ISSUED:

REPLACED:

03/28/19 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

PAGE(S) 14

CLAIMS RELATED INFORMATION

Hard copy billing of waiver 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:

DXC Technology (Formerly 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 website at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

Providers are responsible for complying with the requirements in Chapter 1, "General Information and Administration Provider Manual" of the Medicaid Services Manual. This manual is available on the Louisiana Medicaid website under the "Provider Manuals" tab.

www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

LOUISIANA MEDICAID PROGRAM	ISSUED:	03/28/19		
	REPLACED:	09/28/15		
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CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION PAGE(S) 14

This appendix includes the following:

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

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION PAGE(S) 14

CMS 1500 (02/12) INSTRUCTIONS FOR HOME AND COMMUNITY – BASED WAIVER SERVICES

http://www.lamedicaid.com/provweb1/billing_information/CMS_1500_Waiver.pdf

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 "W AI VER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13-digit Medicaid I.D. 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	Situational – Enter the recipient's date of birth using six 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 – Printthe 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	

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

Locator #	Description	Instructions	Alerts
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 beentered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational - Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

Locator #	Description	Instructions	Alerts
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	Situational – Complete if applicable.	
17a	Unlabeled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

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

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

Locator #	Description	Instructions	Alerts
22	Resubmission Code	Situational. Iffiling 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	Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). 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 (PA) Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational	
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	Required Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.	
		More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	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	
24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
241	I.D. Qual.	Optional . If possible, leave blank for Louisiana Medicaid billing.	
24 J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the nonshaded portion of the block is when the 7-digit provider number is entered in the shaded portion.	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

ISSUED: 03/28/19

REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION PAGE(S) 14

Locator #	Description	Instructions	Alerts
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	Reserved 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	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required – Enter the billing provider's 10-digit NPI number.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

REMINDER: MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

Sample forms are on the following pages

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

PAGE(S) 14

SAMPLE WAIVER CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

ALTH INSURANCE CLAIM FORM	WAIVER	3
ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	02/12	PICA TT
the state of the s	HAMPVA GROUP FECA HEALTH PLAN BLK LUNG	OTHER 1a. INSURED'S I.D. NUMBER (For Program in item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (M	lember ID#) (ID#) (ID#)	(E) 9876543210123
ATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SE	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
YCO, TRAVIS	07 31 72 M X	F
ATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSUR Self Spouse Child Of	7. INSURED'S ADDRESS (No., Street)
(°	TATE 8. RESERVED FOR NUCC USE	CITY
CODE TELEPHONE (Indude Area Code)	ZIP CODE TELEPHONE (Include Area Code)
()		
THER INSURED'S NAME (Last Name, First Name, Middle Initia	10. IS PATIENT'S CONDITION RELATE	D TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSUREDS DATE OF BIRTH SEX
L Code if applicable	YES NO	M F
ESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLA	CE (State) b. OTHER CLAIM ID (Designated by NUCC)
SERVED FOR NUCC USE	HALPIEL (M)	UNS PZ CE PL UA W OR PROGRAM NAME
	YES NO	
SURANCE 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 COMP THENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorities this claim. I also request payment of government benefit low.	LETING & SIGNING THIS FORM. prize the release of any medical or other informations a either to myself or to the party who accepts assign	11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undensigned physician or supplier for services described below.
IGNED	DATE	SIGNED
TEOF CURRENT ILLNESS, INJURY, & PREGNANCY (LMF		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
QUAL AME OF REFERRING PROVIDER OR OTHER SOURCE	QUAL 17a	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	71b. NPI	FROM TO
DDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO
AGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	A-L to service line below (24E) ICD Ind. 0	22. RESUBNISSION ORIGINAL REF. NO.
G5 10 a	C.I D.I	CODE CONSTRUCTION
F	G. L. H.L.	23. PRIOR AUTHORIZATION NUMBER
J. [K L	Prior Auth#
From To PLACEOR	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) PT/HCPCS MODIFIER	AGNOSIS ON PARGES UNITS PUN QUAL PROVIDER ID. #
	S5125 UN	A 90 00 30 NP
08 15 10 08 15 12 1	35125 ON	A 30 00 30 MEI
09 15 10 09 15 12	S5125 UN	A 75 00 25 NPI
		I NP
		NPI NPI
	1 8 6 3 1	
		NPI NPI
		NPI NPI
A STATE OF THE STA	TENT'S ACCOUNT NO. 27. ACCEPT ASSIG	NMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234	X YES	6 \$ 165 00 s \$ 165 00
IGNATURE OF PHYSICAN OR SUPPLIER 32. SER (34. UDING DEGREES OR CREDENTIAL S certify that the statements on the reverse poly to this bill and are made a part thereof.)	VICE FACILITY LOCATION INFORMATION	33. BILING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST
Proceeding Code (Company)		ANY TOWN, LA 70000 a 123967654 b 1239876
NED Ima Biller DATE 10/15/15 a.	b	

