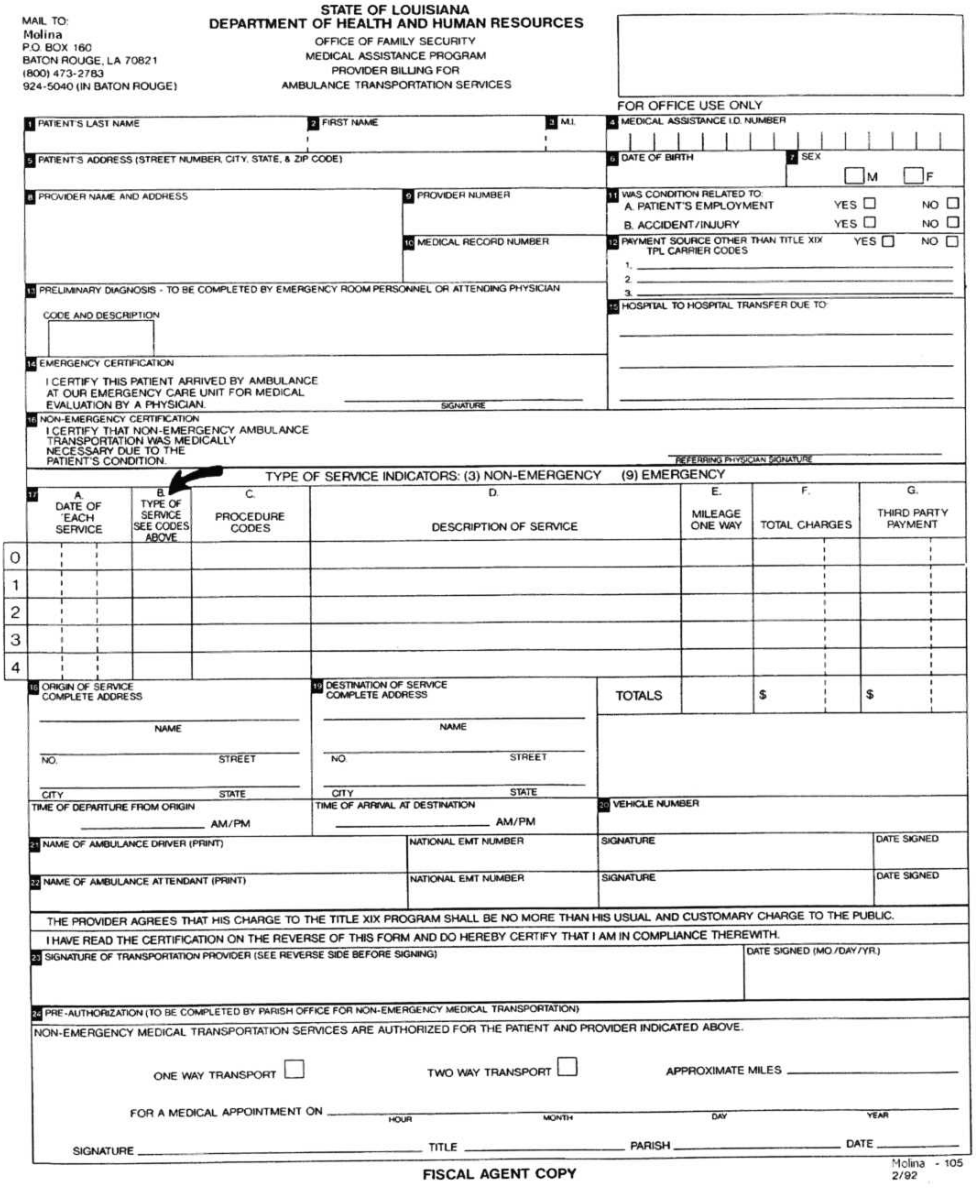
24 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECEIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[X] 99 OTHER - PLEASE EXPLAIN
Trip was canceled

THE PROVIDER AGREES TO BILL TITLE XIX NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

