<u>CHAPTER 10: MEDICAL TRANSPORTATION</u> <u>APPENDIX I – CLAIMS FILING</u>

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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

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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 <u>must</u> 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.	

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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.	

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Example of a 106 Claim Form

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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

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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 <u>must</u> 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.	

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Example of Form 105

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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

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- 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 pickup 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.
- 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.
- 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.
- 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.

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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 <u>www.lamedicaid.com</u>, 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 a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

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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 <u>must</u> 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	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	
	Sex	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.	
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 in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
9с	RESERVED FOR NUCC	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.	
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	

CHAPTER 10: MEDICAL TRANSPORTATION APPENDIX I – CLAIMS FILING

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. Louisiana Medicaid currently accepts ICD-9- CM codes. The acceptance of ICD-10-CM codes will be announced at a later date.
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: <u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only - Recovery 99 = Other <u>Voids</u> 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	

ISSUED: 04/30/2014 REPLACED: 11/01/2010

CHAPTER 10: MEDICAL TRANSPORTATION APPENDIX I – CLAIMS FILING

Locator #	Description	Instructions	Alerts
		Required Enter the date of service for each procedure.	
24A	Date(s) of Service	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.
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	
241	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.	

ISSUED: 04/30/2014 REPLACED: 11/01/2010

CHAPTER 10: MEDICAL TRANSPORTATION APPENDIX I – CLAIMS FILING

Locator #	Description	Instructions	Alerts
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.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	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. 	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	Optional	
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 <u>must</u> appear on paper claims.

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Example of an Ambulance Claim Form

EALTH INSURAN			JCC) 02/12										
PICA													PICA
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Example of an Ambulance Adjustment Form

IEALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NU	UCC) 02/12						
PICA							PICA
1. MEDICARE MEDICAID TRICARE (Medicare #) X (Medicaid #) (ID#/DoD#)	CHAMPVA ((Member ID#) (GROUP HEALTH PLAN (I <i>D</i> #)	FECA OTH BLK LUNG (ID#) (ID#			(F	or Program in Item 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PAT	IENT'S BIRTH DATE	1.2.1.	4. INSURED'S NAME	-	First Name, Middl	le Initial)
Adalam, Mary	06		M F X				
PATIENT'S ADDRESS (No., Street)		IENT RELATIONSH		7. INSURED'S ADDRE	ESS (No., Stre	eet)	
пү	STATE 8, RESE	Spouse C ERVED FOR NUCC	hild Other	СПТҮ			STATE
	STATE 6. RESE	ERVED FOR NOOC	USE				CTATE
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()						()	
. OTHER INSURED'S NAME (Last Name, First Name, Middle)	Initial) 10. IS	PATIENT'S CONDIT	TON RELATED TO:	11. INSURED'S POLIC	CY GROUP O	R FECA NUMBE	R
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMP	LOYMENT? (Currer	t or Previous)	a. INSURED'S DATI	EOFBIRTH		SEX
PL Code if applicable		YES	NO	MM DD		м	F
RESERVED FOR NUCC USE	b. AUT	O ACCIDENT?	PLACE (Sta	b. OTHER CLAIM ID (I	Designated by	y NUCC)	
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INSURANCE PLAN NAME OR PROGRAM NAME	10d. RE	ESERVED FOR LOC		d. IS THERE ANOTHE	R HEALTH B	BENEFIT PLAN?	
				YES	NO If ye	as, complete item:	s 9, 9a and 9d.
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SIGNED	SAN	IPLE	FOR	MF®R			
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD QUAL.	(LMP) 15.OTHER D	MM .	DD 10/	16. DATES PATIENT U	JNABLE TO 1	WORK IN CURRE	ENT OCCUPATION
7 NAME OF REFERRING PROVIDER OR OTHER SOURCE		MPL	ÊÔN		YY PLEASE REL		
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