
CHAPTER 30: PERSONAL CARE SERVICES

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CLAIMS RELATED INFORMATION

Hard copy billing of Personal Care Services (PCS) are billed on the CMS-1500 (02/12) claim form or electronically in the 837P 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
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 samples of completed CMS-1500 claim forms; and

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

CMS 1500 (02/12) Billing Instructions for Personal Care 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 #).	
1a	Insured's I.D. Number	Required – Enter the recipient/beneficiary's 13-digit Medicaid I.D. number exactly as it appears when checking recipient/beneficiary eligibility through MEVS, eMEVS, or REVS. NOTE: The recipient/beneficiary's 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient/beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the recipient/beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Required – Enter the recipient/beneficiary'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/beneficiary.	

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Locator #	Description	Instructions	Alerts
4	Insured's Name	Situational – Complete correctly if the recipient/beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient/beneficiary'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	Leave Blank.	
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.	

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Locator #	Description	Instructions	Alerts
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	Leave Blank.	
17	Name of Referring Provider or Other Source	<p>Situational – Complete if applicable. Enter the applicable qualifier to the left of the vertical, dotted line to Identify which provider is being reported.</p> <p>o DK Ordering Provider</p> <p>In the following circumstances, entering the name (First Name, Middle Initial, Last Name) followed by the credentials of the ordering physician or non-physician practitioner and appropriate qualifier is required:</p> <ul style="list-style-type: none"> • EPSDT - PCS Services always require an ordering 	<p>For LA Medicaid other source is defined as the ordering provider.</p> <p>Any provider entered as an ordering provider must be enrolled with LA Medicaid.</p> <p>Note: LTPCS does not require an ordering provider but if no one is</p>

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Locator #	Description	Instructions	Alerts
		provider	listed on the claim, it must be valid.
17a	Other ID #	Situational Complete if applicable. Enter the 7-digit Medicaid ID number of the ordering provider.	Enter the 7- digit Medicaid ID Number here.
17b	NPI#	Situational – Complete if applicable. Enter the NPI number of the ordering provider.	The 10-digit NPI Number is <u>required</u> .
18	Hospitalization Dates Related to Current Services	Optional.	
19	Additional Claim Information (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Leave Blank.	

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Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>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.</p> <p>0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p> <p>NOTE: ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as <u>non-primary</u> diagnosis codes</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p>

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Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	<p>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.</p> <p>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.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient/Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	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 prior authorization number for the authorized services.	
24	Supplemental Information	Situational.	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	

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Locator #	Description	Instructions	Alerts
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered in the unshaded area(s).</p> <p>Enter appropriate modifier with procedure code:</p> <p>UB = LT-PCS EP = EPSDT-PCS</p>	
24E	Diagnosis Pointer	<p>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number letter (“A”, “B”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
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.	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
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/beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers	

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Locator #	Description	Instructions	Alerts
		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	Leave Blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Practitioner or Supplier Including Degrees or Credentials Date	Optional – For the PCS CMS 1500, 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	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.	The 10-digit NPI Number must appear on paper claims.

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Locator #	Description	Instructions	Alerts
33b	Other ID #	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.

Sample PCS Claim Form – See below.

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail completed forms to:

DXC Technology

P.O. Box 91020

Baton Rouge, LA 70821

<input type="checkbox"/> PICA <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> EEC/SEK/UNG <input type="checkbox"/> OTHER		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE		3. PATIENT'S BIRTH DATE 06 11 05 M F <input checked="" type="checkbox"/> SEX	
5. PATIENT'S ADDRESS (No., Street) 1234 ANYLANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY: MYTOWN STATE: LA		7. INSURED'S ADDRESS (No., Street) CITY: STATE:	
ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		4. INSURED'S DATE OF BIRTH MM DD YY SEX M F <input type="checkbox"/>	
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.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED: DATE:		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JOHN DOE, MD		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE DELAY? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Please A-L to service line below (24E) ICD Ind: 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. G808 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 123456789	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPTICPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OF ILLNESS H. EPISODES PER YEAR I. ID QUAL J. REFERRING PROVIDER ID #	
1 03 01 19 03 01 19 12 T1019 EP A 48 00 16 NPI		29. TOTAL CHARGE \$ 165.00 29. AMOUNT PAID \$ 30. Rev'd for NUCC Use	
2 03 02 19 03 02 19 12 T1019 EP A 45 00 15 NPI		31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (Certify that the statements on the reverse apply to this bill and are made a part thereof)	
3 03 05 19 03 05 19 12 T1019 EP A 48 00 16 NPI		32. SERVICE FACILITY LOCATION INFORMATION	
4 03 06 19 03 06 19 12 T1019 EP A 24 00 8 NPI		33. BILLING PROVIDER INFO & PH# (800) 233-3333	
5		PCS AGENCY 700 MAIN ST ANY TOWN, LA 70000	
6		a. 1326547895 b. 1987654	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMS-0935-1197 FORM 1500 (02-12)

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Adjustments and Voids

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 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/Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid recipient/beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

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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.

Sample PCS Claim Form Adjustment Form – See below.

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail completed forms to:

DXC Technology

P.O. Box 91020

Baton Rouge, LA 70821

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRI-CARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA EXEMPT <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE		3. PATIENT'S BIRTH DATE MM DD YY 06 11 05 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) 1234 ANYLANE CITY MYTOWN STATE LA		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) CITY STATE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F		12. INSURED'S POLICY GROUP OR FICA NUMBER	
13. INSURED'S NAME (Last Name, First Name, Middle Initial)		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> #yes, complete items 9, 9a, and 9d.	
15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____	
17. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL _____		18. OTHER DATE MM DD YY QUAL _____	
19. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JOHN DOE, MD		20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (S4E)) A. G808 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		24. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 9070123456002	
25. PRIOR AUTHORIZATION NUMBER PA # IF APPLICABLE		26. PRIOR AUTHORIZATION NUMBER	
27. DATE(S) OF SERVICE From MM DD YY To MM DD YY		28. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) T1019 EP MODIFIER _____	
29. DATE(S) OF SERVICE From MM DD YY To MM DD YY		30. DIAGNOSIS POINTER A	
31. \$ CHARGES 42.00		32. \$ CHARGES 14	
33. NPI NPI		34. NPI NPI	
35. NPI NPI		36. NPI NPI	
37. NPI NPI		38. NPI NPI	
39. NPI NPI		40. NPI NPI	
41. NPI NPI		42. NPI NPI	
43. NPI NPI		44. NPI NPI	
45. NPI NPI		46. NPI NPI	
47. NPI NPI		48. NPI NPI	
49. NPI NPI		50. NPI NPI	
51. NPI NPI		52. NPI NPI	
53. NPI NPI		54. NPI NPI	
55. NPI NPI		56. NPI NPI	
57. NPI NPI		58. NPI NPI	
59. NPI NPI		60. NPI NPI	
61. NPI NPI		62. NPI NPI	
63. NPI NPI		64. NPI NPI	
65. NPI NPI		66. NPI NPI	
67. NPI NPI		68. NPI NPI	
69. NPI NPI		70. NPI NPI	
71. NPI NPI		72. NPI NPI	
73. NPI NPI		74. NPI NPI	
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77. NPI NPI		78. NPI NPI	
79. NPI NPI		80. NPI NPI	
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83. NPI NPI		84. NPI NPI	
85. NPI NPI		86. NPI NPI	
87. NPI NPI		88. NPI NPI	
89. NPI NPI		90. NPI NPI	
91. NPI NPI		92. NPI NPI	
93. NPI NPI		94. NPI NPI	
95. NPI NPI		96. NPI NPI	
97. NPI NPI		98. NPI NPI	
99. NPI NPI		100. NPI NPI	
101. NPI NPI		102. NPI NPI	
103. NPI NPI		104. NPI NPI	
105. NPI NPI		106. NPI NPI	
107. NPI NPI		108. NPI NPI	
109. NPI NPI		110. NPI NPI	
111. NPI NPI		112. NPI NPI	
113. NPI NPI		114. NPI NPI	
115. NPI NPI		116. NPI NPI	
117. NPI NPI		118. NPI NPI	
119. NPI NPI		120. NPI NPI	
121. NPI NPI		122. NPI NPI	
123. NPI NPI		124. NPI NPI	
125. NPI NPI		126. NPI NPI	
127. NPI NPI		128. NPI NPI	
129. NPI NPI		130. NPI NPI	
131. NPI NPI		132. NPI NPI	
133. NPI NPI		134. NPI NPI	
135. NPI NPI		136. NPI NPI	
137. NPI NPI		138. NPI NPI	
139. NPI NPI		140. NPI NPI	
141. NPI NPI		142. NPI NPI	
143. NPI NPI		144. NPI NPI	
145. NPI NPI		146. NPI NPI	
147. NPI NPI		148. NPI NPI	
149. NPI NPI		150. NPI NPI	
151. NPI NPI		152. NPI NPI	
153. NPI NPI		154. NPI NPI	
155. NPI NPI		156. NPI NPI	
157. NPI NPI		158. NPI NPI	
159. NPI NPI		160. NPI NPI	
161. NPI NPI		162. NPI NPI	
163. NPI NPI		164. NPI NPI	
165. NPI NPI		166. NPI NPI	
167. NPI NPI		168. NPI NPI	
169. NPI NPI		170. NPI NPI	
171. NPI NPI		172. NPI NPI	
173. NPI NPI		174. NPI NPI	
175. NPI NPI		176. NPI NPI	
177. NPI NPI		178. NPI NPI	
179. NPI NPI		180. NPI NPI	
181. NPI NPI		182. NPI NPI	
183. NPI NPI		184. NPI NPI	
185. NPI NPI		186. NPI NPI	
187. NPI NPI		188. NPI NPI	
189. NPI NPI		190. NPI NPI	
191. NPI NPI		192. NPI NPI	
193. NPI NPI		194. NPI NPI	
195. NPI NPI		196. NPI NPI	
197. NPI NPI		198. NPI NPI	
199. NPI NPI		200. NPI NPI	
201. NPI NPI		202. NPI NPI	
203. NPI NPI		204. NPI NPI	
205. NPI NPI		206. NPI NPI	
207. NPI NPI		208. NPI NPI	
209. NPI NPI		210. NPI NPI	
211. NPI NPI		212. NPI NPI	
213. NPI NPI		214. NPI NPI	
215. NPI NPI		216. NPI NPI	
217. NPI NPI		218. NPI NPI	
219. NPI NPI		220. NPI NPI	
221. NPI NPI		222. NPI NPI	
223. NPI NPI		224. NPI NPI	
225. NPI NPI		226. NPI NPI	
227. NPI NPI		228. NPI NPI	
229. NPI NPI		230. NPI NPI	
231. NPI NPI		232. NPI NPI	
233. NPI NPI		234. NPI NPI	
235. NPI NPI		236. NPI NPI	
237. NPI NPI		238. NPI NPI	
239. NPI NPI		240. NPI NPI	
241. NPI NPI		242. NPI NPI	
243. NPI NPI		244. NPI NPI	
245. NPI NPI		246. NPI NPI	
247. NPI NPI		248. NPI NPI	
249. NPI NPI		250. NPI NPI	
251. NPI NPI		252. NPI NPI	
253. NPI NPI		254. NPI NPI	
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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLUX LUNG OTHER (Medicare#) (Medicaid#) (ID#/DC#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX MM DD YY M F									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()									
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLAGE (State) YES NO									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete Items 9, 9a, and 9d.									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										20. OUTSIDE LAB? \$ CHARGES YES NO									
A. B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. REPORT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1										NPI									
2										NPI									
3										NPI									
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6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
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.)										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO									
32. SERVICE FACILITY LOCATION INFORMATION										28. TOTAL CHARGE 29. AMOUNT PAID 30. Paid for NUCC Use									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # ()									