25 SIGNATURE OF PROVIDER Ima Biller
26 DATE SIGNED 11/3/10

Molina 206
1/93
FISCAL AGENT COPY

Example of Form 105



MAIL TO:
Molina
P.O. BOX 160
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
AMBULANCE TRANSPORTATION SERVICES

FOR OFFICE USE ONLY

1 PATIENT'S LAST NAME | 2 FIRST NAME | 3 M.I. | 4 MEDICAL ASSISTANCE I.D. NUMBER

5 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, & ZIP CODE) | 6 DATE OF BIRTH | 7 SEX ☐M ☐F

8 PROVIDER NAME AND ADDRESS | 9 PROVIDER NUMBER | 10 MEDICAL RECORD NUMBER

11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES ☐ NO ☐
B. ACCIDENT/INJURY YES ☐ NO ☐

12 PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODES YES ☐ NO ☐
1.
2.
3.

13 PRELIMINARY DIAGNOSIS - TO BE COMPLETED BY EMERGENCY ROOM PERSONNEL OR ATTENDING PHYSICIAN
CODE AND DESCRIPTION

15 HOSPITAL TO HOSPITAL TRANSFER DUE TO:

14 EMERGENCY CERTIFICATION
I CERTIFY THIS PATIENT ARRIVED BY AMBULANCE AT OUR EMERGENCY CARE UNIT FOR MEDICAL EVALUATION BY A PHYSICIAN.
SIGNATURE

16 NON-EMERGENCY CERTIFICATION
I CERTIFY THAT NON-EMERGENCY AMBULANCE TRANSPORTATION WAS MEDICALLY NECESSARY DUE TO THE PATIENT'S CONDITION.
REFERRING PHYSICIAN SIGNATURE

TYPE OF SERVICE INDICATORS: (3) NON-EMERGENCY (9) EMERGENCY

17	A. DATE OF EACH SERVICE	B. TYPE OF SERVICE SEE CODES ABOVE	C. PROCEDURE CODES	D. DESCRIPTION OF SERVICE	E. MILEAGE ONE WAY	F. TOTAL CHARGES	G. THIRD PARTY PAYMENT
0							
1							
2							
3							
4							
				TOTALS		$	$

18 ORIGIN OF SERVICE COMPLETE ADDRESS
NAME
NO. STREET
CITY STATE

19 DESTINATION OF SERVICE COMPLETE ADDRESS
NAME
NO. STREET
CITY STATE

TIME OF DEPARTURE FROM ORIGIN ____ AM/PM
TIME OF ARRIVAL AT DESTINATION ____ AM/PM

20 VEHICLE NUMBER

21 NAME OF AMBULANCE DRIVER (PRINT) | NATIONAL EMT NUMBER | SIGNATURE | DATE SIGNED

22 NAME OF AMBULANCE ATTENDANT (PRINT) | NATIONAL EMT NUMBER | SIGNATURE | DATE SIGNED

THE PROVIDER AGREES THAT HIS CHARGE TO THE TITLE XIX PROGRAM SHALL BE NO MORE THAN HIS USUAL AND CUSTOMARY CHARGE TO THE PUBLIC.
I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

23 SIGNATURE OF TRANSPORTATION PROVIDER (SEE REVERSE SIDE BEFORE SIGNING) | DATE SIGNED (MO./DAY/YR.)

24 PRE-AUTHORIZATION (TO BE COMPLETED BY PARISH OFFICE FOR NON-EMERGENCY MEDICAL TRANSPORTATION)
NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES ARE AUTHORIZED FOR THE PATIENT AND PROVIDER INDICATED ABOVE.

