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CMS 1500 (08/05) 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's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2. 	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date 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	
	Jex	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	Patient Status	Optional.	
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 coverage, the state assigned 6-digit TPL carrier code is required in this block (the carrier code list can be found at www.lamedicaid.com under the Forms/Files link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9c	Employer's Name or School Name	Situational – Complete if appropriate or 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	Employer's Name or School Name	Situational – Complete if appropriate or 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	If Patient Has Had Same or Similar Illness Give First Date	Optional.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational	
17a	Unlabelled	Optional.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	The most specific diagnosis codes must be used.

Locator #	Description	Instructions	Alerts
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	Required – Enter the prior authorization number for the authorized services.	
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	Optional	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter appropriate modifier with procedure code:	
		UB = LT-PCS EP = EPSDT-PCS	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
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.	
241	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank	
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

Locator #	Description	Instructions	Alerts
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay.	
		If TPL does not apply to the claim, leave blank.	
30	Balance Due	Situational – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Required The claim form MUST be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabelled	Situational	
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional – Enter the billing provider's NPI number.	
33b	Unlabelled	Required – Enter the billing provider's 7-digit Medicaid ID number.	

APPENDIX J: CLAIMS FILING

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LT-PCS – Example Claim Form

PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/09	5						
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ЯТҮ	STATE 8. PATIENT STATUS		CITY	STATE			
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SIGNED	DATE		SIGNED				
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11/01/10 10/01/97

APPENDIX J: CLAIMS FILING

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EPSDT-PCS – Example Claim Form

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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

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Adjustments and Voids

Completing the 213 Adjustment/Void Form

The 213 adjustment/void form is used to adjust or void incorrect payments on the CMS-1500. These forms may be obtained from Molina Medicaid Solutions by calling Provider Relations at (800) 473-2783 or at <u>www.lamedicaid.com</u> using the Forms/Files/User Guides link. Instructions and an example of a completed 213 adjustment form are shown on the following pages.

If a claim has been paid using the 837P claim transaction, an adjustment or void may be submitted electronically or by using the Molina 213 adjustment/void form.

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

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

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

- 1. A claim is approved on the remittance advice dated 07/17/2010, ICN 0266156789000.
- 2. The claim is adjusted on the remittance advice dated 12/11/2010, ICN 0035126742100.
- 3. If the claim requires further adjustment or needs to be voided, the most recently approved control number (0035126742100) and RA date (12/11/2010) must be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of an adjustment appears within this document.

To file a void, the provider must enter all the information from the original claim exactly as it appeared on the original claim. When the void claim is approved, it will be listed under the "void" column of the RA and a corrected claim may be submitted (if applicable).

ISSUED: REPLACED:

CHAPTER 30: PERSONAL CARE SERVICES APPENDIX J: CLAIMS FILING

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Filing Adjustments for a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare reimburses the claim, and the claim becomes a "crossover" to Medicaid for consideration of payment of the Medicare deductible and/or co-insurance/co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should re-bill Medicare for a corrected payment. These claims may "crossover" from Medicare to Medicaid, but cannot be automatically processed by Medicaid (as the electronic crossover claim appears to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy adjustment claim (Molina Form 213) with Medicaid. These should be sent with a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached to:

Molina Medicaid Solutions Attention: Crossover Adjustments P.O. Box 91023 Baton Rouge, LA 70821

In addition, the provider should write "2X7" at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

11/01/10 10/01/97

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Instructions for Completing the 213 Adjustment/Void Form

- 1. **REQUIRED** ADJ/VOID Check the appropriate block
- 2. **REQUIRED** Patient's Name
 - a. Adjust Print the name exactly as it appears on the original claim if not adjusting this information.
 - b. Void Print the name exactly as it appears on the original claim.
- 3. Patient's Date of Birth
 - a. Adjust Print the date exactly as it appears on the original claim if not adjusting this information.
 - b. Void Print the name exactly as it appears on the original claim.
- 4. **REQUIRED** Medicaid ID Number Enter the 13 digit recipient ID number
- 5. Patient's Address and Telephone Number
 - a. Adjust Print the address exactly as it appears on the original claim.
 - b. Void Print the address exactly as it appears on the original claim.
- 6. Patient's Sex
 - a. Adjust Print this information exactly as it appears on the original claim if not adjusting this information.
 - b. Void Print this information exactly as it appears on the original claim.
- 7. Insured's Name Leave blank
- 8. Patient's Relationship to Insured Leave blank
- 9. Insured's Group No. Complete if appropriate or leave blank
- 10. Other Health Insurance Coverage Complete with 6-digit TPL carrier code if appropriate or leave blank

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- 11. Was Condition Related to Leave blank
- 12. Insured's Address Leave blank
- 13. Date of Leave blank
- 14. Date First Consulted You for This Condition Leave blank
- 15. Has Patient Ever had Same or Similar Symptoms Leave blank
- 16. Date Patient Able to Return to Work—Leave blank
- 17. Dates of Total Disability-Dates of Partial Disability Leave blank
- 18. Name of Referring Physician or Other Source Leave blank
- 18a. Referring ID Number –Leave blank.
- 19. For Services Related to Hospitalization Give Hospitalization Dates Leave blank
- 20. Name and Address of Facility Where Services Rendered (if other than home or office) Leave blank
- 21. Was Laboratory Work Performed Outside of Office Leave blank
- 22. **REQUIRED** Diagnosis of Nature of Illness
 - a. Adjust Print the information exactly as it appears on the original claim if not adjusting the information.
 - b. Void Print the information exactly as it appears on the original claim.
- 23. Attending Number Leave this space blank
- 24. Prior Authorization # Enter the PA number.

25. **REQUIRED** A through F

- a. Adjust Print the information exactly as it appears on the original claim if not adjusting the information.
- b. Void Print the information exactly as it appears on the original claim.

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- 26. **REQUIRED** Control Number Print the correct Control Number as shown on the remittance advice
- 27. **REQUIRED** Date of remittance advice that Listed Claim was Paid Enter MM DD YY from RA form
- 28. **REQUIRED** Reasons for Adjustment Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.
- 29. **REQUIRED** Reasons for Void Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.
- 30. **REQUIRED** Signature of Physician or Supplier All Adjustment/Void forms must be signed.
- 31. **REQUIRED** Physician's or Supplier's Name, Address, Zip Code and Telephone Number Enter the requested information appropriately plus the seven digit Medicaid provider number and provider NPI number.
- 32. Patient's Account Number Enter the patient's provider-assigned account number.

REQUIRED items must be completed or <u>form will be returned</u>.

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LT-PCS – Example Adjustment Form

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