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:

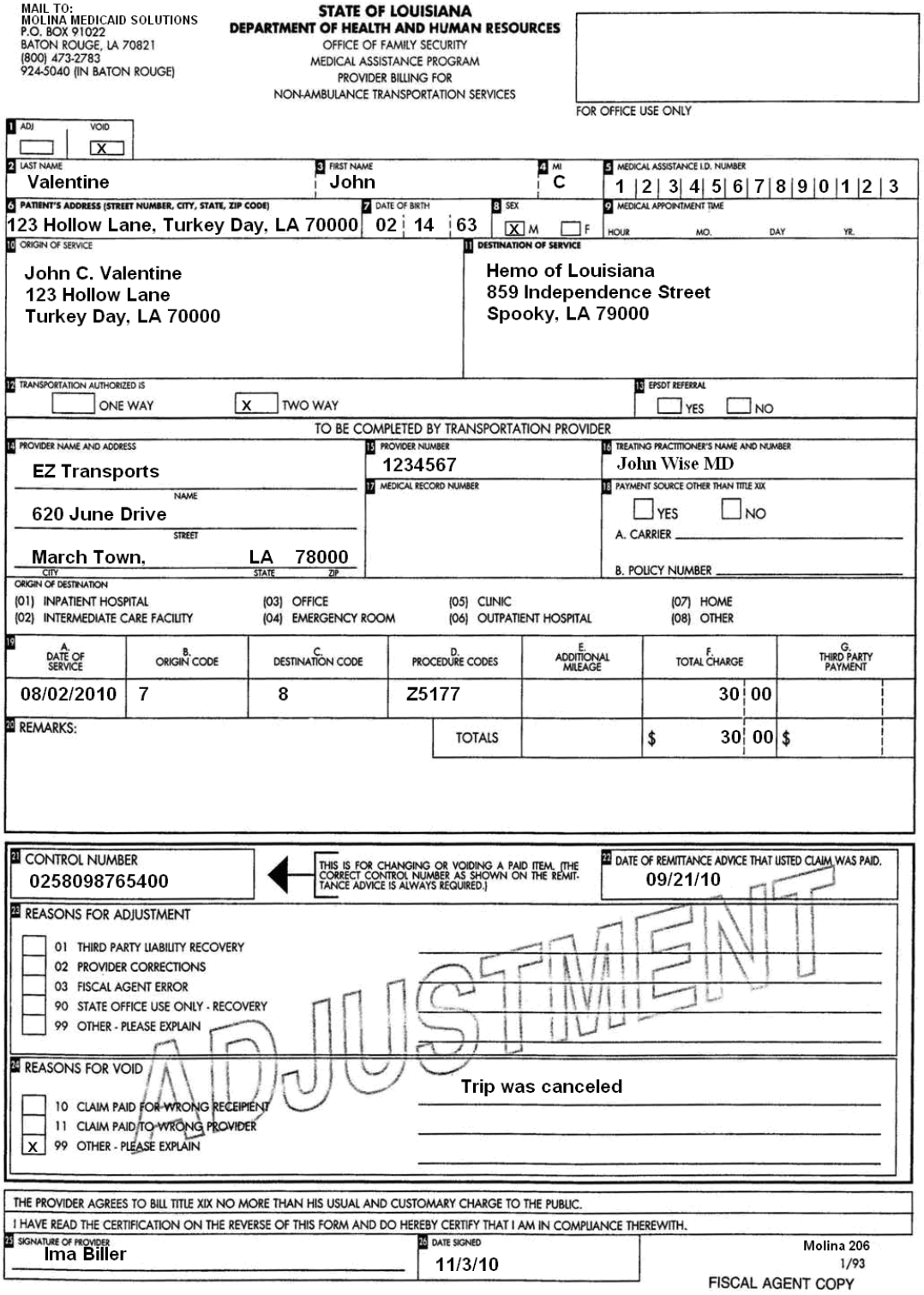
Molina Medicaid Solutions
P. O. Box 91022
Baton Rouge, LA 70821