ONE WAY TRANSPORT ☐ TWO WAY TRANSPORT ☐ APPROXIMATE MILES ____

FOR A MEDICAL APPOINTMENT ON ____ HOUR ____ MONTH ____ DAY ____ YEAR

SIGNATURE ____ TITLE ____ PARISH ____ DATE ____

FISCAL AGENT COPY

Molina - 105
2/92

INSTRUCTIONS FOR COMPLETION OF FORM 105

1. Enter recipient's last name.
2. Enter recipient's first name.
3. Enter recipient's middle initial.
4. Enter the 13-digit Medicaid Identification number of the recipient. This information can be accessed by utilizing the REVS or MEVS system and entering the 16-digit CCN (Card Control Number) along with the social security number or a birthdate.
5. Enter the recipient's address. If residence is a nursing home, the name of the nursing home should be given.
6. Enter the recipient's date of birth.
7. Enter the recipient's sex.
8. Enter the provider's name and complete address.
9. Enter the provider's 7-digit Medicaid number.
10. (**Optional) Enter the recipient's medical record number.
11. Indicate whether the transport was due to recipient's employment or an auto accident in which the recipient was involved in.
12. Enter the TPL carrier code of any other insurance coverage which the recipient may carry. If the recipient does have other coverage for this type of service, it will be necessary to bill the other insurance and include the EOB when submitting to Medicaid.
13. Enter the preliminary or admitting diagnosis (ICD-9 Code) of the recipient obtained from the emergency room staff members in emergency cases, and from the referring physician in non-emergency cases.
14. N/A
15. N/A
16. N/A

17A. Enter the date of service in which this transport was performed (to be entered in a month/day/year format, i.e. 09/27/99)

17B. Enter the type of service code:
9 - Emergency
3 - Non-emergency

17C. Enter the 5-digit procedure code. Enter the 5-digit procedure code followed by a valid 2-digit modifier. **Effective with date of service October 1, 2003, spaces are not recognized as a valid modifier for those procedures requiring a modifier.**

17D. Enter the description of service that corresponds to the service rendered.

17E. Enter the mileage for one-way, not indicating tenths of miles.

17F. Enter the total charges for the services rendered.

17G. If block 12 was completed, it will be necessary to enter any payment amount received.

18. Enter the origin of service only if it was a nursing home or a hospital. If the pick-up point was a place of residence, do not complete this block.
Enter the time of departure from the point of pick up.

19. Enter the name and show the complete address of the hospital or other provider
of service the recipient is being transported to.
Enter the time of arrival at this destination.

20. Enter the assigned number of the ambulance vehicle which transported this recipient.

21. Enter the complete name of the ambulance driver.
Enter the Emergency Medical Transportation Number assigned to the ambulance driver.
Signature of the ambulance driver must be in this block.
Enter the date the ambulance driver signed the claim.

22. Enter the complete name of the ambulance attendant.
Enter the Emergency Medical Transportation Number assigned to the ambulance attendant.
Signature of the ambulance attendant must be in this block.
Enter the date the ambulance attendant signed the claim.

23. Signature of a representative of the ambulance provider must sign and date this line.

24. This section is to be completed by the Parish Office if the transport was due to a non-emergency medical situation.

Ambulance Transportation Billing Overview

Hard copy billing of ambulance and air ambulance services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required, situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required (but only in certain circumstances as detailed in the instructions that follow).

Paper claims should be submitted to:

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

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms.
- Instructions for adjusting/voiding a claim and a samples of adjusted CMS 1500 claim forms.

CMS 1500 (02/12) Billing Instructions for Ambulance and Air Ambulance Services

You must write "AMB" at the top center of the claim form!

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "AMB" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Required – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	Leave Blank.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Leave blank	
17a	Unlabelled	Leave blank	
17b	NPI	Leave blank	
18	Hospitalization Dates Related to Current Services	Leave blank	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave blank	
20	Outside Lab?	Leave blank	

