CLAIMS RELATED INFORMATION

This appendix contains the following information:

- Instructions for billing using the CMS-1500 Claim Form
- Samples of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim
- Samples 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

LOUISIANA MEDICAID PROGRAM

CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS RELATED INFORMATION

PAGE(S) 32

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:

DXC Technology P.O. Box 91020 Baton Rouge, LA 70821

Services may be billed using:

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

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

This appendix includes the following:

• Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and

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

LOUISIANA MEDICAID PROGRAM

CHAPTER 40: RURAL HEALTH CLINICSAPPENDIX D: CLAIMS RELATED INFORMATIONPAGE

PAGE(S) 32

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

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's ID 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 <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	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).	
	Sex	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 NUCCUse	Leave Blank.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. This carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	ONLY the 6-digit code should beentered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	Reserved for NUCCUse	Leave Blank.	
9с	Reserved for NUCCUse	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
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 block is required: 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	Unlabeled	Leave Blank.	
17b	NPI#	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM Required – Enter the most current ICD diagnosis code. NOTE: The ICD-10 External Cause of Injury Codes, the "V", "W", "X", and "Y" diagnosis series codes are allowable as non-primary diagnoses codes when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable. ICD-10diagnosis codes must be used on claims for dates of service 10/1/15 forward. 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)
22	Resubmission Code and/or Original Reference Number	Situational. Iffiling an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	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 (PA) Number	Situational – Complete if appropriate or leave blank. 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. CURRENTLY, THIS IS NOT A REQUIREMENT FOR RHC PROVIDERS. 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 <u>shallbe</u> <u>entered</u> in the shaded section of 24A through 24G. Claims for these drugs shall include the NDC from the label of the product administered. 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. 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. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram 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. 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. Enter the appropriate encounter procedure code on the first line. Encounter Codes: • RHC encounter visit: T1015 • RHC obstetrical service: T1015 w/TH modifier. • RHC EPSDT service: T1015 w/EP modifier. • RHC Behavioral Health encounter visit H2020 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. 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. More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	Required Enter usual and customary charges, or zero when appropriate, 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	ID Qualifier	Optional.	

Locator #	Description	Instructions	Alerts
24J	Rendering Provider ID	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 ID 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 . Claimfiling acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
		Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor.	
29	Amount Paid	Enter '0' if the third party did not pay.	
		If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional . – The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI#	Optional.	
32b	Other ID#	Optional.	
33	Billing Provider Info & Phone #	Required Enter the provider name, address including zip code and telephone number.	

