# CLAIMS FILING

This appendix contains the information about the following:

- Instructions for billing using the CMS-1500 Claim Form
- Sample of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim
- Sample of a CMS-1500 Claim Form Adjustment
- Instructions for billing using the ADA Dental Claim Form
- Sample of the ADA Dental Claim Form
- Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form
- Sample of the 209 Adjustment/Void Form
- Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form
- Sample of the 210 Adjustment/Void Form

## CMS 1500 (02/12) Billing Instructions for RHC Services

Hard copy billing of RHC 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 a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

# CMS 1500 (02/12) Billing Instructions for RHC 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.<br>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<br>Sex | Situational – 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).<br>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 | Leave Blank. | |
| 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.<br>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. This carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number.<br>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. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 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<br><br>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 | 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 | Optional. | |
| 17 | Name of Referring Provider or Other Source | Situational – Complete if applicable.<br><br>In the following circumstances, entering the name of the appropriate physician block is required:<br><br>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. | |
| 17a | Unlabelled | Leave Blank. | |
| 17b | NPI | Leave Blank. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 18 | Hospitalization Dates Related to Current Services | Leave Blank. | |
| 19 | ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | Leave Blank. | |
| 20 | Outside Lab? | Optional. | |
| 21 | ICD Ind.<br><br>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.<br>9 ICD-9-CM<br>0 ICD-10-CM<br><br>Required – Enter the most current ICD diagnosis code.<br><br>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.<br><br>Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD-10-CM codes will be announced at a later date. |
| 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.<br><br>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.<br><br>Appropriate reason codes follow:<br><br><u>Adjustments</u><br>01 = Third Party Liability Recovery<br>02 = Provider Correction<br>03 = Fiscal Agent Error<br>90 = State Office Use Only – Recovery<br>99 = Other<br><br><u>Voids</u><br>10 = Claim Paid for Wrong Recipient<br>11 = Claim Paid for Wrong Provider<br>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).<br><br>To adjust or void a claim, only the encounter line should be adjusted/voided since all payment is made on this line. The internal control number of the encounter line is used. |