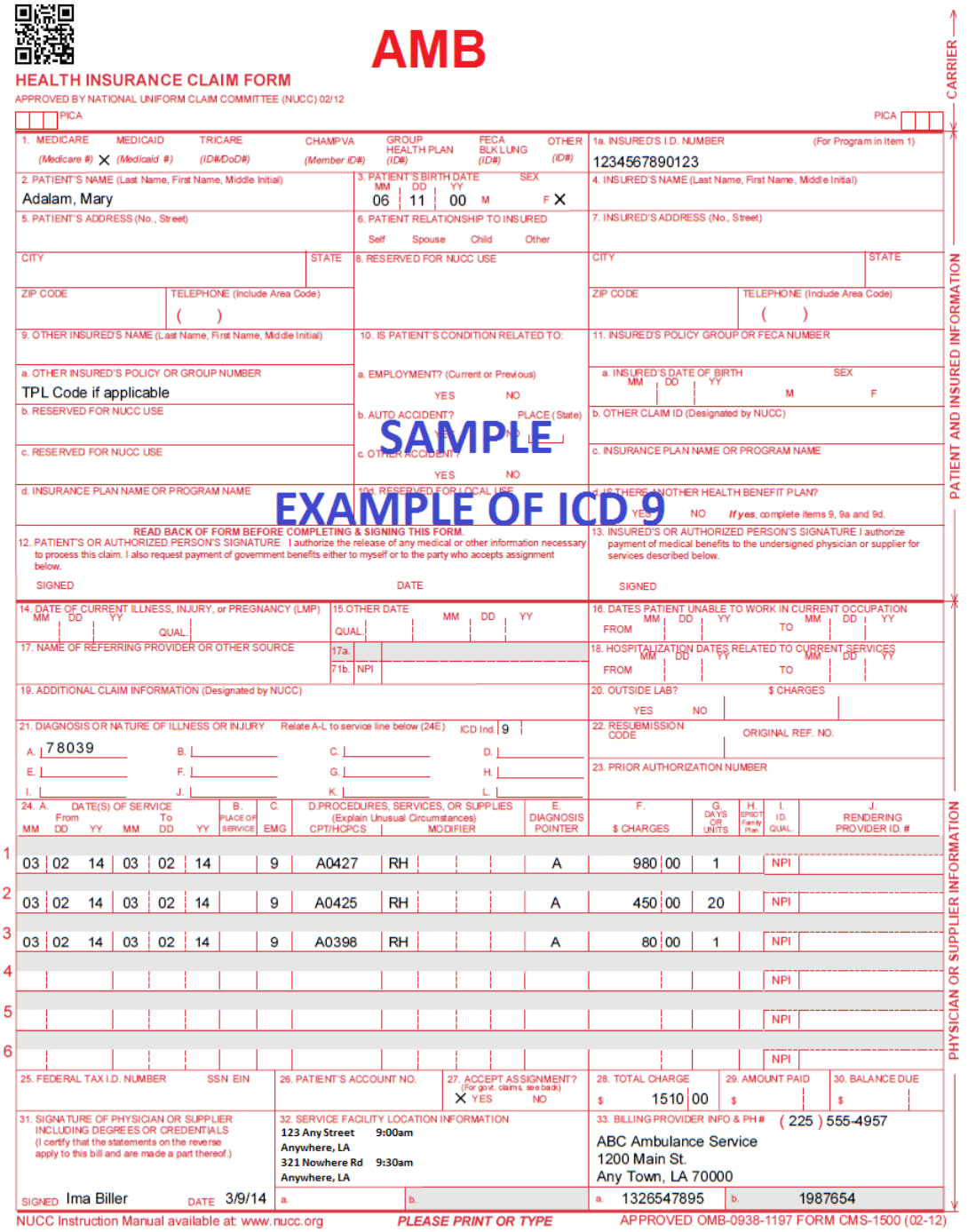
Locator #	Description	Instructions	Alerts
21	ICD Ind. Diagnosis or Nature of Illness or Injury	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM Required – Enter the most current ICD diagnosis code. NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid	The most specific diagnosis codes must be used. General codes are not acceptable. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10-diagnosis codes must be used on claims for dates of service 10/1/15 forward. Refer to the provider notice concerning the federally required implementation of the ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com .

Locator #	Description	Instructions	Alerts
22	Medicaid Resubmission Code	Situational – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only - Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization Number	Situational – Complete if appropriate or leave blank. If the services being billed are Air Ambulance and must be Prior Authorized, the PA number is **required** to be entered.	Air Ambulance Services must be Prior Authorized and the 9-digit PA number must be entered in this field.
24	Supplemental Information	Leave Blank	
24A	Date(s) of Service	Required -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Leave blank	
24C	EMG	Required – Enter type of service: 9 or Y – Emergency 3 or N – Non-emergency	Providers may enter a 9 or Y for emergency services and a 3 or N for non-emergency services. Failure to enter an indicator will default to non-emergency.

Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter the appropriate modifier if applicable.	
24E	Diagnosis Pointer	Optional.	
24F	$Charges	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D or the one-way mileage as applicable.	Ensure that the appropriate units are entered for the service (i.e., 1 unit for transport and the number of miles for mileage).
24H	EPSDT Family Plan	Leave blank	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank	
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. Do not report Medicare payments in this field.	
30	Rsvd for NUCC use	Leave Blank.	

Locator #	Description	Instructions	Alerts
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of form completion.	
32	Service Facility Location Information	Required – Enter: • The complete address of origin of services. • The time of departure from origin. • The complete address of destination. • The time of arrival at destination.	Enter the complete address of the origin of services, the time of departure from origin (including a.m. or p.m.), the complete address of destination, and the time of arrival at destination (including a.m. or p.m.)
32a	NPI	Leave blank	
32b	Unlabelled	Leave blank	
33	Billing Provider Info & Ph #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required – Enter the billing provider's 10-digit NPI number.	
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier – Optional – If possible, do not enter a qualifier for Louisiana Medicaid claims.	The 7-digit Medicaid Provider Number must appear on paper claims.

Example of an Ambulance Claim Form with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)



AMB

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Adalam, Mary

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 00 | SEX M | F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

SAMPLE

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

EXAMPLE OF ICD 9

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9
A. 78039 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 02 14	03 02 14		9	A0427	RH	A	980 00	1		NPI	
2 03 02 14	03 02 14		9	A0425	RH	A	450 00	20		NPI	
3 03 02 14	03 02 14		9	A0398	RH	A	80 00	1		NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1510 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Ima Biller DATE 3/9/14

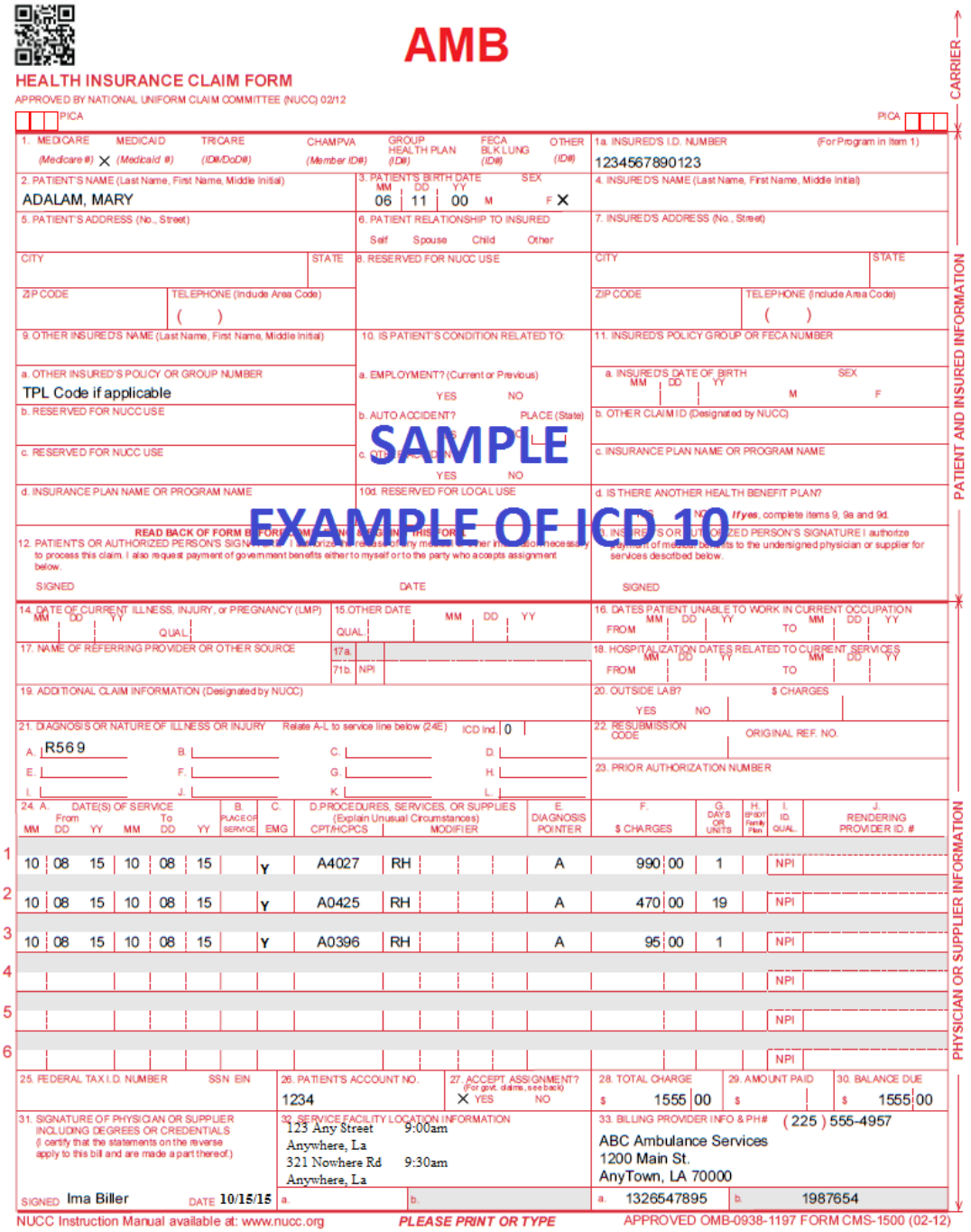
32. SERVICE FACILITY LOCATION INFORMATION
123 Any Street 9:00am
Anywhere, LA
321 Nowhere Rd 9:30am
Anywhere, LA
a. b.

