LOUISIANA MEDICAID PROGRAM

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CHAPTER 32: NEW OPPORTUNTIES WAIVER

APPENDIX F – CLAIMS FILING

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CLAIMS FILING

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:

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

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

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 "WAIVER" 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 Sex	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 – 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		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9с	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.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
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.	
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)

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Locator #	Description	Instructions	Alerts
22	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	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.	

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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.	
24J	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 non- shaded portion of the block is optional .	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.	
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.	

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Locator #	Description	Instructions	Alerts
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	Optional.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper
		ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	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

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SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

EALTH INSURANCE CLAIM FORM		AIVER		
				PICA
MEDICARE MEDICAID TRICARE	CHAMPVA GROUP	FECA OTHER	1a. INSURED'S I.D. NUMBER ()	For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#)	LAN BLKLUNG (ID#) (ID#)	9876543210123	i of thogram in the thirty
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BI MM DD	RTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Mide	dle Initial)
AYCO, TRAVIS	07 31	72 м × ⊧		
PATIENT'S ADDRESS (No., Street)	6. PATIENT REL Self Spor	ATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
ПҮ	STATE 8. RESERVED FO	50 0110 0110	СПУ	STATE
P CODE TELEPHONE (Include Area	(Code)		ZIP CODE TELEPHONE (In	dude Area Code)
()			()	
OTHER INSURED'S NAME (Last Name, First Name, Middle	e Initial) 10. IS PATIENT	S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBI	ER
OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMEN	IP (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY	SEX
PL Code if applicable		YES NO	MM DD YY M	F
RESERVED FOR NUCC USE	b. AUTO ACCIDE	NT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
RESERVED FOR NUCC USE	SA	IVIPLE	C. INSURANCE PLAN NAME OR PROGRAM NAME	
RESERVED FOR NUCC USE	C. OTHER ACCIE	IENT?	C. INSURVICE PERMINE OR PROGRAM NAME	-
INSURANCE PLAN NAME OR PROGRAM NAME	104 RECEPTED		A CHERE NOTHER HEALTH BENEFIT PLAN?	
	-XAMP	LE ()F I(YES NO Hyes complete item	
READ BACK OF FORM BEFORE O	COMPLETING & SIGNING THIS	FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIG payment of medical benefits to the undersigned	
to process this claim. I also request payment of government to below.	benefits either to myself or to the p	arty who accepts assignment	services described below.	proyactant or supplier for
SIGNED	DATE		SIGNED	
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY MM DD YY	(LMP) 15.0THER DATE		16. DATES PATIENT UNABLE TO WORK IN CURP MM DD YY MM	RENT OCCUPATION
MM DD YY QUAL	QUAL.	MM DD YY	FROM DD YY TO MM	DD YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE	E 17a.		18. HOSPITALIZATION DATES RELATED TO CUR	RENT SERVICES
	71b. NPI		FROM TO	
ADDITIONAL CLAIM INFORMATION (Designated by NUC	:C)		20. OUTSIDE LAB? \$ CHARGE	S
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R	elate A-L to service line below (24	E) ICD Ind. 9	YES NO 22. RESUBMISSION CODE ORIGINAL REF.	
3510 B.	C.	D I	CODE ORIGINAL REF.	NO.
E. E.	G.	н.	23. PRIOR AUTHORIZATION NUMBER	
J	К.	L	4123123123	
I. A. DATE(S) OF SERVICE B. C. From To PLACE OF M. M DD YY MM DD YY SERVICE EMG	D.PROCEDURES, SERVICE (Explain Unusual Circui CPT/HCPCS N	S, OR SUPPLIES E. Instances) DIAGNOSIS	F. G. H. I. DAYS BPSOT ID.	J. RENDERING
M DD YY MM DD YY SERVICE EMG	CPT/HCPCS N	ODIFIER POINTER	\$ CHARGES UNITS Pan QUAL.	PROVIDER ID. #
3 31 14 03 31 14 12	S5125 UN	A	90 00 30 NPI	
4 02 14 04 02 14 12	S5125 UN	A	75 00 25 NPI	
	1 1 1			
			NPI	
			· · · · · · · · · · · · · · · · · · ·	
			NPI	
	1 1 1	1 1 1		
FEDERAL TAX I.D. NUMBER SSN EIN 26	. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID	30. BALANCE DUE
20 CON LINE 100 CON LINE 20		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	s 165 00 s	\$
SIGNATURE OF PHYSICIAN OR SUPPLIER 32	SERVICE FACILITY LOCATION) 555-4957
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse			Here For You Waiver	,
apply to this bill and are made a part thereof.)			200 Main St	
			Any Town, LA 70000	
GNED Jane Doe DATE 4/5/14 a.	b.		a. 1239876543 b. 123	39876