PAGE(S) 32

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

Sample forms on the following pages

Sample of RHC CMS-1500 Claim Form with ICD-10 Diagnosis Code

HEALTH INSURANCE CLAIM FOR PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE TTTPICA	E (NUCC) 02/12							PICA
1. MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP	FECA	OTHER	1a. INSURED'S I.D. N	MBER	ß	For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#)	(Member ID4	GROUP HEALTH PLA (/D#)	N BLKLUNG (IDII)	(IDII)	123456789012			arriagen in main 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initia	si) (le	MM DD	TDATE SEX		4. INSURED'S NAME		First Name, Midd	le initial)
LOU, JANNIE			85 M	FX				
PATIENT'S ADDRESS (No., Street)	e	Solf Spouse	ONSHIP TO INSURE Child Off		7. INSURED'S ADDRE	:55 (NO., 5)	(reet)	
лтү	STATE 8	RESERVED FOR			CITY			STATE
							and an and the	
IP CODE TELEPHONE (Indude A	rea Code)				ZIP CODE		TELEPHONE (Inc	sude Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Mil	ddie loifiel)	10 IS PATIENT'S C	ONDITION RELATE	DTO	11. INSURED'S POLIC	YGROUP	OR FECA NUMBE	R
Content and on a boot and the part of the rest of the	ours in noisy	IN INFAILURE OF		0.10.	11	in one of	Chi i con i cino	
OTHER INSURED'S POLICY OR GROUP NUMBER		EMPLOYMENT?	(Current or Previous)		a INSURED'S DATE	E OF BRTH	1	SEX
PL Code if applicable		YE					м	F
RESERVED FOR NUCCUSE	1	AUTO ACCIDENT	PLAC	CE (State)	b. OTHER CLAIMID (Designated	by NUCC)	
RESERVED FOR NUCC USE		A	VP	Ė	G. INSURANCE PLAN	NAME OR	PROGRAM NAME	
		YE	IS NO					
INSURANCE PLAN NAME OR PROGRAM NAME	17.000	01 RESERVED FO	R LOCAL USE	1111	d. IS THERE ANOTHE	R HEALTH	BENEFIT PLAN?	N.
	YA I	ADI	EO	C I	CD_1		ves, complete item	C. S. C. S. C. S. C. S. C.
READ BACK OF FORM BELOR	E / I I DI C						DED CAN'S SIGN	NATURE I authorize
PATIENTS OR AUTHORIZED PERSON'S SIGNATION	almarize he	Sease or any medice	RM	necessary	1 INSULED SOR A payment of medica	nuerte as to		physician or supplier for
PATIENTS OR AUTHORIZED PERSONS SIGNATIons to process this claim. I also request payment of governme below.	aumerize tre int benefits either to	Sense of any medic myself or to the party	RM For other information who accepts assignment	nent	1 INSULED SOR A payment of medica services described	below.		
to process this claim. I also request payment of governme	aumenize the internet to	Sector of any mode myself or to the party DATE	RM For over information who accepts assignment	n Hecessary nent		below.		
to process this claim. Lake request payment of governme below. SIGNED		DATE	RM To other information who accepts assigns	n mecessary nent	SIGNED	below.	WORK IN CURR	ohysician or supplier for
to process this claim. I also request payment of governme below. SIGNED	ICY (LMP) 15.0T QUAL	DATE		nent	SIGNED SIGNED 16. DATES PATIENT I MM DC FROM	JNABLETC	WORK IN CURR TO	ENT OCCUPATION
to process this claim. I also request payment of governme below. SIGNED	ICY (LMP) 15.OT QUAL ROE 17a			nent	SIGNED SIGNED 16. DATES PATIENT (FROM 18. HOSPITAL (ZATION MM DO MM DO	JNABLETC	WORK IN CURR TO ELATED TO CURR	ENT OCCUPATION
to process this claim. I also request payment of governme below. SIGNED LOATE OF CURRENT ILLNESS, INJURY, or PREGNAN MALE OF REPERTING PROVIDER OR OTHER SOU	ICY (LMP) 15.0T QUAL ROE 17a 71b. 1	DATE		nent	SIGNED SIGNED 16. DATES PATIENT I MM DC FROM	JNABLETC	WORK IN CURR TO	
to process this claim. I also request payment of governme below. SIGNED	ICY (LMP) 15.0T QUAL ROE 17a. 71b. 1 IUOC)			n ent	SIGNED SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL ZATION FROM 20. OUTSIDE LAB? YES	JNABLETC	D WORK IN CURR TO ELATED TO CURR TO	ENT OCCUPATION
to process this claim. I also request payment of governme below. SIGNED I GATE OF CURRENT ILLNESS, INJURY, or PREGNAN MATE OF CURRENT ILLNESS, INJURY, or PREGNAN OVER OF REFERRING PROVIDER OR OTHER SOUL 9. ADDITIONAL CLAIM INFORMATION (Designated by N I DAGNOSIS OR NATURE OF ILLNESS OR INJURY	ICY (LMP) 15.0T QUAL ROE 17a. 71b. 1 IUOC)			1 Hoodsart	SIGNED SIGNED 16. DATES PATIENT (FROM 18. HOSPITALIZATION FROM 20. OUTSIDE LAB?	JNABLE TC	D WORK IN CURR TO ELATED TO CURR TO	ENT OCCUPATION I DD VY VY PENT SERVICES S
to process this claim. I also request payment of governme below. SIGNED I ANTE OF CURRENT ILLNESS, INJURY, or PREGNAN WITE OF CURRENT ILLNESS, INJURY, or PREGNAN I ANTE OF REFERRING PROVIDER OR OTHER SOUL A ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A, JZ30011 8. [ICY (LMP) 15 OT QUAL ROE <u>17a</u> 71b. 1 IUOC) Relate A-L to serv C. L			Invoesary	Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL ZATION FROM 20. OUTSIDE LA B? YES 22. RESUBMISSION CODE	JNABLETC	the undersigned p O WORK IN CURR TO MM ELATED TO CUR TO \$ CHARGE ORIGINAL REF. I	ENT OCCUPATION
to process this claim. I also request payment of governme below. SIGNED I ANTE OF CURRENT ILLNESS, INJURY, or PREGNAN WITE OF CURRENT ILLNESS, INJURY, or PREGNAN I ANTE OF REFERRING PROVIDER OR OTHER SOUL A ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A, JZ30011 8. [ICY (LMP) 15 OT QUAL ROE 172 71b 1 IUOC) Relate A-L to serv C. L G. L				Services described SIGNED 16. DATES PATIENT (FROM 18. HOSPITAL (ZATION MM FROM 20. OUTSIDE LAB? YES	JNABLETC	the undersigned p O WORK IN CURR TO MM ELATED TO CUR TO \$ CHARGE ORIGINAL REF. I	ENT OCCUPATION
to process this claim. I also request payment of governme below. SIGNED ATE OF CURRENT ILLNESS, INJURY, or PREGNAN MATE OF CURRENT ILLNESS, INJURY, or PREGNAN ALL OF CONTRENT ILLNESS, INJURY, or PREGNAN AND CONTRENT ILLNESS, INJURY, or PREGNAN ADDITIONAL CLAIM INFORMATION (Designated by N DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. JZ30011 B. L 4. DATE(S) OF SERVICE B. C	ICY (LMP) 15.0T QUAL ROE 17.6.1 IUOC) Relate A-L to serv C G K D. PROCED	DATE			Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL ZATION FROM 20. OUTSIDE LA B? YES 22. RESUBMISSION CODE	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	D WORK IN CURR TO MURE IN CURR ELATED TO CURI TO \$ CHARGE ORIGINAL REF. I MBER	Invision or supplier for