33. BILLING PROVIDER INFO & PH# (225) 555-4957
ABC Ambulance Service
1200 Main St.
Any Town, LA 70000
a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Example of an Ambulance Claim Form with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)



AMB

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ADALAM, MARY

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 00 SEX M F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO If yes, complete items 9, 9a and 9d.

SAMPLE

EXAMPLE OF ICD 10

READ BACK OF FORM BEFORE SIGNING. IMPORTANT INFORMATION HERE FOR ...

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize ... 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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. R569 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 08 15	10 08 15		Y	A4027	RH		A	990 00	1		NPI	
2	10 08 15	10 08 15		Y	A0425	RH		A	470 00	19		NPI	
3	10 08 15	10 08 15		Y	A0396	RH		A	95 00	1		NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE: $ 1555 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 1555 00

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

SIGNED Ima Biller DATE 10/15/15

32. SERVICE FACILITY LOCATION INFORMATION
123 Any Street 9:00am
Anywhere, La
321 Nowhere Rd 9:30am
Anywhere, La

a. b.

33. BILLING PROVIDER INFO & PH# (225) 555-4957
ABC Ambulance Services
1200 Main St.
AnyTown, LA 70000

a. 1326547895 b. 1987654

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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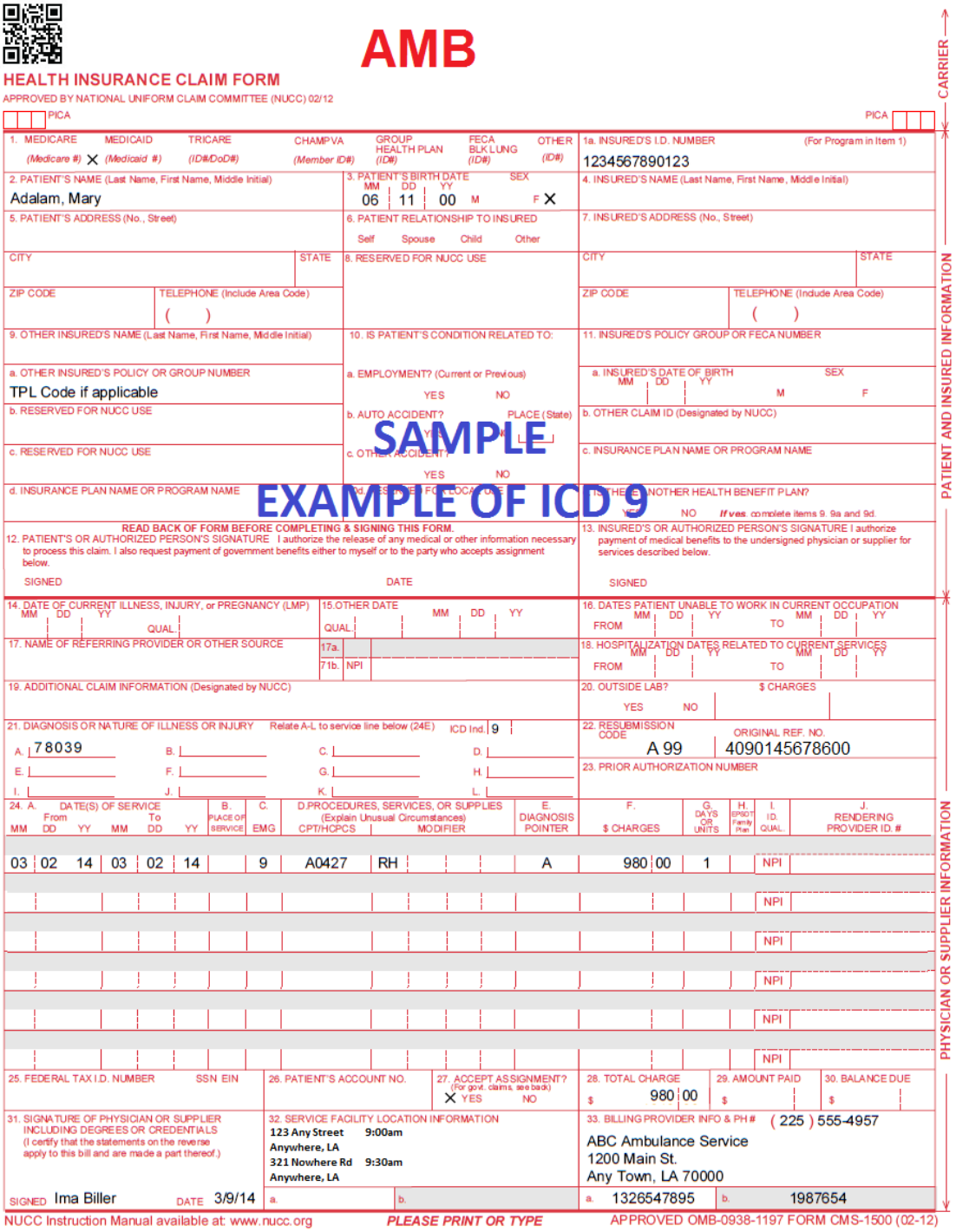
Example of an Ambulance Claim Form Adjustment with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)



AMB

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Adalam, Mary

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 00 SEX M F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

SAMPLE

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

EXAMPLE OF ICD 9

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 78039 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 99 ORIGINAL REF. NO.: 4090145678600

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03 02 14	03 02 14		9	A0427	RH	A	980 00	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 980 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED Ima Biller DATE 3/9/14

32. SERVICE FACILITY LOCATION INFORMATION
123 Any Street 9:00am
Anywhere, LA
321 Nowhere Rd 9:30am
Anywhere, LA

a. b.