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

			IM FC	ORM		W		VE	R	
PROVED BY NATIONAL U	IFORM (CLAIM	сомміт	TEE (NU	JCC) 02/12					Pica (
MEDICARE MEDICA			ARE			0001				
(Medicare#) X (Medica			(DoD#)		CHAMPVA (Member ID#)	HEALT (ID#)	P H PLAN	FECA BLKLUN (ID#)	G OTHER	1a. INSURED'S LD. NUMBER (For Program in Item 1)
PATIENT'S NAME (Last N			,	nitial)		ATIENTS	BRTH		SEX	9876543210123 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
AYCO, TRAVIS						07 3		°2 м×	F	
PATIENT'S ADDRESS (No	., Street)				6. F	ATIENT R	ELATIO	NSHIP TO INS	URED	7. INSURED'S ADDRESS (No., Street)
					s	ielf S	pouse	Child	Other	
ЯТY					STATE 8. R	ESERVED	FOR N	JCC USE		CITY STATE
1P CODE	TELE	EPHON	IE (Induc	te Area (Code)					ZIP CODE TELEPHONE (Include Area Code)
	1)			,					
OTHER INSURED'S NAME	(Last Na	rme, Fir	rst Name	Middle	Initial) 10.	IS PATIE	NT'S CO	NDITION REL	ATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLI		ROUP	NUMBER	t	a. E	MPLOYM	ENT? (C	urrent or Previo	ous)	a. INSURED'S DATE OF BIRTH SEX
PL Code if applica							YES	NO		M F
RESERVED FOR NUCCU	SÉ						IDENT?		PLACE (State)	b. OTHER CLAIMID (Designated by NUCC)
RESERVED FOR NUCC U	SE.		}	<u>- X</u>	AN	P	YE	- (^M		INS R4 CE PL LN W OR PROGRAM NAME
- NEGENVED FOR NUCCU						AC				
INSURANCE PLAN NAME	OR PRO	GRAM	NAME		100	RESERV	TES ED FOR	LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
										YES NO Ifyes, complete items 9, 9a and 9d.
RE	DBACK	OFFC	ORM BE	FOREC	OMPLETING & SI	GNING TH	IS FOR	M.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
 PATIENT'S OR AUTHORI to process this claim. I also 	ceDPER request p	SON'S ayment	SIGNAT	ore 1:	authorize the relea nefits either to my	selfortoth	medical e party v	in other information of the accepts ass	ation necessary ignment	payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED						DAT	-			SIGNED
	E00	104	- DPT CT	LANDAY	LMD AR OWNER		-			
4. DATE OF CURRENT ILLI	ESS, INJ	UKY, d	PREG	NANCY (LMP) 15.OTHE QUAL	RDATE	M		ΥY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
7. NAME OF REFERRING P		R OR O	THERS	OURCE	QUAL. 17a.			i_		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
					71b. NP					FROM TO TO TO
9. ADDITIONAL CLAIM INFO	RMATIO	N (Des	signated t	by NUCC)					20. OUTSIDE LAB? \$ CHARGES
										YES NO
1. DIAGNOSIS OR NATURE	OF ILL N	ESS O	RINJUR	Y Rei	ate A-L to service	line below	(24E)	ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
_{A. I} G5 10	В.				C.		_	D.		
E	F.				G		_	н		23. PRIOR AUTHORIZATION NUMBER Prior Auth#
I. DATE(S) OF SER	J. VICE	<u> </u>	В.	C.	K.	ES. SERV	ICES. O	L. R SUPPLIES	E	F G H L J
MM DD YY MM	To DD	m	PLACE OF SERVICE	EMG		Jnusual Ci		nces)	DIAGNOSIS	S CHARGES UNITS Plan QUAL. PROVIDER ID. #
10 08 15 10	08	15	12		S5125	UN			A	90 00 30 NPI
						1				
10 09 15 10	09	15	12		S5125	UN			A	75 00 25 NPI
1				1		1			1	NPI
									I	
				1						NPI
										· · · · · ·
										NPI
5. FEDERAL TAX I.D. NUM	ĸК	SS	N EIN		PATIENT'S ACCO	JUNT NO.	2	 ACCEPT AS (For govt. claims X YES 	SIGNMENT? ,seeback) NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DU \$ 165 00 \$ \$ 165
1. SIGNATURE OF PHYSIC	AN OR S		FR		34 SERVICE FACILI	TYLOCAT			NO	s 165 00 s s 165 33. BILLING PROVIDER INFO & PH# (225) 555-4957
INCLUDING DEGREES C (I certify that the statemen	R CREDE	ENTIAL	.s		autorios rinolui			and the second states		HERE FOR YOU WAIVER
apply to this bill and are m	ade a part	t thereo	of.)							200 MAIN ST
										ANY TOWN, LA 70000
Ima Biller		DATE	10/15/	15 a.		b.				a. 123967654 b. 1239876
							_			APPROVED OMB-0938-1197 FORM CMS-1500 (0

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ADJUSTING/VOIDING CLAIMS

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

<u>Only a paid claim can be adjusted or voided</u>. 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 those 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.
- 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.

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.

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.

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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.

Sample forms are on the following pages.

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/01/15)

ALTH INSURAN						IV		•					
ROVED BY NATIONAL UNIF	ORM CLAIM COMM	ITTEE (NU	JCC) 02/12										
MEDICARE MEDICAI	TRICARE		CHAMPVA	GROUP HEALTH		FECA BLK LUN	OTHER	1a. INSURED:	S I.D. NUME	ER		(For Progr	am in Item 1)
(Medicare #) 🗙 (Medicaid	#) (ID#/DoD#)		(Member ID#)	(11,244)		(ID#)	(12/14)	98765432					
ATIENT'S NAME (Last Nam	e, First Name, Middl	e Initial)	3.	PATIENT'S I MM D			SEX .	4. INSURED'S	NAME (Las	t Name	, First Name, Mi	ddle Initial)	
YCO, TRAVIS	N			07 31		м×	F	7. INSURED'S	ADDRESS	(No. 0	treat)		
ATIENT'S ADDRESS (No.,	street)			PATIENT RE		HP TO INSI Child	Other	7. INSURED S	AUDRESS	(140., 5	reer)		
Y			STATE 8.1	RESERVED		USE		СПҮ					STATE
CODE	TELEPHONE (Inc	lude Area (code)					ZIP CODE			TELEPHONE (I	ndude Are	a Code)
THER INSURED'S NAME (ne, Middle	Initial) 10	0. IS PATIEN	T'S COND	ITION RELA	TED TO:	11. INSURED	S POLICY G	ROUP	OR FECA NUM	BER	
THER INSURED'S POLICY		ER	a.	EMPLOYME			us)	a. INSURED MM	SDATE OF	SBIRTH YY		SEX	_
L Code if applicable ESERVED FOR NUCC USE					YES	NO		b. OTHER CL4	MID (Deel	anatari	M NUCC)		F
			D.	C AUTO AUGI		IDJ	LACE (State)	D. OTHER OD	UNITO (Desi	A- Hanco	5, 1000)		
ESERVED FOR NUCC USE			c.	OTHER ACC	DENT?			c. INSURANCE	E PLA N NAM	IE OR	PROGRAM NAM	ЛЕ	
					YES	NO							
SURANCE PLAN NAME O	R PROGRAM NAME	F	ΧΔΪ	ΜР	D FOR LC		F 1(THERE C	NOTHER H		BENEFIT PLAN		
READ	BACK OF FORM B	EFORE CO	OMPLETING & S	SIGNING TH	S FORM.			13. INSURED'S	OR AUTH		ves. complete ite D PERSON'S SI	GNATURE	lauthorize
ATIENT'S OR AUTHORIZE process this claim. I also re	D PERSON'S SIGN	ATURE 1 a	authorize the rele	ease of any m	nedical or o	ther informa accepts assi	tion necessary gnment	payment of	medical ber scribed belo	nefits to	the undersigned	d physician	or supplier for
elow. IGNED				DATE				SIGNED					
ATE OF CURRENT ILLNE	S IN LIRY of PRE	GNANCY (MP) 15 OTH	ER DATE						BLE TO	WORK IN CUR	RENT OC	CURATION
		onnior	QUAL		MM	DD	Y	FROM	DD	YY	WORK IN CUR N TO	IM DD	YY
AME OF REFERRING PR	VIDER OR OTHER	SOURCE	17a.					18. HOSPITAL	ZATION DA	TESR	ELATED TO CU		RVICES
			71b. NF	91				FROM			то		
ADDITIONAL CLAIM INFOR	WATION (Design ate	d by NUCC	;)					20. OUTSIDE I YES	JAB? NO	1	\$ CHARG	ES	
AGNOSIS OR NATURE O	FILLNESS OR INJU	RY Rel	ate A-L to servio	e line below (24E) IC	D Ind. 9		22. RESUBMIS			ORIGINAL REF		
3510	в.]		C.			D.		A 00		4(094198765		
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A. DATE(S) OF SERVI	J. L	C.	K.	DEC CEDVA			E.	41231231		6			
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APPENDIX F – CLAIMS FILING

PAGE(S) 14

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

EALTH INSURANCE CLAIM FORM	WAIVER		
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA			PICA
MEDICARE MEDICAID TRICARE CHAMP	VA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Member	(D#) ((D#) ((D#)	9876543210123	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name,	First Name, Middle Initial)
JAYCO, TRAVIS	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Str	9 0
	Self Spouse Child Other		
STATE STATE	8. RESERVED FOR NUCC USE	СПҮ	STATE
1P CODE TELEPHONE (Indude Area Code)	_	ZIP CODE 1	TELEPHONE (Include Area Code)
		ZIPCODE	()
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP O	X /
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY	
PL Code if applicable RESERVED FOR NUCCUSE	YES NO	h OTHER CLAIM IS CONTRACT	M F
NUMBER OF THE OF THE OFF	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIMID (Designated b	y NUCC)
RESERVED FOR NUCC USE		G. INSURANCE PLAN NAME OR P	ROGRAM NAME
	YES NO		
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH	BENEFIT PLAN?
EVA			es, complete items 9, 9a and 9d.
READ BACK OF FORM E FORM OWNERN PATIENT'S OR AUTHORIZED PERSONS SIGN TEXT 1 sensitive to process this claim. I also request payment of government benefits eithe below.	I A TIG IN THIS FOR I. In reads of any more of other mounts on necessar rto myself or to the party who accepts assignment		PERSON'S SIGNATURE I authorize the undersigned physician or supplier for
SIGNED	DATE	SIGNED	
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15	OTHER DATE NUL DD VV	16. DATES PATIENT UNABLE TO	WORK IN CURRENT OCCUPATION
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APPENDIX F – CLAIMS FILING

PAGE(S) 14

SAMPLE CLAIM FORM

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MEDICARE MEDICAID TRICARE CHAMPVA		1 1a. INSURED'S I.D. NUMBE	R (For F	rognam in lilem 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member EDI PATIENT'S NAME (Last Namo, First Namo, Middle Initial)	(IDW) (IDW) (IDW) 3. PATIENT'S BIRTH DATE SEX MM DD YY SEX	4. INSURED'S NAME (Last N	Jama First Name Middle I	nitieD
	MM DO YY M F			
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (N	io., Street)	- A.
TTY STATE	8 RESERVED FOR NUCC USE	CITY		STATE
P CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Includ	le Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GR	OUP OR FECA NUMBER	
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OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	A. INSURED'S DATE OF BIE		SEX
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Design		
RESERVED FOR NUCC USE	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME	OR PROGRAM NAME	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HE	ALTH BENEFIT PLAN?	
READ BACK OF FORM BEFORE COMPLETING		YES NO	8 yes, complete items	
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE faultotice the re to process the claim. I also request payment of government benefits either to below.		SIGNED		T OCCUPATION
A. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. O MM DD QUAL QUAL QUAL		16. DATES PATIENT UNABL MM DD FROM	TO NORK IN CORREN	DO YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DAT		NT SERVICES
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S, FEDERAL TAX I.D. NUMBER 88N EIN 28. PATIENT'S AC	COUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE		30. Ravel for NUCC L