to process this claim. I also request payment of governme bidow. SIGNED OVER EVENT ILLNESS, INJURY, or PREGNAN OUAL QUAL OUAL	ICY (LMP) 15.07 QUAL ROE 17a 17b 1 100C) Rolate A-L to serv C. L G. L	DATE		E Indoessary	Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL ZATION FROM 20. OUTSIDE LA B? YES 22. RESUBMISSION CODE	JNABLETC	TO WORK IN CURR TO MARE IN CURR TO MA ELATED TO CUR TO S CHARGE ORIGINAL REF. (MBER HID TO MBER	Physician or supplier for ENT OCCUPATION DD YY PENT SERVICES S NO. RENDERING PROVIDER ID. #
to process this claim. I also request payment of governme below. SIGNED OVER OF CURRENT ILLNESS, INJURY, or PREGNAN MATE OF CURRENT ILLNESS, INJURY, or PREGNAN MATE OF CURRENT ILLNESS, INJURY, or PREGNAN OUTONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [23 00 11 B.] EF	ICY (LMP) 15.0T QUAI QUAI ROE 17a. 17b.1 1 IUOC) C C	DATE		E IAGNOSIS POINTER	Services described SIGNED 16. DATES PATIENT I FROM MINION FROM 10. INTERPATIENT FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 23. PRIOR AUTHORIZ 5. CHARGES	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	TO WORK IN CURR TO MARK IN CURR TO MARK ELATED TO CUR TO S CHARGE ORIGINAL REF. 1 MBER	Physician or supplier for ENT OCCUPATION I DD YY RENT SERVICES S NO. RENDERING PROVIDER ID # 36548
to process this claim. I also request payment of governme below. SIGNED OVER OF CURRENT ILLNESS, INJURY, or PREGNAN MATE OF CURRENT ILLNESS, INJURY, or PREGNAN MATE OF CURRENT ILLNESS, INJURY, or PREGNAN OUTONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [23 00 11 B.] EF	ICY (LMP) 15.07 QUAL RCE 17a 17b 1 100C) Relate A-L to serv C. L G. L D. PROCEE (Solid	DATE		E	Services described SIGNED 16. DATES PATIENT I FROM FROM FROM CONSTRUCTION FROM CONSTRUCTION CONSTRUCTION 20. OUTSOURCE LAB? 22. RESUBMISSION COOSE 23. PRIOR AUTHORIZ F.	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	DWORK IN CURR TO MMR ELATED TO CUR S CHARGE ORIGINAL REF. 1 MBER MBER MBER 1 1 12 NPI 12	Invision or supplier for
to process this claim. I also request payment of governme biox. SIGNED ATE OF CURRENT ILLNESS, INJURY, or PREGNAN QUAL NAME OF REPERRING PROVIDER OR OTHER SOUL ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY , IZ30011 B E F. L J. RAME OF SERVICE From DD M DD V NM D1 15 10 10	ICY (LMP) 15.0T QUAI QUAI ROE 17a. 17b.1 1 IUOC) C C	DATE		E IAGNOSIS POINTER	Services described SIGNED 16. DATES PATIENT I FROM MINION FROM 10. INTERPATIENT FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 23. PRIOR AUTHORIZ 5. CHARGES	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	D WORK IN CURR TO MM ELATED TO CUR BLATED TO CUR TO \$ CHARGE ORIGINAL REF. 1 MBER H. L. ID. ID. ID. ID. ID. ID. ID. ID. ID. ID	Physician or supplier for ENT OCCUPATION I DD YY RENT SERVICES S NO. RENDERING PROVIDER ID # 36548
10 process this claim. I also request payment of governme boxe. SIGNED Image: Signed boxer of the second sec	ICY (LMP) 15 OT QUAL RCE 17a 77b 1 77b 1 NUCC) Relate A-L to serv C. L C. L C. L C. L C. L C. L C. L C. L	DATE		E IAGNOSIS POINTER A	Services described SIGNED 16. DATES PATIENT I FROM FROM 20. OUTSOTAL CATION FROM 20. OUTSOTAL CATION FROM 20. OUTSOTAL CATION 20. OUTSOTAL CATION 20. OUTSOTAL 21. RESUMMISSION CODE 23. PRIOR AUTHORIZ F. \$ CHARGES 160, 00	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	TO WORK IN CURR TO MM ELATED TO CUR BLATED TO CUR TO \$ CHARGE ORIGINAL REF 1 MBER H L ID ID ID ID ID ID ID ID ID ID ID ID ID	PHT OCCUPATION
to process the claim L also request payment of government below. SIGNED ME OF CURRENT ILLNESS, INJURY, or PRECINAN ADD TIONAL CLAIM INFORMATION (Design ated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY 1 2300 11 8 L 1 F 2300 11 8 L 1 F 1 2300 11 8 L 2 J 1 0 115 10 10 15 11 0 10 15 10 10 15 11 400703680 101 UN150.00 DEPO-RC	ICY (LMP) 15 OT QUAL RCE 17a 77b 1 77b 1 NUCC) Relate A-L to serv C. L C. L C. L C. L C. L C. L C. L C. L	DATE		E IAGNOSIS POINTER A	Services described SIGNED 16. DATES PATIENT I FROM FROM 20. OUTSOTAL CATION FROM 20. OUTSOTAL CATION FROM 20. OUTSOTAL CATION 20. OUTSOTAL CATION 20. OUTSOTAL 21. RESUMMISSION CODE 23. PRIOR AUTHORIZ F. \$ CHARGES 160, 00	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	TO WORK IN CURR TO MURE IN CURR TO MIN ELATED TO CUR TO \$ CHARGE ORIGINAL REF. 1 MBER H 12 NE NE NE NE NE NE NE 12 NPI 12	Physician or supplier for Physician of Supplic for Physician of Supplier for Physician of Supplier
to process this claim. I also request payment of governme boxe. SIGNED SIGNED QUAL APTE OF CLURRENT ILLNESS, INJURY, or PRECINAN ALL CLAIM INFORMATION (Designated by N ADDITIONAL CLAIM INFORMATION (Designated by N DACNOSISOR NATURE OF ILLNESS OR INJURY ALZ 300 11 B C A. DATE(S) OF SERVICE From Y MM DO 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10	ICY (LMP) 15.07 QUA ROE 17a 71b 100C) Refate A-L to serv C L C L C D PROCED (Explantion (Explantion) C D PROCED (Explantion) 10015 992213 DOVERA INJ	DATE		AGNOSIS POINTER A	Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE 123. PRIOR AUTHORIZ F. \$ CHARGES 160, 00 0, 00	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	DWORK IN CURR TO MMR ELATED TO CUR S CHARGE ORIGINAL REF. 1 MBER MBER 12 NPI 12 NPI 12 NPI 12	Import occupation Import occupation
to process this claim. I also request payment of governme boxe. SIGNED SIGNED QUAL APTE OF CLURRENT ILLNESS, INJURY, or PRECINAN ALL CLAIM INFORMATION (Designated by N ADDITIONAL CLAIM INFORMATION (Designated by N DACNOSISOR NATURE OF ILLNESS OR INJURY ALZ 300 11 B C A. DATE(S) OF SERVICE From Y MM DO 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10	ICY (LMP) 15.07 QUA ROE 17a 71b 100C) Refate A-L to serv C L C L C D PROCED (Explantion (Explantion) C D PROCED (Explantion) 10015 992213 DOVERA INJ	DATE		AGNOSIS POINTER A	Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE 123. PRIOR AUTHORIZ F. \$ CHARGES 160, 00 0, 00	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	TO WORK IN CURR TO MURE IN CURR TO MIN ELATED TO CUR TO \$ CHARGE ORIGINAL REF. 1 MBER H 12 NE NE NE NE NE NE NE 12 NPI 12	Import occupation Import occupation
to process this claim. I also request payment of governme boxe. SIGNED SIGNED QUAL APTE OF CLURRENT ILLNESS, INJURY, or PRECINAN ALL CLAIM INFORMATION (Designated by N ADDITIONAL CLAIM INFORMATION (Designated by N DACNOSISOR NATURE OF ILLNESS OR INJURY ALZ 300 11 B C A. DATE(S) OF SERVICE From Y MM DO 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10	ICY (LMP) 15.07 QUA ROE 17a 71b 100C) Refate A-L to serv C L C L C D PROCED (Explantion (Explantion) C D PROCED (Explantion) 10015 992213 DOVERA INJ	DATE		AGNOSIS POINTER A	Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE 123. PRIOR AUTHORIZ F. \$ CHARGES 160, 00 0, 00	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	DWORK IN CURR TO MMR ELATED TO CUR S CHARGE ORIGINAL REF. 1 MBER MBER 12 NPI 12 NPI 12 NPI 12	Import occupation Import occupation
0 process this claim. I also request payment of governme below. SIGNED 1 AFTE OF CURRENT ILLNESS. INJURY. or PREGNAN MILL 2 ALTE OF CURRENT ILLNESS. INJURY. or PREGNAN MILL 2 ALTE OF CURRENT ILLNESS. INJURY. or PREGNAN MILL 2 ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [23 00 11 8 L 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [23 00 11 8 L 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY M DD YY MILL 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY M DD YY MILL 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY M DD YY MILL 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY M DD YY MILL 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY M DD YY MILL 1 DAGNOSIS OR NATURE OF ILLNESS OR INJURY M DD YY MILL 1 DAGNOSIS ON DI 1 D 10 15 11 1 D 10 15 10 10 15 11 1 D 10 15 11	ICY (LMP) 15.07 QUA ROE 17a 71b 100C) Refate A-L to serv C L C L C D PROCED (Explantion (Explantion) C D PROCED (Explantion) 10015 992213 DOVERA INJ	DATE		AGNOSIS POINTER A	Services described SIGNED 16. DATES PATIENT I FROM 18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE 123. PRIOR AUTHORIZ F. \$ CHARGES 160, 00 0, 00	JNABLE TY JNABLE TY JYY I DATES RI NO I KATION NUI	Pe undersigned p WORK IN CURR TO MM ELATED TO CURN TO \$ CHARGE ORIGINAL REF 1 MBER H 10 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12 12 12 12 12 12 12 12 12 12	Import occupation Import occupation
10 100 r00003 bits claim. I also request payment of governme boxe. SIGNED QUAL 1 QUAL 2 QUAL 3 ADDITIONAL CLAIM INFORMATION (Designated by N 0 DAGNOSIS OR NATURE OF ILLINESS OR INJURY 4 A FOR F. J. J. 4.0 DATE(S) OF SERVICE FOR PLACE OF FOR PLACE OF ID 10 15 10 10 15 11 400703680101 UN150.000 DEPO-RC 10 10 15 11	ICY (LMP) 15 OT OLAI ROE 17a 77b 1 ROE 77b 1 Rolate A-L to serv C L G L K L D PROCED I D PROCED I T1015 99213 DVERA INJ J1050	DATE	ICD Ind 0 YY ICD Ind 0 D	AGNOSIS POINTER A A A	Services described SIGNED 16. DATES PATIENT FROM 18. HOSPITUL ZATION FROM 20. OUTSICE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ F. \$ CHARGES 160 00 0 00 0 00	INABLETC IDATES RI I DATES RI I D	WORK IN CURR TO MMR ELATED TO CUR TO S CHARGE ORIGINAL REF. 1 MBER MBER 12 NPI 12 NPI 12 NPI 12 NPI 12 NPI 12 NPI 12 NPI 12 NPI 12 NPI 12 NPI 12	Import occupation Import occupation
10 100 r00003 bits claim. I also request payment of governme boxe. SIGNED QUAL 1 QUAL 2 QUAL 3 ADDITIONAL CLAIM INFORMATION (Designated by N 0 DAGNOSIS OR NATURE OF ILLINESS OR INJURY 4 A FOR F. J. J. 4.0 DATE(S) OF SERVICE FOR PLACE OF FOR PLACE OF ID 10 15 10 10 15 11 400703680101 UN150.000 DEPO-RC 10 10 15 11	ICY (LMP) 15 OT OLAI ROE 17a 17b 1 ROE 77b 1 ROISTO A-L to serv C L K C C L K C C L K C C TTACPC I T1015 99213 DVERA INJ J1050 20. PATIENTS AC	DATE	ICD ind. 0 ICD ind. 0 D		Services described SIGNED 16. DATES PATIENT I FROM FROM 20. OUTSOTAL CATOO FROM 20. OUTSOTAL CATOO FROM 20. OUTSOTAL 21. RESUMISSION 22. RESUMISSION 23. PRIOR AUTHORIZ F. \$ CHARGES 160 00 0 00 0 00 28. TOTAL CHARGE	INABLETC IDATES RI IDATES	Be undersigned (To MARK IN CUPR To MAR To S CHARGE ORIGINAL REF. (MBER ID	Import occurrent or supplier for Import occurrent occ
1 also request payment of governme boxes. SIGNED QUAL 1 QUAL 2 QUAL 2 QUAL 2 QUAL 3 ADD TIONAL CLAIM INFORMATION (Designated by N 0 DAGNOSIS OR NATURE OF ILLNESS. OR INJURY 4 A. 200 11 5 B	ICY (LMP) 15 OT QUA ROE 17a. 71b. 100C) Relate A-L to serv C L C L C D-PROCED (Spala CPT/HCPC 99213 DVERA INJ J1050	DATE	ICD Ind 0 YY ICD Ind 0 G I I I I I I I I I I I I I I I I I I I	AGNOSIS POINTER A A A	Services described SIGNED 16. DATES PATIENT I FROM FROM 20. OVERSITAL CATOO FROM 20. OVERSITAL CATOO FROM CONSTRUCTION FROM FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM FROM CONSTRUCTION FROM CONSTRUCTION FROM CONSTRUCTION FROM FRO	Debow.	DWORK IN CURR TO MM ELATED TO CUR TO S CHARGE ORIGINAL REF 1 MBER H 10 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12 12 NPI 12	Image: Strain
below. SIGNED 4 WIT EOCURRENT ILLNESS. INJURY. or PREGNAN QUAL 7. NAME OF REPERRING PROVIDER OR OTHER SOUL 9. ADDITIONAL CLAM INFORMATION (Designated by N 10. DAGNOSIS OR NATURE OF ILLNESS OR INJURY 4. A. DATE(S) OF SERVICE From DD 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15 10. 10. 15	ICY (LMP) 15 OT QUA ROE 17a. 71b. 100C) Relate A-L to serv C L C L C D-PROCED (Spala CPT/HCPC 99213 DVERA INJ J1050	DATE	ICD Ind 0 YY ICD Ind 0 G I I I I I I I I I I I I I I I I I I I		Services described SIGNED 16. DATES PATIENT I FROM FROM 20. OUTSOTAL CATOO FROM 20. OUTSOTAL CATOO FROM 20. OUTSOTAL 21. RESUMISSION 22. RESUMISSION 23. PRIOR AUTHORIZ F. \$ CHARGES 160 00 0 00 0 00 28. TOTAL CHARGE	Debow.	DWORK IN CURR TO MURCHINCURR ELATED TO CURN TO S CHARGE ORIGINAL REF 1 MBER 12 NPI 12 NPI 12	Import of supplier for Import occuPation

CHAPTER 40: RURAL HEALTH CLINICSAPPENDIX D: CLAIMS RELATED INFORMATIONPAGE(S) 32

Sample of a Claim Form

PICA															
MEDIÇARE MEDI	CAID TR	CARE		CHAMPVA	GRO	JIP TH PLAN		G	1a. INSURED'S I.D. I	UMBER			(For Pro	gnam in	lliem 1)
(Medicare#) (Medic		(DoD#)		(Member ED#	- Incert		(ID#)	(IDM)							
PATIENT'S NAME (Last N	lame, Finat Nome	, Middle In	ittal)	2	A PATIENT'S			SEX F	4. INSURED'S NAME	(Last Nam	ie, Arat	Name,	Middle Initi	lel)	
PATIENT'S ADDRESS (N	o., Street)				. PATIENT	RELATION	ISHIP TO INS		7. INSURED'S ADDR	E88 (No.,	Street)	-			
					Self	Spouse	Child	Other			1				
ΠY				STATE (B. RESERVE	D FOR NL	JCC USE		CITY					5	TATE
PCODE	TELEPHO	NE (Includ	le Area C	(ebo)					ZIP CODE		TELE	PHON	E (Include /	Area Co	(eb)
	())		
OTHER INSURED'S NAM	E (Last Name, F	ret Name,	Middle in	nitial) 1	IO. IS PATIE	NT'S CON	DITION FIELA	TED TO:	11. INSURED'S POL	CY GROU	PORF	ECA NU	MBER		
													-		-
OTHER INSURED'S POLI	UT OH GHOUP	NUMBER		1	R. EMPLOYN	YES	Iment or Previo	1 and the second	A. INSURED'S DATE	UF BIRTH		M		EX F	-
RESERVED FOR NUCC I	USE				. AUTO ACA			PLACE (State)	b. OTHER CLAIM ID	(Designate	d by NL				
				-		YES									
RESERVED FOR NUCC U	JSE			4	D. OTHER AU	and the second			a. INSURANCE PLAT	NAME OF	PROG	BRAM N	AME		
INSURANCE PLAN NAME	OR PROGRAM	NAME			IDd. CLAIM	YES	esignated by I		d. IS THERE ANOTH	ER HEALT	H BENI	EFIT PL	AN7		
									YES	1.05			e Items 9,	9a, and	9d.
RE PATIENT'S OR AUTHOR to process this claim. I also below.	EAD BACK OF F			WPLETING &		HIB FORM	d. other informatio	an necessary	13. INSURED'S OR A	UTHORIZE	ED PER	SONS	SIGNATU	RELaut	horiza
to process this claim. I also	o request paymer	t of govern	ment ber	nefits either to	myself or to t	the party wi	ho accepts as	Ignment	payment of medic services describe	d below.					
below.															
									RIGNED						
SIGNED	-			LMP) 15.0	DA'				SIGNED	UNABLE	io woi	RK IN C	URRENT	CCCUP.	ATION
SIGNED	NEBS, INJURY, QUAL	or PREGN	IANCY (L	LMP) 15. O	DA'		DO	w	18. DATES PATIENT MM E FROM			то			-
SIGNED	NEBS, INJURY, QUAL	or PREGN	IANCY (L	LMP) 15. 01 QUAL 17g.					18. DATES PATIENT MM E FROM 18. HOSPITALIZATIO			TO ED TO (-
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (or PREGN DTHER SC	IANCY (L	LMP) 15. 0 QUAL 17g. 17b.					18. DATES PATIENT MM E FROM			TO ED TO (TO			-
	NEBS, INJURY, QUAL PROVIDER OR (or PREGN DTHER SC	IANCY (L	LMP) 15. 0 QUAL 17g. 17b.					18. DATES PATIENT MM C FROM 18. HOSPITALIZATIC MM C FROM			TO ED TO (TO	URRENT		-
SIGNED	NESS, INJURY, QUAL PROVIDER OR (ORMATION (De	or PREGN DTHER SC signated b	IANCY (L DURCE y NUCC)	LMP) 15. O' QUAL 17e. 17b.	DA THER DATE				18. DATES PATIENT MM FROM 18. HOSPITALIZATIC MM FROM 20. OUTSIDE LAB?	IN DATES	Y	TO ED TO (TO	HARGES		-
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (CORMATION (De E OF ILLNESS C B.	or PREGN DTHER SC signated b	IANCY (L DURCE y NUCC)	A-L to service	DA THER DATE				18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION		ORIG	TO ED TO (TO & CI	HARGES		-
SIGNED	NESS, INJURY, QUAL PROVIDER OR ORMATION (DS E OF ILLNESS C	or PREGN DTHER SC signated b	IANCY (L DURCE y NUCC)	A-L to service C G	DA THER DATE		CD Ind.		18. DATES PATIENT MM 19. HOSPITALIZATIC FROM 20. OUTSIDE LAB? YES		ORIG	TO ED TO (TO & CI	HARGES		-
SIGNED	NEBS, INJURY, QUAL PROVIDEN OR (ORMATION (De E OF ILLNESS C B. F. J.	or PREGN OTHER SC signated b	URCE VIRCE Y Relate	A-L to service C K D. PROCEDI	DA' IMER DATE	24E)	CD ind.	YY 	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION		ORIG	TO ED TO (TO \$ CI IINAL RI	HARGES	J.	
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B. F.	or PREQN DTHER SC signated b	URCE VIRCE Y Relate	A-L to service C K D. PROCEDI	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	w	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? VES 22. RESUBMISSION 23. PRIOR AUTHOR		ORIG	TO ED TO (TO & CI NINAL RI	HARGES	SERVI DD	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBMISSION 23. PRIOR AUTHOR F.		ORIG	INAL R	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBMISSION 23. PRIOR AUTHOR F.		ORIG	TO ED TO (TO \$ CI IINAL RI 1 1 1 1 1 1 1	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBMISSION 23. PRIOR AUTHOR F.		ORIG	INAL R	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.		ORIG	TO ED TO 6 TO \$ CI INAL RI IL ID. QUAL NPI NPI	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.		ORIG	INAL RI	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.		ORIG	TO ED TO 6 TO \$ CI INAL RI IL ID. QUAL NPI NPI	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.		ORIG	TO ED TO (TO \$ CI INAL RI IL ID. QUAL NPI NPI NPI	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.		ORIG	TO ED TO (TO \$ CI IINAL RI IL LID. QUAL NPI NPI	HARGES	J.	RING
SIGNED	NEBS, INJURY, QUAL PROVIDER OR (ORMATION (De E OF ILLNESS C B F. J.	or PREGN OTHER SC signated b	URCE VINCC) VINCC) Fields C.	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE NPI a line below (URES, SERV Unusual Cin	24E)	CD Ind.	YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.		ORIG	TO ED TO (TO \$ CI INAL RI IL ID. QUAL NPI NPI NPI	HARGES	J.	RING
SIGNED		or PREGN OTHER SC signated b	IANCY (L DURCE y NUCC) Y Relate	LMP) 15. 01 CULU 178. 178. 176. 176. 176. 176. 176. 176. 176. 176	DA' THER DATE	24E)		YY E. DIAGNOSIS	18. DATES PATIENT FROM 18. HOSPITALIZATIC FROM 20. OUTSIDE LAB? 22. BESUBAIISSION 23. PRIOR AUTHOR F.			TO ED TO (TD & CI NINAL RI ID. QUAL NIPI NIPI NIPI NIPI	LURGENT MARGES EF. NO.	J, J, PENDE	RING
SIGNED	NEBS, IKURY, QUAL ORMATION (De E OF ILLINESS (D B) F. DD VVICE To DD VVI CE To DD VVICE To DD VVICE To DD VVICE To DD VV	B INJURY	IANCY (I. DURCE y NUCC) Y Rotate C. EMG	A-L to service C. L G. L D. PROCEDU (Explain CPT/HDPC)	DA' THER DATE		CD Ind.	E. DIAGNOSIS POINTER	19. DATES PARENT FROM 19. HOSPITALIZATIC FROM 20. OUTBIOE LAB? 22. ESSUEMISSION 23. PRIOR AUTHOR 5. \$ CHARGES			TO ED TO TO TO A CL INAL RI ID. CLAL NPI NPI NPI NPI	LURGENT MARGES EF. NO.	J, J, PENDE	RING

Adjustments and Voids

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

<u>Only a paid claim can be adjusted or voided</u>. Denied claims must be corrected and resubmitted – not adjusted or voided.

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

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment, with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under Adjustment or Voided Claim. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

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.

Sample of a Claim Form Adjustment with ICD-10 Diagnosis Code

EALTH INSURANCE CLAIM FOR						
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE	(NUCC) 02/12					PICA
MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP FECA HEALTH PLAN BLK LUN	OTHER	1a INSURED'S I.D. NUMBER	For	Program in item 1)
(Medicare #) 🗙 (Medicaid #) (ID#/DoD#)	(Member ID	#) (ID#) (ID#)	G (100)	1234567890123		
PATIENT'S NAME (Last Name, First Name, Middle Initial)	MM DD YY	SEX	4. INSURED'S NAME (Last N	ame, First Name, Middle i	nitial)
LOU, JANNIE		06 19 85 M	FX			
I. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INS Self Spouse Child	Other	7. INSURED'S ADDRESS (No	a, Street)	
CITY	STATE	Self Spouse Child 8. RESERVED FOR NUCC USE	Otran	CITY		STATE
				The second se		
TELEPHONE (Indude Ar	aa Code)			ZIP CODE	TELEPHONE (Includ	a Area Code)
()					()	
LOTHER INSUREDS NAME (Last Name, First Name, Mid	die Initial)	10. IS PATIENT'S CONDITION REL	ATED TO:	11. INSURED'S POLICY GRO	UP OR FECA NUMBER	
OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previ	DUS)	a INSURED'S DATE OF B	RTH	SEX
TPL Code if applicable		YES NO		MM DO YY	м	F
RESERVED FOR NUCCUSE			PLACE (State)	b. OTHER CLAIMID (Designa	ited by NUCC)	
		SAND				
RESERVED FOR NUCC USE			له اله	C. INSURANCE PLAN NAME	OR PROGRAM NAME	
INSURANCE PLAN NAME OR PROGRAM NAME		YES NO 10d. RESERVED FOR LOCAL USE)	d IS THERE ANOTHER HEA	TH BENEET DI AND	
					If yes, complete items 9	On and Od
READ BACK OF FORM B FOR		GIN THIS OR L		TINS RE SOR UT OF	ZED PERSON'S SIGNAT	URE I authorize
 PATIENTS OR AUTHORIZED PERSONS SIGN TOR to process this claim. Laiso request payment of government 	I authorize the r	reloase of any modeout or other into the myself or to the party who accepts as:	ation necessary signment	 playment of metacar benañ services described below. 	ts to the undersigned phys	sician or supplier for
below.				and the second sec		
SIGNED		DATE		SIGNED		
4. DATE OF CURRENT ILLNESS, INJURY, & PREGNANO			YY	16. DATES PATIENT UNABLI	TO WORK IN CURREN	DD YY
QUAL	QUA					
7. NAME OF REFERRING PROVIDER OR OTHER SOUR	CE 17a	the second s				I SERVICES
7. NAME OF RÉFERRING PROVIDER OR OTHER SOUR	20000	NPI		18. HOSPITALIZATION DATE		VT SERVICES
	715		_,	18. HOSPITALIZATION DATE	S RELATED TO CURREN	VI SERVICES
9. ADDITIONAL CLAIM INFORMATION (Designated by N	71b.	NPI		18. HOSPITALIZATION DATE	S RELATED TO CURRENT	
9. ADD TIONAL CLAIM INFORMATION (Designated by N 1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	71b.			18. HOSPITALIZATION DATE FROM	S RELATED TO CURREN TO S CHARGES ORIGINAL REF. NO.	
ADDITIONAL CLAIM INFORMATION (Designated by NI DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [71b. UOC) Relate A-L to sen C. L	vice line below (24E) ICD ind 0	l	18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUBMISSION CODE A 02	S RELATED TO CURREN TO S CHARGES ORIGINAL REF. NO 529919879870	
ADDITIONAL CLAIM INFORMATION (Designated by NI DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [71b. JOC) Relate A-L to sen C. L G. L	vice line below (24E) ICD ind. 0		18. HOSPITALIZATION DATE FROM	S RELATED TO CURREN TO S CHARGES ORIGINAL REF. NO 529919879870	
ADDITIONAL Q.AM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [Z30011 B. [F. [L J. [] A. DATE(S) OF SERVICE B. [C.]	71b. JOC) C. L G. L K. L	vice line below (24E) ICD ind 0	 E	18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION CODE A02 23. PRIOR AUTHORIZATION	S RELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO. 529919879870 NUMBER	00
ADDITIONAL CLAIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF [71b. 71b.	Vice line below (24E) ICD Ind. 0	E DIAGNOSIS POINTER	18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? 20. OUTSIDE LAB? 21. RESUMMISSION CODE A02 23. PRIOR AUTHORIZATION		00
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	S RELATED TO CURRENT TO TO \$ CHARGES ORIGINAL REF. NO 529919379870 NUMBER ************************************	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 71b.	NPI	DIAGNOSIS	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUBINISSION CODE A 02 23. PRIOR AUTHORIZATION F. B	S RELATED TO CURRENT TO TO \$ CHARGES ORIGINAL REF. NO 529919379870 NUMBER ************************************	00
ADDITIONAL Q.AIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A, [Z30011 B.] Fi. Fi. Fi. Fi. Fi. Fi. Fi. Fi. Fi.	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SRELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO. S29919879870 NUMBER a THM L S ITAN NUMBER 1236 NPI	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	S RELATED TO CURRENT TO TO \$ CHARGES ORIGINAL REF. NO 529919379870 NUMBER ************************************	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SRELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO. S29919879870 NUMBER a THM L S ITAN NUMBER 1236 NPI	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SPELATED TO CURRENT TO S CHARGES SCHARGES	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SPELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO 529919879870 NUMBER B H D 1236 NPI 1236	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SPELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO. 529919879870 NUMBER 1236 NPI 1236 NPI NPI	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SPELATED TO CURRENT TO S CHARGES SCHARGES	DO RENDERING PROVIDER ID # 1548
ADDITIONAL Q.AIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [EF EF A	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	NPI	DIAGNOSIS POINTER	19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SPELATED TO CULRENT TO S CHARGES ORIGINAL REF. NO SZ2919879870 NUMBER B ##01 ID S TREE ID NUMBER ID	DO RENDERING PROVIDER ID # 1548
ADDITIONAL CLAIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A [Z30011 B [Fr	71b. 100C) Relate A-L to sen C. L. G. L. K. L. D.PROCED (Explicit) G. CPT/HCPC	Vice line below (24E) ICD Ind D L L D L L D URES, SERVICES, OR SUPPLES an Unueval Croamstances S NOCHPIER		19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION ODDE A 02 23. PRIOR AUTHORIZATION F. GR. \$ CHARGES	SRELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO SZ291987987(NUMBER Image: Image of the second se	DO RENDERING PROVIDER ID # 1548
ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [F. [71b UCC) Relate AL to ser G. L G. L C. L C	Vice line below (24E) ICD Ind		19. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? 20. OUTSIDE LAB? 21. RESUMMISSION A 02 23. PRIOR AUTHORIZATION 5. CHARGES 160 00	SRELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO SZ291987987(NUMBER Image: Image of the second se	00 RENGERID # 548 549875
ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A [230011 B [71b UOC) Relate A-L to ser G. L K. L D.PROCE G. CPT/HCR T1015 20. PATIENTS AI 1234	Vice line below (24E) ICO Ind 0 D L H L DURES, SERVICES, OR SUPPLES an Unusual Croumstances) S MOCRER CCOUNT NO. Z7 ACCEPT, AS CCOUNT NO. Z7 ACCEPT, AS		18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION A02 23. PRIOR AUTHORIZATION F. S CHARGES UNT 160 00 28. TOTAL CHARGE	SRELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO S CHARGES S CHARGES Image: State of the s	00 RENOTER D. # 1548 1549875 30 BALANCE DUE \$ 160 00
ADDITIONAL CLAIM INFORMATION (Designated by N DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011	71b UOC) Relate A-L to ser G. L K. L D.PROCE G. CPT/HCR T1015 20. PATIENTS AI 1234	NR vice line below (24E) ICD Ind. 0		18. HOSPITAL 2ATON DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION A 02 23. PRIOR AUTHORIZATION F: \$ CHARGES 160 00 28. TOTAL CHARGE \$ 160 00 33. BILLING PROVIDER INF ALWAYS OPEN RH	SPELATED TO CURRENT TO S CHARGES ORIGINAL REF NO. 529919879870 NUMBER Image: Second Street S	00 RENOTER ID. # 1548 1549875 30. BALANCE DUE \$ 160 00 22-3333
ADOITIONAL CLAIM INFORMATION (Designated by NI DAGNOSIS OR NATURE OF ILLNESS OR INJURY A. [230011 B. [E	71b UOC) Relate A-L to ser G. L K. L D.PROCE G. CPT/HCR T1015 20. PATIENTS AI 1234	NR vice line below (24E) ICD Ind. 0		18. HOSPITAL ZATION DATE FROM 20. OUTSIDE LAB? 20. OUTSIDE LAB? 22. RESUMMISSION A 02 23. PRIOR AUTHORIZATION F. S CHARGES 160 00 24. TOTAL CHARGE S 160 00 33. BILING PROVIDER INF ALWAYS OPEN RH 123 MAIN ST	SPELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO SZ291987987(NUMBER Image: I	00 RENOTER ID. # 1548 1549875 30. BALANCE DUE \$ 160 00 22-3333
A _ 23 00 11 B _ F	71b UOC) Relate A-L to ser G. L K. L D.PROCE G. CPT/HCR T1015 20. PATIENTS AI 1234	NR vice line below (24E) ICD Ind. 0		18. HOSPITAL 2ATON DATE FROM 20. OUTSIDE LAB? YES NO 22. RESUMMISSION A 02 23. PRIOR AUTHORIZATION F: \$ CHARGES 160 00 28. TOTAL CHARGE \$ 160 00 33. BILLING PROVIDER INF ALWAYS OPEN RH	SPELATED TO CURRENT TO S CHARGES ORIGINAL REF. NO SZ291987987(NUMBER Image: I	00 RENOTER ID. # 1548 1549875 30. BALANCE DUE \$ 160 00 22-3333

LOUISIANA MEDICAID PROGRAM

CHAPTER 40: RURAL HEALTH CLINICSAPPENDIX D: CLAIMS RELATED INFORMATIONPAGE(S) 32

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 <u>required</u> 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:

DXC Technology P. O. Box 91022 Baton Rouge, LA 70821

PAGE(S) 32

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. Situational – Check box marked "EPSDT Title XIX" if patient is Medicaid eligible and under 21 years of age. 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. Claims for payment that are sent to DXC Technology 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 – 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, <u>www.lamedicaid.com</u> (The carrier code list can be found at <u>www.lamedicaid.com</u> under the Forms/Files link) 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. 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	Required Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS.	
15	ID	Do not use the 16-digitCard 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. 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. 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.	
		A service must have been performed/delivered before billing Medicaid for payment.	

06/01/19 07/19/17

CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS RELATED INFORMATION

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. 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. <u>If a tooth number or letter is required by Medicaid, do not</u> <u>enter an oral cavity designator in Block 25.</u>	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: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial, and O = Occlusal Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.	

PAGE(S) 32

06/01/19

07/19/17

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 first 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. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/". In the following circumstances, this information is required: If the claim is for the Adult Denture Program. If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy.	

06/01/19 07/19/17

CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
		Situational – Enter the amount paid by the primary payor if block 9 is completed.	
		Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [\$0] payment) in this block.	
35	Remarks	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).	
		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.	
20	Discuss of Two shounds	Situational – Check the applicable box if services are to be, or were provided, at a location other than the address entered in Block 48.	
38	Place of Treatment	If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is required .	
		Situational – Enter 00 to 99 in applicable boxes.	
39	Number of Enclosures	Claims submitted for prior authorization are required to contain the identified attachments.	
		Claims submitted for payment should not contain any of the attachments listed in Block 39.	
		Situational – Complete if applicable.	
40	Is Treatmentfor Orthodontics?	Claims requesting comprehensive orthodontic services are required to enter information in this block.	
		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	Replacementof 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 8-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. 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	

PAGE(S) 32

Sample of ADA Claim Form

.....