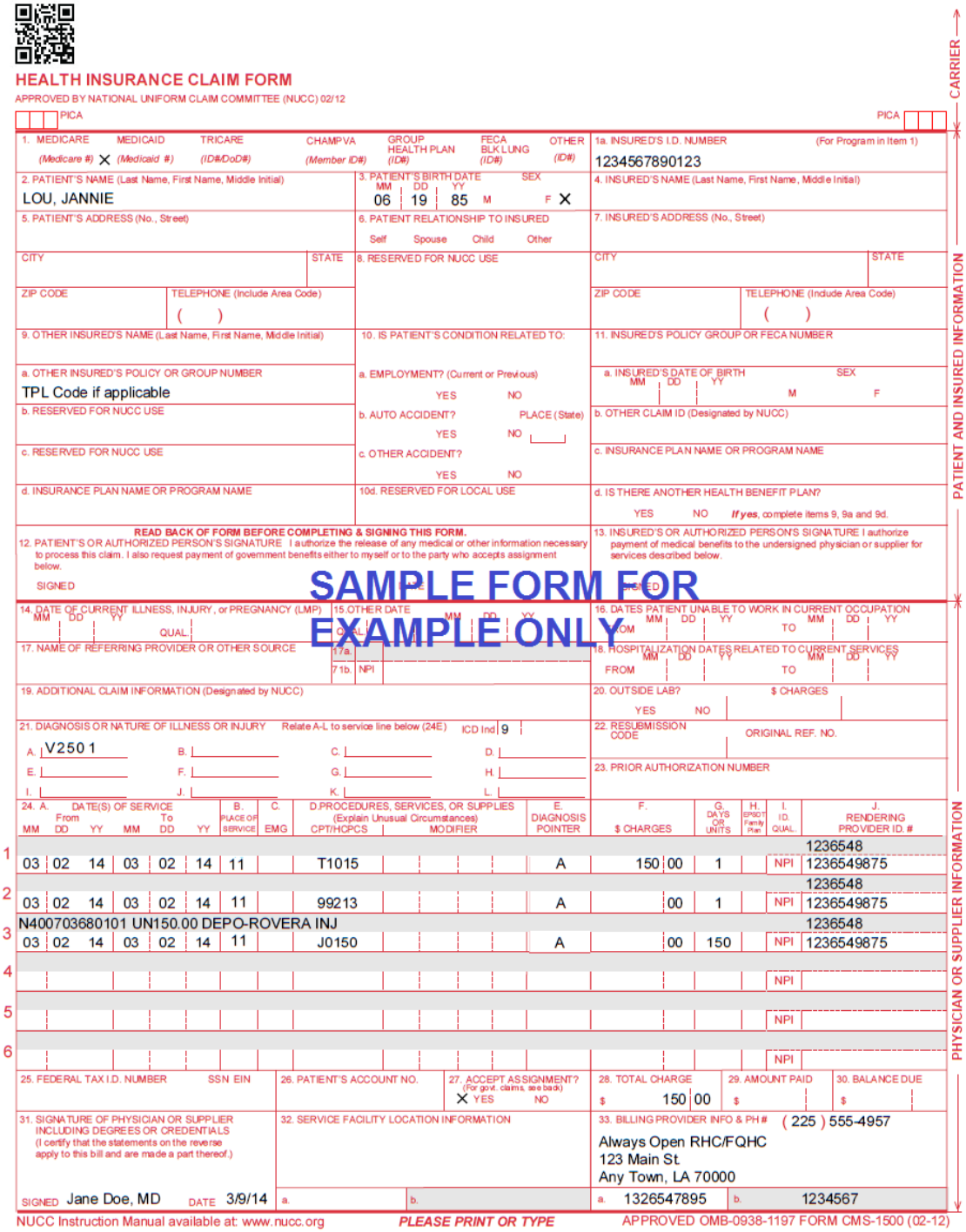
| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 23 | Prior Authorization Number | Situational – Complete if appropriate or leave blank.<br><br>If the services being billed must be prior authorized, the 9 digit numeric PA number is required to be entered. | |
| 24 | Supplemental Information | Situational – Applies to the detail lines for drugs and biologicals only.<br><br>CURRENTLY, THIS IS NOT A REQUIREMENT FOR RHC PROVIDERS.<br><br>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. Claims for these drugs shall include the NDC from the label of the product administered.<br><br>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.<br><br>Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.<br><br>The following qualifiers are to be used when reporting NDC units:<br><br>F2 International Unit<br>ML Milliliter<br>GR Gram<br>UN Unit | RHCs who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s) |
| 24A | Date(s) of Service | Required -- Enter the date of service for each procedure.<br><br>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 24B | Place of Service | Required -- Enter the appropriate place of service code for the services rendered. | |
| 24C | EMG | Situational – Complete if appropriate or leave blank. | |
| 24D | Procedures, Services, or Supplies | Required -- Enter the procedure code(s) for services rendered.<br><br>Enter the appropriate encounter procedure code on the first line.<br><br>Encounter Codes:<br>• RHC encounter visit: T1015<br>• RHC obstetrical service: T1015 w/TH modifier.<br>• RHC EPSDT service: T1015 w/EP modifier.<br><br>In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered. | If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.<br><br>For claims involving TPL, a claim line with the encounter code and the encounter rate must be added to the claim. |
| 24E | Diagnosis Pointer | Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A" "B", etc.) in this block.<br>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. | |
| 24I | I.D. Qual. | Optional. | |
| 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.<br><br>Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional. | |
| 25 | Federal Tax I.D. Number | Optional. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 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.<br><br>Enter '0' if the third party did not pay.<br><br>If TPL does not apply to the claim, leave blank. | |
| 30 | Rsvd for NUCC use | Leave Blank. | |
| 31 | Signature of Physician or Supplier Including Degrees or Credentials<br><br>Date | Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required.<br><br>Required -- Enter the date of the signature. | |
| 32 | Service Facility Location Information | Situational – Complete as appropriate or leave blank. | |
| 32a | NPI | Optional. | |
| 32b | Unlabelled | Optional. | |
| 33 | Billing Provider Info & Ph # | Required -- Enter the provider name, address including zip code and telephone number. | |
| 33a | NPI | Optional | |
| 33b | Unlabelled | Required – Enter the billing provider's 7-digit Medicaid ID number.<br><br>ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing. | The 7-digit Medicaid Provider Number must appear on paper claims. |

**Sample form on the following page**

## Sample of RHC CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | 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 SEX 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)

CITY | STATE

8. RESERVED FOR NUCC USE

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

SAMPLE FORM FOR EXAMPLE ONLY

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. V2501 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. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 03 02 14 | 03 02 14 | 11 | | T1015 | | A | 150 00 | 1 | | NPI | 1236548 1236549875 |
| 2 | 03 02 14 | 03 02 14 | 11 | | 99213 | | A | 00 | 1 | | NPI | 1236548 1236549875 |
| 3 | N400703680101 UN150.00 DEPO-ROVERA INJ 03 02 14 | 03 02 14 | 11 | | J0150 | | A | 00 | 150 | | NPI | 1236548 1236549875 |
| 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) X YES NO

28. TOTAL CHARGE $ 150 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 Jane Doe, MD DATE 3/9/14

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # ( 225 ) 555-4957
Always Open RHC/FQHC
123 Main St.
Any Town, LA 70000
a. 1326547895 b. 1234567

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

## 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 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.

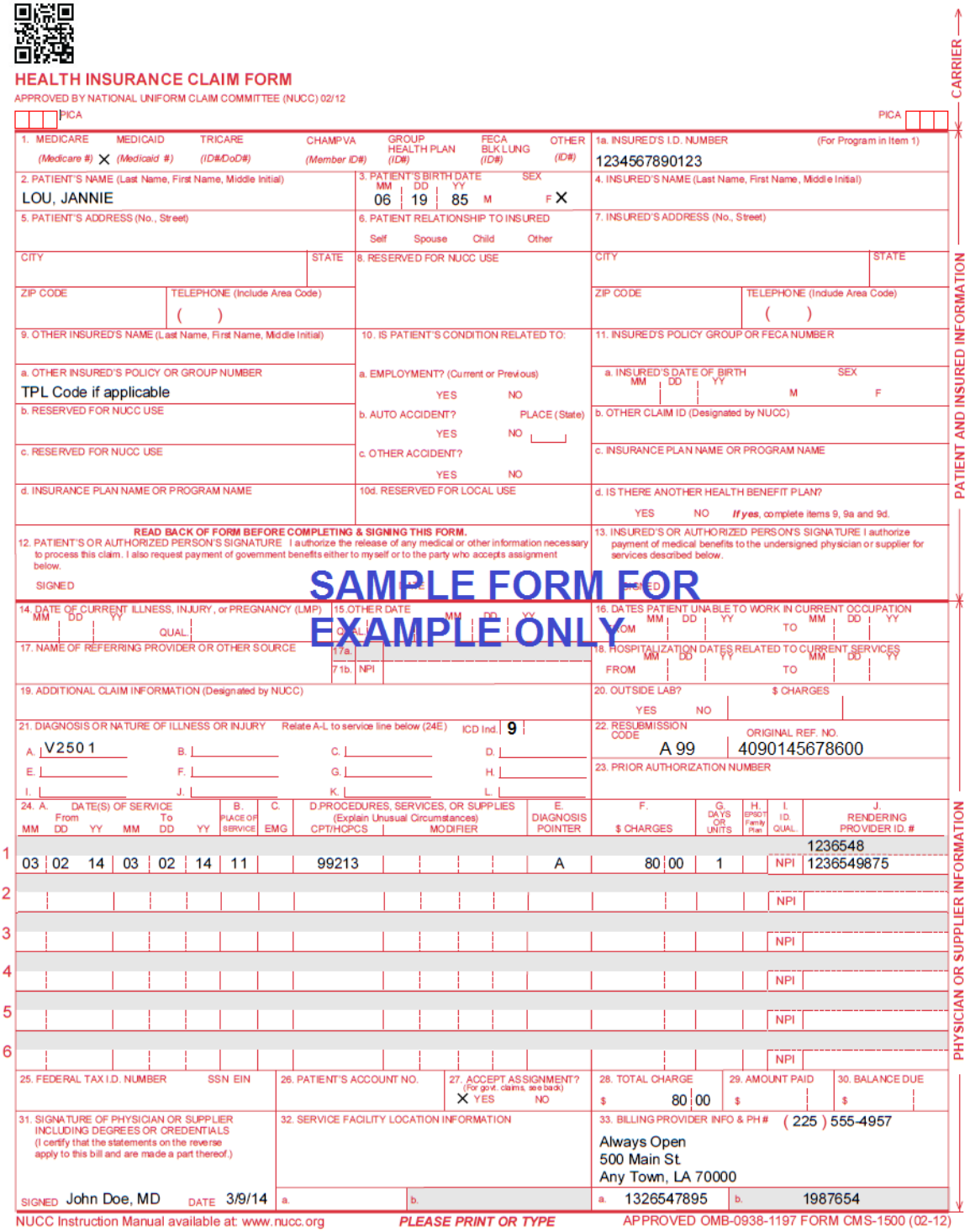
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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.

**A sample form is on the following page**

## Sample of a Claim Form Adjustment



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | 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 SEX 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)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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

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

SAMPLE FORM FOR EXAMPLE ONLY

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. V2501 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: A 99 ORIGINAL REF. NO.: 4090145678600

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. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 03 02 14 | 03 02 14 | 11 | | 99213 | | A | 80 00 | 1 | | NPI | 1236548 1236549875 |
| 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) 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

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# ADA Claim Form Billing Instructions for RHC Services

## Medicaid EPSDT Dental and Adult Denture Program Services

The 2006 American Dental Association Claim Form is the only hardcopy dental claim form accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program or Adult Denture Program. These claim forms may be obtained by contacting the American Dental Association or your dental supply company.

The following billing instructions correspond to the 2006 ADA Claim Form.

**Required** information must be entered to ensure claims processing.

**Situational** information may be required only in certain situations as detailed in each instruction item.

Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form.

EPSDT Dental Program and Adult Denture Program claims should be submitted to:

Molina Medicaid Solutions
P. O. Box 91022
Baton Rouge, LA 70821

# ADA Claim Form Billing Instructions for RHC Services

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 1 | Type of Transaction | Required -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.<br><br>Situational – Check box marked "EPSDT Title XIX" if patient is Medicaid eligible and under 21 years of age.<br><br>If block is not checked, the claim will be processed as an adult claim. | If a claim is being submitted for payment, you must mark "Statement of Actual Services" in Block 1 of the claim form.<br><br>Claims for payment that are sent to Molina Medicaid Solutions should never include radiographs. |
| 2 | Predetermination / Preauthorization Number | Situational – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization. | |
| 3 | Company / Plan Name, Address, City, State, Zip Code | Situational – Enter the primary payer information if applicable. | |
| 4 | Other Dental or Medical Coverage? | Situational – If yes, complete Block 9. | |
| 5 | Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) | Situational. | |
| 6 | Date of Birth (MM/DD/CCYY) | Situational. | |
| 7 | Gender | Situational. | |
| 8 | Policyholder/Subscriber ID | Situational. | |
| 9 | Plan/Group Number | Situational –<br><br>If there is other coverage, the state assigned 6-digit TPL carrier code is required in this block. This code is returned through MEVS recipient eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, www.lamedicaid.com.. (The carrier code list can be found at www.lamedicaid.com under the Forms/Files link)<br><br>If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 10 | Patient's Relationship to Person Named in #5 | Situational. | |
| 11 | Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code | Situational. | |
| 12 | Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code | Required -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS.<br><br>Recipient's address is optional. | |
| 13 | Date of Birth (MM/DD/CCYY) | Required -- Enter the recipient's eight-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. | |
| 14 | Gender | Optional – Check appropriate block. | |
| 15 | Policyholder/Subscriber ID | Required -- Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS.<br><br>Do not use the sixteen-digit Card Control Number (CCN) from the recipient's Medicaid card. | |
| 16 | Plan / Group Number | Situational. | |
| 17 | Employer Name | Situational. | |
| 18 | Relationship to Policyholder/Subscriber in #12 above. | Situational. | |
| 19 | Student Status | Situational. | |
| 20 | Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code | Situational. This field should be used only when other private insurance is primary.<br><br>Note: The Medicaid recipient's name is required to be entered in Block 12. | |
| 21 | Date of Birth (MM/DD/CCYY) | Situational. | |
| 22 | Gender | Situational. | |
| 23 | Patient ID / Account # (Assigned by Dentist) | Optional – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice.<br><br>The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters. | |
| 24 | Procedure Date (MM/DD/CCYY) | Required -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.<br><br>A service must have been performed/delivered before billing Medicaid for payment. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 25 | Area of Oral Cavity | Situational – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding oral cavity designator.<br><br>If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter in Block 27. | Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator. |
| 26 | Tooth System | Leave Blank | |
| 27 | Tooth Number(s) or Letter(s) | Situational – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number or letter.<br><br>If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator in Block 25. | Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator. |
| 28 | Tooth Surface | Situational – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes:<br>B = Buccal<br>D = Distal<br>F = Facial<br>I = Incisal<br>L = Lingual<br>M = Mesial, and<br>O = Occlusal<br><br>Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 29 | Procedure Code | Required – Enter the all-inclusive encounter code (D0999) on the first line then enter the appropriate dental procedure codes from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule. | REMINDER: The all inclusive encounter code (D0999) must be entered on the 1st line of the claim form. Tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered. |
| 30 | Description | Required – Enter the description of the service performed. | |
| 31 | Fee | Required -- Enter the dentist's full (usual and customary) fee for the dental procedure reported. | |
| 32 | Other Fee(s) | Leave Blank | |
| 33 | Total Fee | Required – Total of all fees listed on the claim form. | |
| 34 | (Place an 'X' on each missing tooth) | Situational – Complete if applicable.<br>Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".<br>In the following circumstances, this information is required:<br>If the claim is for the Adult Denture Program.<br>If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 35 | Remarks | Situational – Enter the amount paid by the primary payor if block 9 is completed.<br><br>Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [$0] payment) in this block.<br><br>Enter any additional information required by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include).<br><br>For prior authorization requests, if the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record. | |
| 36 | Authorizations | Optional. | |
| 37 | Authorizations | Optional. | |
| 38 | Place of Treatment | Situational – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48.<br><br>If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is required. | |
| 39 | Number of Enclosures | Situational – Enter 00 to 99 in applicable boxes.<br><br>Claims submitted for prior authorization are required to contain the identified attachments.<br><br>Claims submitted for payment should not contain any of the attachments listed in Block 39. | |
| 40 | Is Treatment for Orthodontics? | Situational – Complete if applicable.<br><br>Claims requesting comprehensive orthodontic services are required to enter information in this block.<br><br>Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 41 | Date Appliance Placed | Situational. | |
| 42 | Months of Treatment Remaining. | Situational. | |
| 43 | Replacement of Prosthesis | Situational – Check appropriate box if applicable; if checked, complete Block 44 if known. | |
| 44 | Date Prior Placement | Situational – If Block 43 is checked and if known, enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY). | |
| 45 | Treatment Resulting from | Situational – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is required. Check the appropriate box. | |
| 46 | Date of Accident (MM/DD/CCYY). | Situational. If Block 45 is completed, then this block is required. Enter the eight-digit date in month, day and year (MM/DD/CCYY). | |
| 47 | Auto Accident State | Situational. If Auto Accident is checked in Block 45, this block is required. Enter the state in which the auto accident occurred. | |
| 48 | Billing Dentist Name, Address, City, State, Zip Code | Required. Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group.<br><br>Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made. | |
| 49 | NPI | Optional – Enter the billing provider's 10-digit NPI number. | |
| 50 | License Number | Optional. | |
| 51 | SSN or TIN | Optional. | |
| 52 | Phone Number | Required -- Enter the phone number for the billing dental provider. | |
| 52A | Additional Provider ID | Required – Enter the 7-digit Medicaid Provider ID of the billing dental provider. | |
| 53 | Signature | Optional. | |
| 54 | NPI | Optional – Enter the 10-digit NPI of the treating (attending) dental provider | |
| 55 | License Number | Required – Enter the license number of the treating (attending) dental provider. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 56 | Address, City, State, Zip Code | Situational – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48. | |
| 56A | Provider Specialty Code | Optional. | |
| 57 | Signature | Optional. | |
| 58 | NPI | Optional – Enter the 10-digit NPI of the treating (attending) dental provider | |

## Sample of ADA Claim Form

**ADA Dental Claim Form**

MSA 07-02
Attachment 1

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[X] EPSDT/Title XIX

2. Predetermination/Preauthorization Number: 123456789

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE**

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number: TPL Carrier Code | 10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:
Brown, Wade
8269 Chilly Rd
Winter, LA 70000

13. Date of Birth (MM/DD/CCYY): 08/14/2004 | 14. Gender [X] M [ ] F | 15. Policyholder/Subscriber ID (SSN or ID#): 1234567890123

16. Plan/Group Number | 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender [ ] M [ ] F | 23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|
| 1 | 1/14/12 | | | | | D0999 | Encounter - All Inclusive | 100.00 |
| 2 | 1/14/12 | 10 | | | | D4341 | Periodontal Scaling and Root Planing | 110.00 |
| 3 | 1/14/12 | | | 13 | | D2954 | Post & Core | 94.00 |
| 4 | 1/14/12 | | | 15 | | D2931 | Stainless Steel Crown | 140.00 |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)

| Permanent | | | | | | | | | | | | | | | | Primary | | | | | | | | | | 32. Other Fee(s) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J | | |
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K | 33. Total Fee | 444.00 |

35. Remarks: If TPL involved: write the words "Carrier Paid" and enter the amount paid by the TPL here.

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment: [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99): Radiographic(s) | Oral Image(s) | Model(s)

40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from: [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code:
XYZ Dental Group
8956 No Cavity Ave.
Smiley, LA 700000

49. NPI: 1987654321 | 50. License Number | 51. SSN or TIN

52. Phone Number: 222-999-4444 | 52A. Additional Provider ID: 1234567

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Dr. Mary Cleanteeth 3/14/12
Signed (Treating Dentist) Date

54. NPI: 1234567890 | 55. License Number: 99999

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID: 1987654

## EPSDT Dental Services Adjustment/Void (209) and Adult Dental Services Adjustment/Void (210) Form

The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service.

Additionally, when submitting adjustments/voids for the Adult Denture Program for all dates of service, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04).

For both adjustment/void forms, the Form Locator 15 has been renamed as "Patient I.D./Account# Assigned by Dentist". If the patient's account (medical record) number is entered here, it will appear on the Medicaid Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

Providers can obtain these forms from Molina Medicaid Solutions or through the Louisiana Medicaid website at www.lamedicaid.com. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

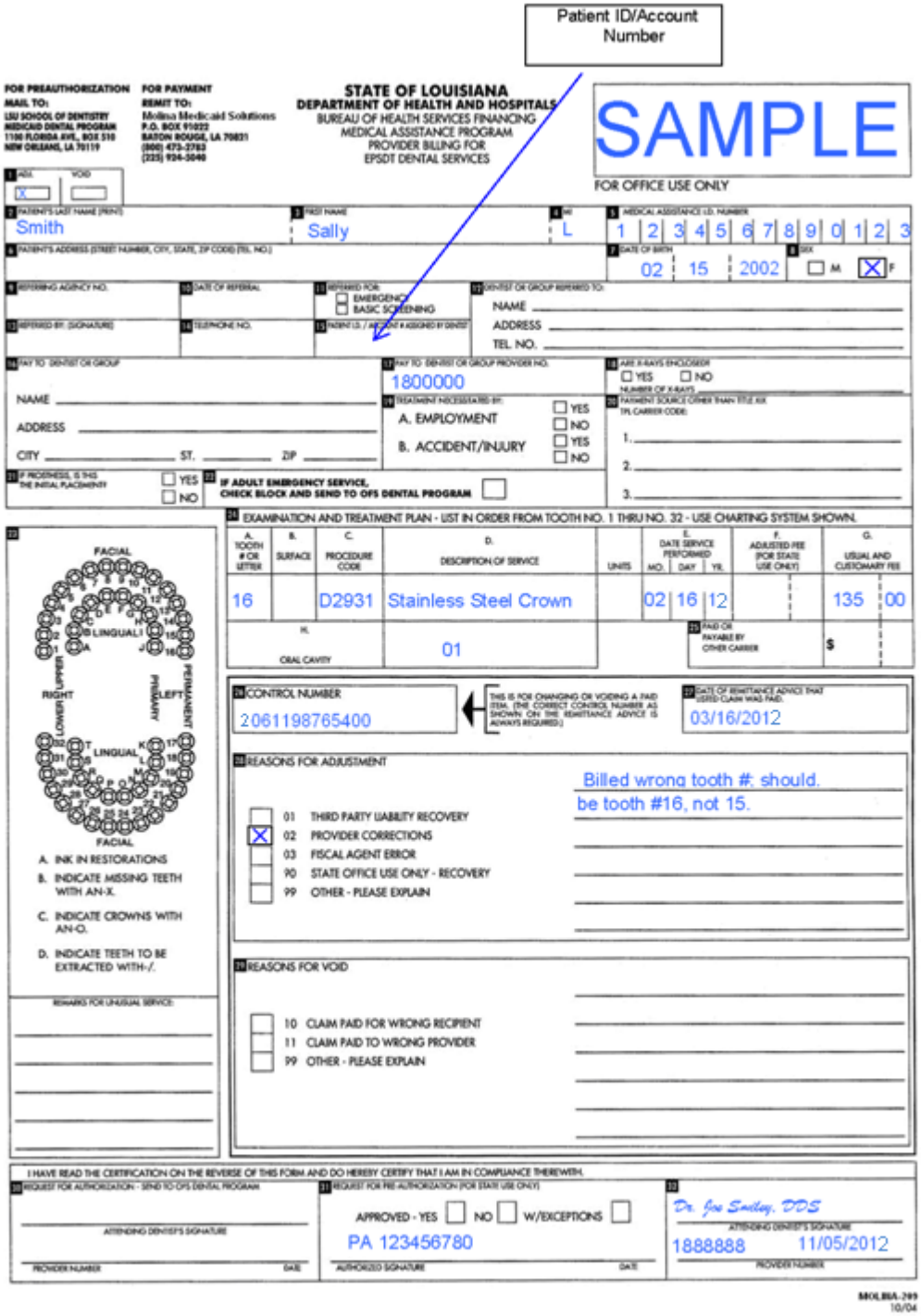
# Instructions for Completing 209 Adjustment/Void Form (EPSDT)

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 1 | Adj/Void | Check the appropriate box. | |
| 2<br>3<br>4 | Patient's Last Name First Name<br>MI | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 5 | Medical Assistance ID Number | Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.<br>Void - Enter the information exactly as it appeared on the original invoice. | |
| 6 | Patient's Address | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 7 | Date of Birth | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 8 | Sex | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 9-14 | | Not Required | |
| 15 | Patient ID/Account Number (Assigned By Dentist) | Adjust – Enter the information exactly as it appeared on the original invoice<br>Void – Enter the information exactly as it appeared on the original invoice | |
| 16 | Pay to Dentist or Group | Adjust – Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 17 | Pay to Dentist or Group Provider No. | Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.<br>Void – Enter the information exactly as it appeared on the original invoice | |
| 18 | Are X-Rays Enclosed | Not required | |
| 19 | Treatment Necessitated By | Adjust - Enter the information exactly as it appeared on the original invoice.<br>Void - Enter the information exactly as it appeared on the original invoice. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 20 | Payment Source Other Than Title XIX | Adjust - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code.<br>Void - Enter the information exactly as it appeared on the original invoice. | |
| 21, 22 | | Leave these spaces blank | |
| 23 | Diagram | Not required | |
| 24 | Examination and Treatment Plan | Adjust - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 25 | Paid or Payable by Other Carrier | Adjust - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0).<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 26 | Control Number | Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved. | |
| 27 | Date of Remittance Advice | Enter the date of the Remittance Advice that paid or denied claim | |
| 28, 29 | Reasons for Adjustment/Void | Check the appropriate box and give a written explanation, when applicable. | |
| 30 | Request for Authorization | Leave this space blank. | |
| 31 | Request for Prior Authorization | Enter the 9 digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization | |
| 32 | Attending Dentist's Provider Number | The provider number must be entered. | |

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Molina Medicaid Solutions for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

## Sample of 209 Adjustment/Void Form (EPSDT)



# Instructions for Completing 210 Adjustment/Void Form (Adult)

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 1 | Adj/Void | Check the appropriate box. | |
| 2<br>3<br>4 | Patient's Last Name First Name<br>MI | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 5 | Medical Assistance ID Number | Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.<br>Void - Enter the information exactly as it appeared on the original invoice. | |
| 6 | Patient's Address | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 7 | Date of Birth | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 8 | Sex | Adjust - Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 9-14 | | Not Required | |
| 15 | Patient ID/Account Number (Assigned By Dentist) | Adjust – Enter the information exactly as it appeared on the original invoice<br>Void – Enter the information exactly as it appeared on the original invoice | |
| 16 | Pay to Dentist or Group | Adjust – Enter the information exactly as it appeared on the original invoice<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 17 | Pay to Dentist or Group Provider No. | Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.<br>Void – Enter the information exactly as it appeared on the original invoice | |
| 18 | Are X-Rays Enclosed | Not required | |
| 19 | Treatment Necessitated By | Adjust - Enter the information exactly as it appeared on the original invoice.<br>Void - Enter the information exactly as it appeared on the original invoice. | |

| Locator # | Description | Instructions | Alerts |
|---|---|---|---|
| 20 | Payment Source Other Than Title XIX | Adjust - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code.<br>Void - Enter the information exactly as it appeared on the original invoice. | |
| 21 | | Not required | |
| 22 | | Leave blank | |
| 23 | A-G | Adjust – Enter the information exactly as it appeared on the original invoice unless this information is being adjusted.<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 24 | Paid of Payable by Other Carrier | Adjust – Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0).<br>Void - Enter the information exactly as it appeared on the original invoice | |
| 25 | Other Information | Leave blank | |
| 26 | Control Number | Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved. | |
| 27 | Date of Remittance Advice | Enter the date of the Remittance Advice that paid or denied claim | |
| 28, 29 | Reasons for Adjustment/Void | Check the appropriate box and give a written explanation, when applicable. | |
| 30 | Request for Authorization | Leave this space blank. | |
| 31 | Request for Prior Authorization | Enter the 9 digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization | |
| 32 | Attending Dentist's Provider Number | The provider number must be entered. | |

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Molina Medicaid Solutions for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

## Sample of 210 Adjustment/Void Form (Adult)