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

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

10 ORIGIN OF SERVICE:
John C. Valentine
123 Hollow Lane
Turkey Day, LA 70000

11 DESTINATION OF SERVICE:
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:
EZ Transports (NAME)
620 June Drive (STREET)
March Town, LA 78000 (CITY STATE ZIP)

15 PROVIDER NUMBER: 1234567

16 TREATING PRACTITIONER'S NAME AND NUMBER: 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 (02) INTERMEDIATE CARE FACILITY (03) OFFICE (04) EMERGENCY ROOM (05) CLINIC (06) OUTPATIENT HOSPITAL (07) HOME (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

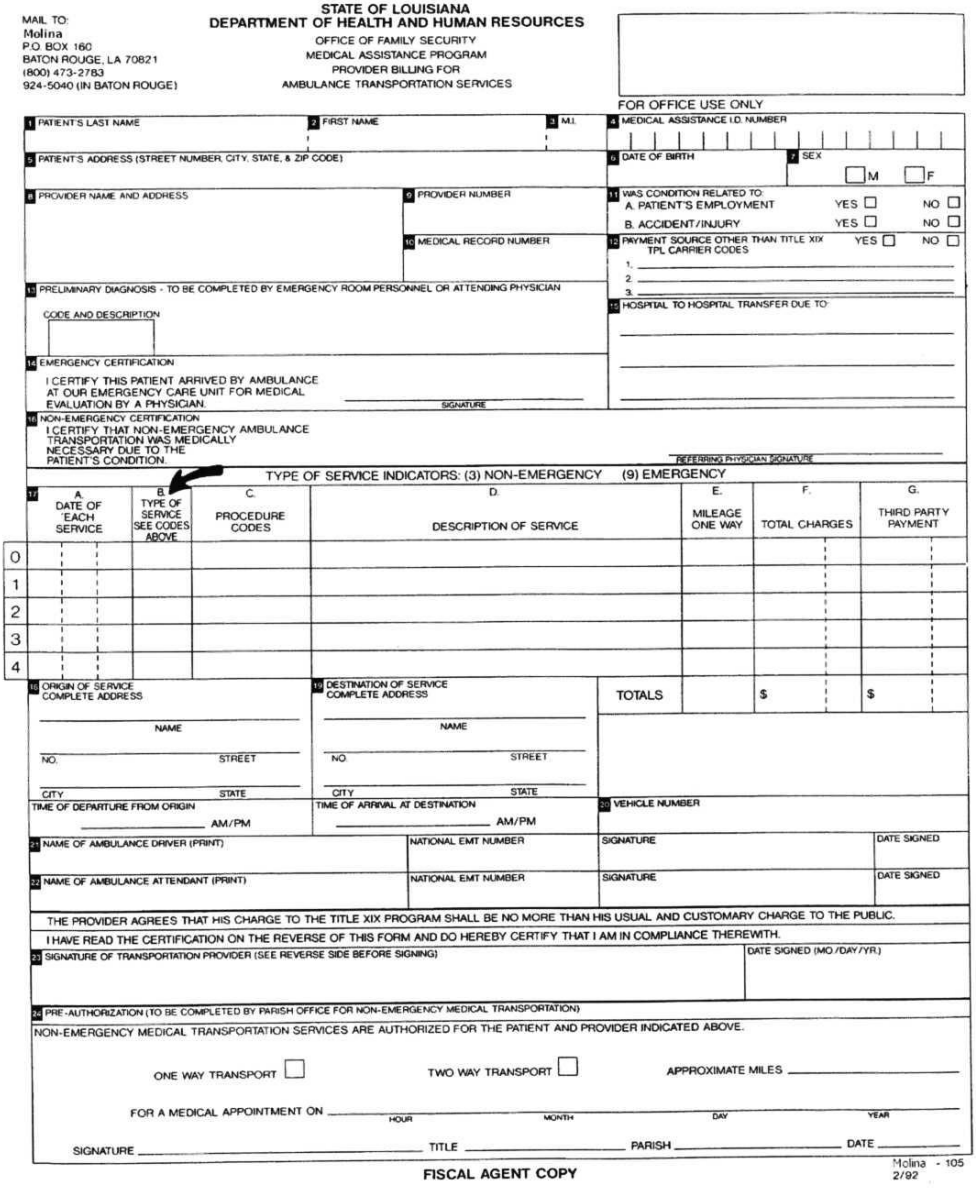
24 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECEIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[X] 99 OTHER - PLEASE EXPLAIN
Trip was canceled