ISSUED: REPLACED:

03/28/19 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

PAGE(S) 14

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line, if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the adjustment exactly as it appeared on the original claim, changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim. Providers are required to submit adjustment claims for all PAID services that are adjusted in their EVV system or LaSRS.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history. The timely filing requirements apply to resubmitted claims that were previously voided (one year from date of service).

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

ISSUED: REPLACED:

03/28/19 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

PAGE(S) 14

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

BILLING FOR SERVICES ON HOSPITAL ADMIT/DISCHARGE DATES

Claims for waiver services that overlap with a hospital stay will be denied with a 508 denial code. In order for the claim to be considered for reimbursement, the claim must be submitted manually. The following documentation must be submitted in order to receive payment for services rendered.

- Hospital admission and discharge paperwork. The date <u>AND</u> time of admit and/or discharge must be clearly denoted on the hospital paperwork with the recipient's name;
- Timesheets for date of admit/discharge;
- Service logs for date of admit/discharge; and
- Properly completed CMS 1500 claim form for services provided as instructed previously in this section.

Mail claim form and supporting documentation to:

Louisiana Department of Health, OCDD Attn: Provider Program Manager P.O. Box 3117, Bin 21 Baton Rouge, LA 70821-3117

Keep a copy of all claim forms and supporting documentation for your files.

Sample forms are on the following pages.

ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

PAGE(S) 14

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

HEALTH INSURANCE CLAIM FORI PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE									
PICA									PICA
MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP HEALTH PLA	FECA N BLKLUNG	OTHER	1a INSUREDS	LD. NUMBE	R	(For Program in item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#)	(Member ID#	(IDII)	(IDIII)	(ID#)	98765432				
PATIENT'S NAME (Last Name, First Name, Middle Initial	0	MM DD			4. INSURED'S	NAME (Last	Name, First	Name, Mid	de Initial)
AYCO, TRAVIS PATIENT'S ADDRESS (No., Street)		07 31	72 M X	F	7. INSURED'S	ADDRESS A	to Cometi		
PATIENT'S ADDRESS (NO., ST991)		Self Spouse			/. INSUREUS	ADDRESS (NO., SHEET		
TY	STATE 8	RESERVED FOR	-	RD1	СПУ				STATE
P CODE TELEPHONE (Indude An	ea Code)				ZIP CODE		TELE	EPHONE (In	dude Area Code)
()								()	
OTHER INSUREDS NAME (Last Name, First Name, Mid	die Initial)	10. IS PATIENT'S	CONDITION RELATED	TO:	11. INSUREDS	POLICY GF	OUP OR F	ECA NUMB	ER
									Marie Company
OTHER INSURED'S POLICY OR GROUP NUMBER	4		(Current or Previous)		a INSURED MM	DO I Y	BRTH		SEX
PL Code if applicable	-	Y AUTO ACCIDEN	ES NO	T (50-4)	b. OTHER CLA	MID Once	neted by All	M	F
		AUTO ACCIDEN	PLAC	CE (State)	or or en our	e ar rur (unasig	men by N	000	
ESERVED FOR NUCC USE		TA A	VIPI		c. INSURANCE	PLAN NAM	E OR PRO	GRAM NAME	
	ľ	Y	FS NO		A CONTROL CONTROL				
NSURANCE PLAN NAME OR PROGRAM NAME	-	Od, RESERVED F	OR LOCAL USE	-	d IS THERE A	NOTHER HE	ALTH BEN	EFIT PLANT	
	VAR	ADI	FOI	- 1	CIN	N	Ifyes.	complete iten	ns 9, 9a and 9d.
READ BACK OF FORM E FOR PATIENTS OR AUTHORIZED PERSONS SIGN	A WW N &	G IN THIS FO	OF E		3. IN IRF /8	OR UT O	ZED PER	RSON'S SIG	NATURE Lauthorize
to process this claim. I also request payment of governmen	t benefits either to	myself or to the part	y who accepts assignm	ent		sofbed below	ints to the u	indensigned	physician or supplier for
below SIGNED		DATE			SIGNED				
	and the late of	THE PERSON NAMED IN				TOTAL TOTAL AND	FTOUR	nu iti ni me	Int committee
MATE OF CURRENT ILLNESS, INJURY, & PREGNANC	CY (LMP) 15.01	HER DATE						RK IN CURR	
			MM DD YY		16 DATES PA	I DD I	YY	TO MA	DD YY
QUAL NAME OF REFERRING PROVIDER OR OTHER SOUR	QUAL		MM DD YY		FROM			10	
QUAL NAME OF REFERRING PROVIDER OR OTHER SOUR	QUAL ICE 17a		MM DO YY		FROM			10	PENT SERVICES
NAME OF REFERRING PROVIDER OR OTHER SOUR	QUAL 17a 71b 1		MM DD YY		18. HOSPITALI	ZATION DAT		ED TO CUR	RENT SERVICES
NAME OF REFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAIM INFORMATION (Designated by NU	QUAL 17a 71b 1		MM DG YY		FROM 18. HOSPITALI FROM 20. OUTSIDE L YES	ZATION DAT		TO CUR TO	RENT SERVICES
NAME OF REFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAIM INFORMATION (Designated by NU DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	QUAL 71b. 1 71b. 1				FROM 18. HOSPITALI FROM 20. OUTSIDE L YES	ZATION DAT	ES RELAT	TO CUR TO \$ CHARGE	PENT SERVICES
NAME OF RÉFERRING PROVIDÉR OR OTHER SOUR ADDITIONAL CLAIM INFORMATION (Designated by NU D'AGNOSIS OR NATURE OF ILLNESS OR INJURY	QUAL 71b. 1 71b. 1	NP			FROM 18. HOSPITALI FROM 20. OUTSIDE L YUS 22. RESUBMIS CODE	ZATION DAT ZATION DAT AB7 NO SION A02	ORK 5299	TO TO CUR TO S CHARGE	PENT SERVICES
NAME OF RÉFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAIM INFORMATION (Designated by NU DIAGNOSIS OR NATURE OF ILLNESS OR INJURY G5 10 a [QUAL (71b.) (17a) (17b.) (1	NP) ICD ind 0		FROM 18. HOSPITALI FROM 20. OUTSIDE L CODE 22. RESUBMIS CODE 23. PRIOR AU	AB7 NO SION A02 THORIZATIO	ORK 5299	TO TO CUR TO S CHARGE	PENT SERVICES
NAME OF REFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY 165 10 8 F. J. J. J. J. J. J. J.	QUAL 71b. 1 100) Relate A-L to serv C. L G. L K. L	NPI	D L		FROM 18. HOSPITALI FROM 20. OUTSIDE L YUS 22. RESUBMIS CODE	AB7 NO SION A02 THORIZATIO	ORK 5299	TO TO CUR TO S CHARGE	PENT SERVICES
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NAME OF REFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAIM INFORMATION (Coolignated by NU DAGNOSIS OR NATURE OF ILLNESS OR INJURY 1 G5 10 B	QUAL TOE 17a 71b. 1 UCC) Relate A-L to serv C G E D.PROCED	NPI	D L L L OR SUPPLES	E. AGNOSIS OINTER	FROM 18. HOSPITALI FROM 20. OUTSIDE L CODE 22. RESUBMIS CODE 23. PRIOR AU	AB7 NO SION A02 THORIZATIO#	ORK 5299	TO ED TO CUR TO S CHARGE	PENT SERVICES SS NO.
NAME OF RÉFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAM INFORMATION (Designated by NU DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 165 10 8	QUAL TOE 17a 71b. 1 UCC) Relate A-L to serv C G E D.PROCED	ice line below (24E	D L L L OR SUPPLES		FROM 18. HOSPITALI FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 22. PRIOR AU Prior Auth F. S. CHARG	AB7 NO SION A02 THORIZATIO #	ORK 5299	TO ED TO CUR TO TO S CHARGE	RENT SERVICES S REPOBLING
NAME OF RÉFERRING PROVIDER OR OTHER SOUR ADDITIONAL CLAM INFORMATION (Designated by NU DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 165 10 8	QUAL 17a	ce line below 24E	D L L L OR SUPPLES	OINTER	FROM 18. HOSPITALI FROM 20. OUTSIDE L YES 22. RESUBMIS CODE 22. PRIOR AU Prior Auth F. S. CHARG	AB7 NO SION A02 THORIZATIO #	ORK 5299 IN NUMBER PRINTS PRINTS	TO S CHARGE SINAL REF. 9198798	RENT SERVICES S REPOBLING
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ISSUED: 03/28/19 REPLACED: 09/28/15

CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

PAGE(S) 14

SAMPLE CLAIM FORM

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IEALTH INSURANCE CLAIM FORM	
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	
PICA MEDICARE MEDICAID TRICARE CHAMPYA GROUP FECA OTHE	PICA PI
. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHE HEALTH PLAN BLUNG (IDI) (Medicarel) (Medicarel) (Medicarel) (Medicarel) (Medicarel) (Medicarel) (Medicarel) (Medicarel)	Hat INSURED S I.D. NUMBER (For Frogram in limit I)
. PATIENT'S NAME (Lest Name, First Name, Middle Initial) 3. PATIENT'S SIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MM DD YY M F	
. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
STATE 8. RESERVED FOR NUCC USE	CITY STATE
STATE 6. RESERVED FOR NOOL USE	GIT
PIP CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include Area Code)
()	
OTHER INSURED'S NAME (Last Name, First Name, Mixide Initial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
a. EMPLOTMENT (Cultural of Previous)	a. INSURED'S DATE OF BIRTH WY M DD WY M F
RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State	b. OTHER CLAIM ID (Designated by NUCC)
YES NO	
RESERVED FOR NUCC USE a. OTHER ACCIDENT?	ZIP CODE TELEPHONE (Include Area Code) 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLANY
YES NO L INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Destanated by NUCC)	d, IS THERE ANOTHER HEALTH BENEFIT PLAN?
L INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	YES NO # yes, complete items 9, 9s, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
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.	payment of medical benefits to the undersigned physician or supplier for services described below.
below.	
SIGNED DATE	SIGNED
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMF) 15. OTHER DATE OUAL DO 1979	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17g.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
17b. NPI	FROM TO TO
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	YES NO
CONTRACTOR OF THE PROPERTY OF	22. RESUBMISSION ORIGINAL REF. NO.
B. C. D. H.	25. PRIOR AUTHORIZATION NUMBER
K L	
A. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES From To PLACEOF (Explain Unusual Circumstances) DIAGNOS	F. G. H. I. J. PAYS BENT II. HENDERING PA \$ CHARGES UNITS PIN QUAL PROVIDER ID. #
MM DD YY MM DD YY SERWCE EMG CPT/HCPCS MODIFIER POINTER	R \$ CHARGES UNTS Par QUAL PROVIDER ID. #
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YES NO	
11. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()
INCLUDING DEGREES OR OREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
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a. ND b	a NDI b
BIGNED DATE	