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, (CITY) LA (STATE) 78000 (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

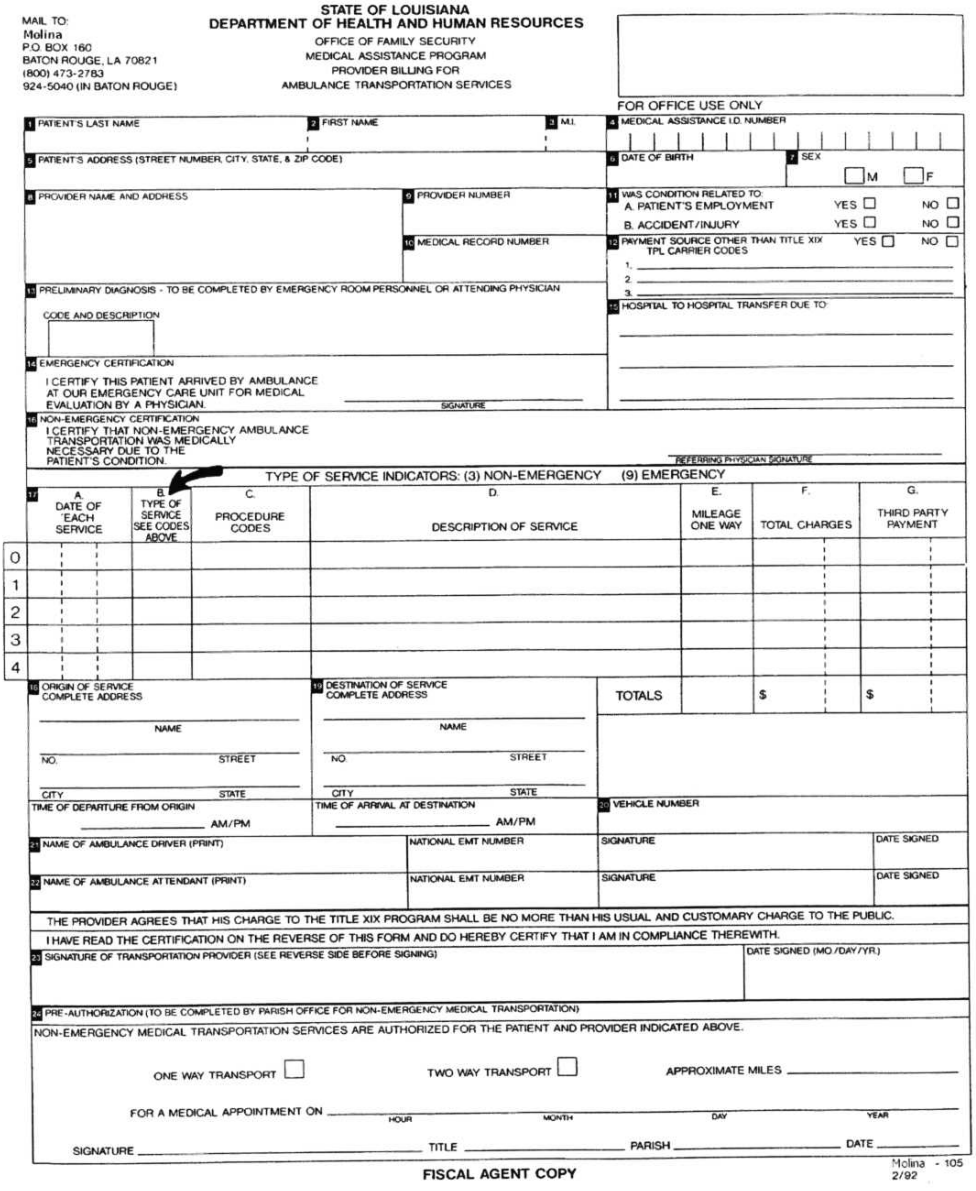
24 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECEIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[X] 99 OTHER - PLEASE EXPLAIN
Trip was canceled

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 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.

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.	
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.	