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

Ambulance Transportation services are billed on the CMS-1500 (08/05) claim form

Items to be completed are either **required** or **situational**.

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

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

Claims should be submitted to:

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

CMS 1500 (08/05) Billing Instructions for Ambulance and Air Ambulance Services

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

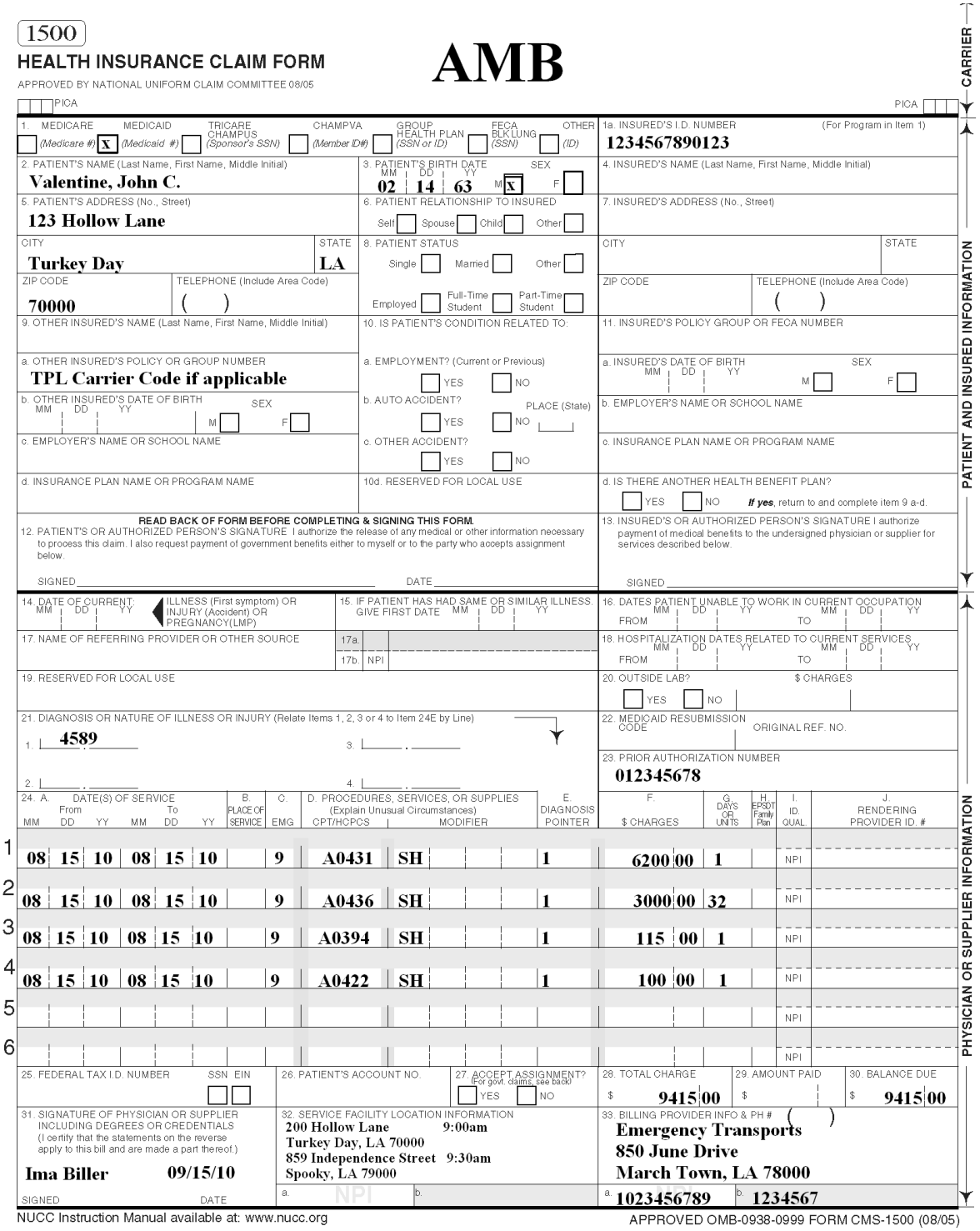
Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Required** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Patient Status	**Optional.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or 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	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	If Patient Has Had Same or Similar Illness Give First Date	**Optional.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	Leave blank	
17a	Unlabelled	Leave blank	
17b	NPI	Leave blank	
18	Hospitalization Dates Related to Current Services	Leave blank	
19	Reserved for Local Use	Leave blank	
20	Outside Lab?	Leave blank	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	The most specific diagnosis codes must be used.

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	
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.	
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	
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	Leave blank	
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.	
24H	EPSDT Family Plan	Leave blank	
24I	I.D. Qual.	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	

Locator #	Description	Instructions	Alerts
24J	Rendering Provider I.D. #	Leave Blank	
25	Federal Tax I.D. Number	**Optional.**	
26	Patient's Account No.	**Optional** – 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.	
30	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**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.	
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	**Optional** – Enter the billing provider's 10-digit NPI number.	
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit Medicaid ID number.	

Example of an Ambulance Claim Form



1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AMB

PICA — PICA — CARRIER

1. MEDICARE (Medicare #) [x] MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Valentine, John C.
3. PATIENT'S BIRTH DATE MM DD YY: 02 14 63 SEX M [x] F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Hollow Lane
6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)

CITY: Turkey Day — STATE: LA
8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY — STATE

ZIP CODE: 70000 — TELEPHONE (Include Area Code): ( )
ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Carrier Code if applicable
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 4589
2.
3.
4.
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 012345678

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	08	15	10	08	15	10		9	A0431	SH	1	6200 00	1		NPI	
2	08	15	10	08	15	10		9	A0436	SH	1	3000 00	32		NPI	
3	08	15	10	08	15	10		9	A0394	SH	1	115 00	1		NPI	
4	08	15	10	08	15	10		9	A0422	SH	1	100 00	1		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) YES NO
28. TOTAL CHARGE $ 9415 00
29. AMOUNT PAID $
30. BALANCE DUE $ 9415 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Ima Biller 09/15/10
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
200 Hollow Lane 9:00am
Turkey Day, LA 70000
859 Independence Street 9:30am
Spooky, LA 79000
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Emergency Transports
850 June Drive
March Town, LA 78000
a. 1023456789 b. 1234567

NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Example of an Ambulance Adjustment Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AMB

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Valentine, John C.**

3. PATIENT'S BIRTH DATE MM DD YY: **02 14 63** SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): **123 Hollow Lane**

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

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

CITY: **Turkey Day** STATE: **LA**

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: **70000** TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

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

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

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

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

1. **4589** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE: **A 02** ORIGINAL REF. NO.: **0272598765400**

23. PRIOR AUTHORIZATION NUMBER: **012345678**

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 **08 15 10**	**08 15 10**		**9**	**A0436**	**SH**	**1**	**6200 00**	**35**		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 $ **3200 00**

29. AMOUNT PAID $

30. BALANCE DUE $ **3200 00**

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

Ima Biller **11/03/10**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
200 Hollow Lane 9:00am
Turkey Day, LA 70000
859 Independence Street 9:30am
Spooky, LA 79000

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Emergency Transports
850 June Drive
March Town, LA 78000

a. **1023456789** b. **1234567**

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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