33. BILLING PROVIDER INFO & PH # (225) 555-4957
ABC Ambulance Service
1200 Main St.
Any Town, LA 70000

a. 1326547895 b. 1987654

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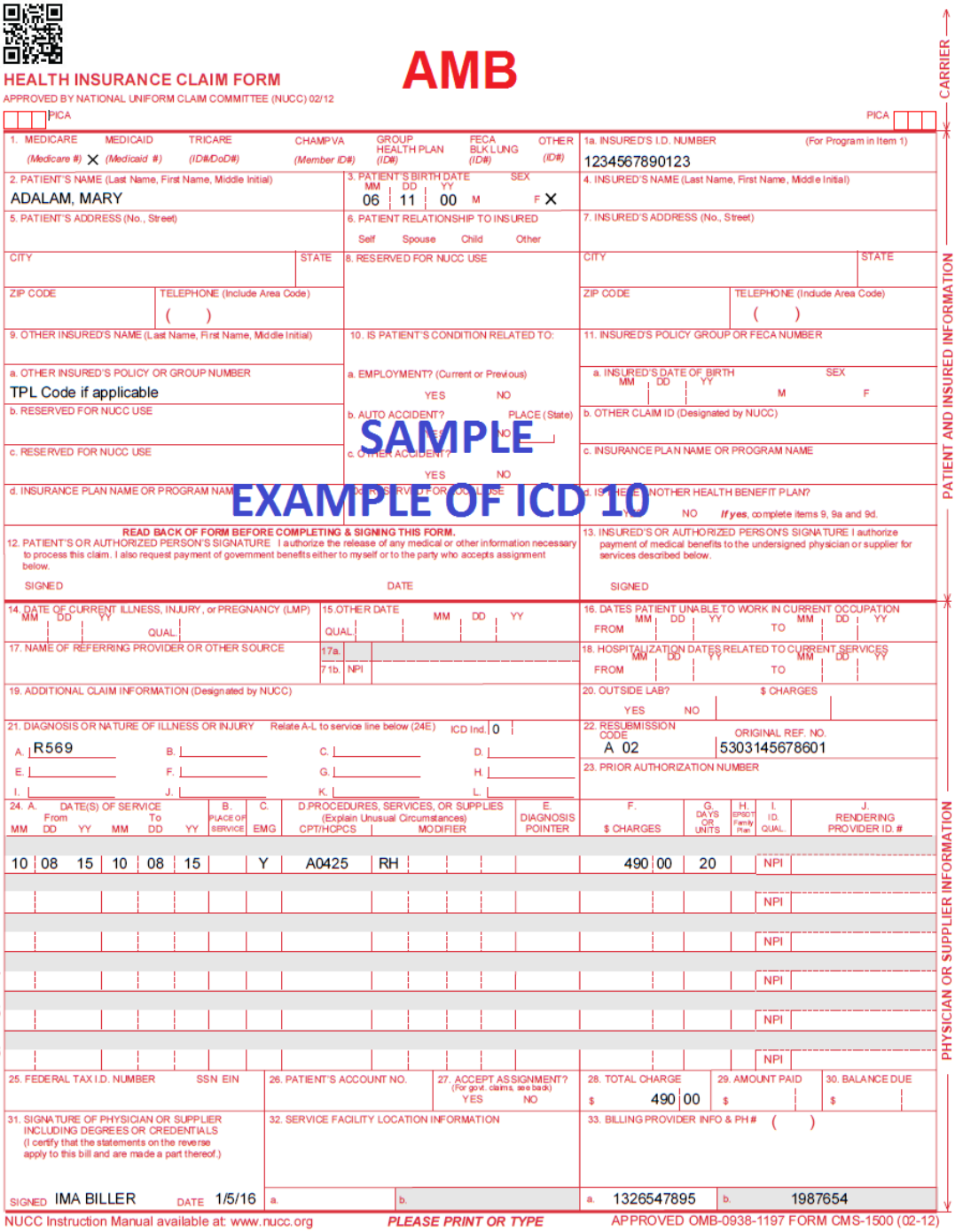
PATIENT AND INSURED INFORMATION

Example of an Ambulance Claim Form Adjustment with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)



HEALTH INSURANCE CLAIM FORM

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

AMB

SAMPLE

EXAMPLE OF ICD 10

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ADALAM, MARY

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 00 SEX M F X

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. R569 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 5303145678601

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 08 15	10 08 15		Y	A0425	RH		490 00	20		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 490 00

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED IMA BILLER DATE 1/5/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. 1326547895 b. 1987654

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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A. B. C. D.
E. F. G. H.
I. J. K. L.

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23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

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a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE