
CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX E – CLAIMS FILING

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CLAIMS FILING

Hard copy billing of professional services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

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

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CMS 1500 (02/12) INSTRUCTIONS FOR PROFESSIONAL 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 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		

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Locator #	Description	Instructions	Alerts
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient has no other insurance coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the Louisiana 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.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	<p>ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</p> <p>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE</p>
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.	

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Locator #	Description	Instructions	Alerts
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.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable. In the following circumstances, entering the name of the appropriate physician is required: <ul style="list-style-type: none"> • If ACA services are delivered by a PA or APRN, the name of the supervising ACA certified physician is required in this field • If services are performed by a CRNA, enter the name of the directing physician • If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name. • If the services are performed by an independent laboratory, enter the name of the referring physician. 	
17a	Unlabeled	Situational – Complete if applicable. ACA Services delivered by a PA or APRN require the identification of the supervising ACA certified physician.	
17b	NPI	Situational – Complete if applicable. ACA Services delivered by a PA or APRN require the identification of the supervising ACA certified physician.	

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Locator #	Description	Instructions	Alerts
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	<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>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p> <p>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.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis 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 (www.lamedicaid.com)</p>

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	<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 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>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).</p> <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.</p>
23	Prior Authorization (PA) Number	<p>Situational – Complete if appropriate or leave blank.</p> <p>If the services being billed must be prior authorized, the PA number is required to be entered.</p>	

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Locator #	Description	Instructions	Alerts
24	Supplemental Information	<p>Situational - Applies to the detail lines for drugs and biologicals only.</p> <p>In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 for physician-administered drugs and shall be entered in the shaded section of 24A through 24G.</p> <p><u>Claims for these drugs shall include the NDC from the label of the product administered.</u></p> <p>To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the 11 digit NDC. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.</p> <p>Providers should then leave one space and then enter the appropriate Unit Qualifier (see below) and the actual units administered in NDC UNITS.</p> <p>Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.</p> <p>The following qualifiers shall be used when reporting NDC units:</p> <ul style="list-style-type: none"> • F2=International Unit • ML=Milliliter • GR=Gram • UN=Unit 	<p>Physicians and other provider types who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A-24G of the appropriate detail lines only.</p> <p>This information must be entered in addition to the procedure code(s).</p> <p>Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units and entry of NDC numbers with less than 11 digits.</p>
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure billed.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	<p>Required -- Enter the appropriate place of service code for the services rendered.</p>	

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Locator #	Description	Instructions	Alerts
24C	EMG	Situational – Complete if appropriate or 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.	
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	Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units.
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. #	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 .	
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.	

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Locator #	Description	Instructions	Alerts
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 primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. Do not report Medicare payments in this field.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional – The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	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. 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 forms are on the following pages

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		TRICARE (ID#DoD#) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (ID#) <input type="checkbox"/>		FECA BLK/LUNG (ID#) <input type="checkbox"/>		OTHER (ID#) <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 19 85 M F <input checked="" type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
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)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? YES NO				11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME					
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								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED				14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 15. OTHER DATE MM DD YY QUAL. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. V250.1 B. C. D. E. F. G. H. I. J. K. L. 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. I.D. QUAL. 1236548			
1 03 02 14 03 02 14 11		99213		A		80 00		1		NPI		1236549875					
2 N400703680101 UN150.00 DEPO-ROVERA INJ		J1050		A		50 00		150		NPI		1236549875					
3												NPI					
4												NPI					
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, use back) X YES NO				28. TOTAL CHARGE \$ 130 00		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED John Doe, MD DATE 3/9/14				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open 500 Main St Any Town, LA 70000				a. 1326547895		b. 1987654			

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APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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SAMPLE PROFESSIONAL CLAIM FORM WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/1/15)

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>		MEDICAID (Medicaid #) <input checked="" type="checkbox"/>		TRICARE (ICM/DoD#) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (ID#) <input type="checkbox"/>		FECA BLK LUNG (ID#) <input type="checkbox"/>		OTHER (ID#) <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 19 85 M F <input checked="" type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()						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 ZIP CODE TELEPHONE (Include Area Code) () ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT YES NO 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH 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.							
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												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL						15. OTHER DATE QUAL MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. Z30.42 B. C. D. E. F. G. H. I. J. K. L.												20. OUTSIDE LAB? \$ CHARGES YES NO 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. BRST Part/Ther		I. ID. QUAL		J. RENDERING PROVIDER ID. #			
10 01 15 10 01 15 12		99213		A		80.00		1		NPI		1236548		1236549875					
10 01 15 10 01 15 12		J1050		A		50.00		150		NPI									
												NPI							
												NPI							
												NPI							
												NPI							
												NPI							
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For prov. claims, see back) YES NO				28. TOTAL CHARGE \$ 130.00				29. AMOUNT PAID \$ 130.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED John Doe, MD DATE				32. SERVICE FACILITY LOCATION INFORMATION a. b.				33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open 500 Main St. Any Town, LA 70000 a. 1326547895 b. 1987654											

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

HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) X (Medicaid #) (ID#DoD#) (Member ID#) (ID#) (ID#)										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 SEX 06 19 85 M F X									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. PATIENT'S ADDRESS (No., Street)									
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street)									
8. RESERVED FOR NUCC USE										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER? YES NO										11. INSURED'S DATE OF BIRTH SEX MM DD YY M F 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									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL									
15. OTHER DATE QUAL MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. V250.1 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. A 99 4090145678600									
23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 03 02 14 03 02 14 11 99213 A 80 00 1 NPI 1236548										2 1236549875									
3										4									
5										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? X YES NO										28. TOTAL CHARGE \$ 80 00									
29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED John Doe, MD DATE 3/9/14										32. SERVICE FACILITY LOCATION INFORMATION a. b.									
33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open 500 Main St Any Town, LA 70000 a. 1326547895 b. 1987654																			

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SAMPLE PROFESSIONAL CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS
CODE (DATES ON OR AFTER 10/1/15)

HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE										3. PATIENT'S BIRTH DATE MM DD YY 06 19 85 M F <input checked="" type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. INSURED'S ADDRESS (No., Street)									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse Child Other										7. INSURED'S ADDRESS (No., Street)									
8. RESERVED FOR NUCC USE										9. RESERVED FOR NUCC USE									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER CAUSE YES NO										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M SEX 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.									
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										13. INSURED OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED									
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 17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10: 0 A. Z30.42 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. A 02 5299198798700									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON/Empty/Full I. ID. QUAL. J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1 10 01 15 10 01 15 12 99213 A 80.00 1 NPI 1236549875										1236548									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO										28. TOTAL CHARGE \$ 80.00									
29. AMOUNT PAID \$										30. BALANCE DUE \$ 80.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED John Doe, MD DATE										32. SERVICE FACILITY LOCATION INFORMATION a. b.									
33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open 500 Main St. Any Town, LA 70000										a. 1326547895 b. 1987654									

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SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA ☐ ☐ PICA ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/>				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 MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)															
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)															
CITY				STATE				CITY				STATE											
ZIP CODE				TELEPHONE (Include Area Code)				ZIP CODE				TELEPHONE (Include Area Code)											
8. RESERVED FOR NUCC USE				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				b. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>															
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)															
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				c. INSURANCE PLAN NAME OR PROGRAM NAME															
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.															
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.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.															
SIGNED _____ DATE _____								SIGNED _____															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b. NPI				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER															
A. _____ B. _____ C. _____ D. _____				F. _____ G. DAYS CHARGES H. EXPENDITURE I. ID. QUAL J. RENDERING PROVIDER ID. #																			
E. _____ F. _____ G. _____ H. _____																							
I. _____ J. _____ K. _____ L. _____																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER																							
1																							
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE				29. AMOUNT PAID				30. Rvd for NUCC Use			
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()															
SIGNED _____ DATE _____				a. NPI b. NPI				a. NPI b. NPI															

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