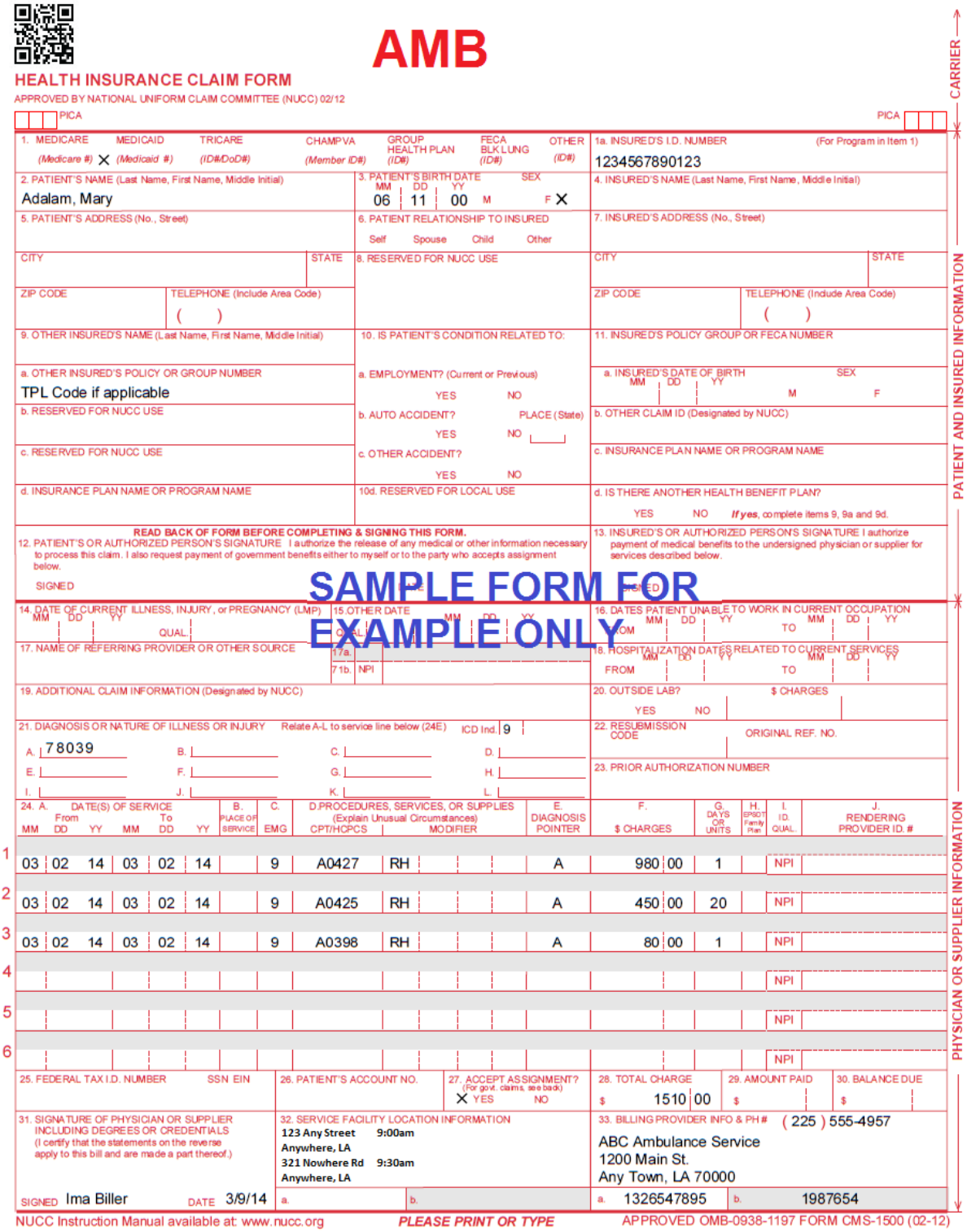
Locator #	Description	Instructions	Alerts
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA 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.	
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. 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: 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	

Locator #	Description	Instructions	Alerts
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.
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.	

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 Date	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required. 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 must appear on paper claims.

Example of an Ambulance Claim Form



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) 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

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

SAMPLE FORM FOR EXAMPLE ONLY

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 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

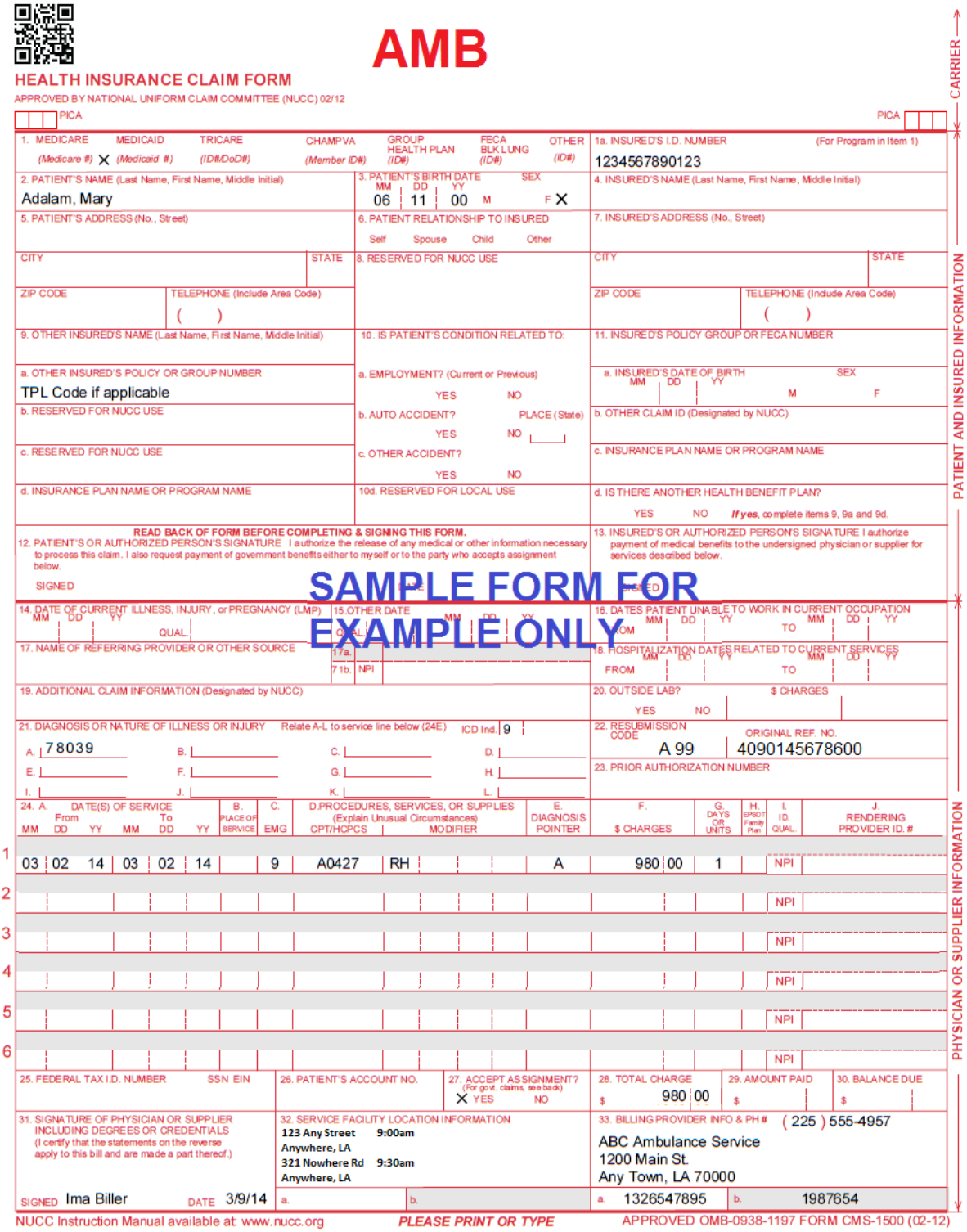
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example of an Ambulance Adjustment Form



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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? YES NO *If yes*, complete items 9, 9a and 9d.

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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	

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
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