HEADER INFORMATION	DA. Dental Claim Form				_			MSA 07-02	
t. Type of Transaction (Mark		Received.						Attachment 1	
					1.5				
Statement of Actual 5	ininoes-	Divegant	to Predeterminato	overeauthors280c	a				
EPSOT/Title XIX									
2 Predetermination/Presult	olization Num	ber				POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code			
123456789						Policyholdes@ablockber fiam	e (Last, First, Middle Int	sat, Sumo), Address, City, State, J	DØ COØe
INSURANCE COMPANY			INFORMATION	a .	-	Brown, Wade			
3. Company/Plan Name, Add	HERE, City, Stat	le, 2ip Code			1	8269 Chilly Ro	1 C		
						Winter, LA 700	and the second se		
						5 Date of Birth (MM/DD/CCYY)		15. Policyholder/Subscriber ID	
62						08/14/2004	X M D *	123456789012	3
OTHER COVERAGE					,	6. Plan/Group Number	17. Employer Name		
4. Other Dental or Medical C		X No (Chip 5-1	Tand	(Complete 5-11)	_				
5. Name of Policyholdes/Dub	scibe: n#4 ()	Last, First, Middle	e Initial, Suffix)			PATIENT INFORMATION			
						E. Fielationship to Policyholden?		19. Student	
6. Date of Birth (MM/OD/CC			8. Policyholder/Sub	bscriber ID (38N		Sef Spouse	and the second of the second rate was been been been been been been been bee	And and an other statements and an other statements and an other statements and an other statements and an other	PT8
]₩ []F		VI-10152525255	2	0. Name (Last, First, Middle Ind	ial, Suffix), Address, City	Illiste, Zip Code	
9. Plan/Group Number			nship to Person Na						
TPL Carrier C			ipouse 🗌 Dep		ther				
11. Other Insurance Company	y/Dental Bene	fit Plan Nome, Ad	States, CRy, State,	Zip Code					
					2	1. Date of Birth (MMDD/CCYY)	22. Gender	23. Patient ENAccount # (Asse)	phed by Deetler)
2						to a transfer the state that is	L M L F	second second second	22. 1997 Filst
RECORD OF SERVICES	PROVIDER	2							
24. Procedure Date	25 Area 2 cf Oral To Cavity Sys	5 27. To:	oth Number(U)	28,7005	29. Procedure		30 Description		31. Fee
(MMCD/CCYY)	Cavey Sys	den or	Lefter(8)	Surface	Code				
1/14/12					D0999	Encounter -	All Inclusive	9	100 00
1/14/12	10	- Andrew		1	D4341	Periodontal	Scaling and	Root Planing	110:00
1/14/12	- C	13			D2954	Post & Core	1	A CONTRACT DOOL NOT	94:00
 1/14/12 		15			D2931	Stainless Ste	el Crown		140 00
5		10000					Contraction of the second second		10 10 10 10 10 10 10 10 10 10 10 10 10 1
6				1.1					
7									
8									
9									1
10									
MISSING TEETH INFOR	MATION			Permanent		the second second	Pimary	22. Other	
34. (Place on % on each mo	nine to other	1 2 3	4 5 6 7	8 9 10	11 12 13	14 15 16 A B C	0 E F G	H I J Fee(S)	
Own to pack put of the earth rest	and over 1	32 31 30 7	29 28 27 26	25 24 23	22 21 20	19 18 17 T G F	OPON	M L K 33 Total Fee	444 00
and the second sec									
35. Remarks		a la sectore de					and the second second	A DESCRIPTION OF TAXABLE PROPERTY.	
25. Hemans If TPL	nvolve	ed: write	the wor	ds -Car	rier Pai	d" and enter t	he amount	paid by the TPL	. here.
IF TPL					14	d" and enter th			. here.
IF TPL					14			ON	
IF TPL					14	ANCILLARY CLAIM/TREAT	TMENT INFORMATE	ON 30. Number of Enclosure Referentes Dial Inc	
IF TPL					14	ANCILLARY CLAIM/TREAT		ON 30. Number of Enclosure Referentes Dial Inc	
IF TPL I					14	NCILLARY CLAIM/TREAT		ON 35. Number of Enclosure Packapustus Ner	
IF TPL I AUTHORIZATIONS 26.1 have been informed of charges for decisit or order a the breating decisit or order of soch charges. To the entent atternation to carry out page X				be responsible to niess prohibited to s prohibiting all or sure of my profiled	r all 5 by line, or 4 a portion of Ned health 4	M. Place of Treatment Provider's Office Ho D Is Treatment for Orthodoxtoc No (Skip 41-42)	TMENT INFORMATION spital BCF C Or (7 res (Complete 41-42)	Africa Sector Sectors	MMDD/CCYY)
IF TPL AUTHORIZATIONS 36.1 have been intermed of charges for dentation services and the base been interest and the baseling dentation to dentation and the service of the existen- antioentation to carry out payer X Patients/Guardian segnature	the trialbroad p ind materials in practice has a semitted by its wort activities i	clin and association of peed by my de- contractual agree as, I consection with	ord frees. I agree to what benefit plan, u ement with my plan our upe and dioclot in this claim. Ou	be responsible to sees proteiting at o prohibiting at o use of my protect	x all 3 by law, or a portion of Ned beatth 4	ANCILLARY CLAMATREAT IS Place of Treatment Provider's Office Ho Is Treatment for Orthodonece No (Skip 41-42) No (Skip 41-42)	TMENT INFORMATH solute BOF C Or (7 res (Complete 41-42) eplacement of Prosthesi	N 30. Number of Enclosure Redregueter 41. Date Applance Flaced 17. 44. Date Prior Placement d	MMDDCCYT)
IF TPL I AUTHORIZATIONS 26.1 have been informed of charges for decisit or order a the breating decisit or order of soch charges. To the entent atternation to carry out page X	the trialbroad p ind materials in practice has a semitted by its wort activities i	clin and association of peed by my de- contractual agree as, I consection with	ord frees. I agree to what benefit plan, u ement with my plan our upe and dioclot in this claim. Ou	be responsible to sees proteiting at o prohibiting at o use of my protect	y last of all y last of all a portion of selection of sel	ANCILLARY CLAMATREAT IS Place of Treatment Provider's Office Ho Is Treatment for Orthodonece No (Skip 41-42) No (Skip 41-42)	TMENT INFORMATION spital BCF C Or (7 res (Complete 41-42)	N 30. Number of Enclosure Redregueter 41. Date Applance Flaced 17. 44. Date Prior Placement d	MMDDCCYT)
IF TPL I AUTHORIZATIONS 26. I have been informed of charges for details envices a such charges for details envices act of harges for the entered information to carry out page X Tablent//Guardian signature 37. I hereity softwares and dree	the trialbroad p ind materials in practice has a semitted by its wort activities i	clin and association of peed by my de- contractual agree as, I consection with	ord frees. I agree to what benefit plan, u ement with my plan our upe and dioclot in this claim. Ou	be responsible to sees proteiting at o prohibiting at o use of my protect	y last of all y last of all a portion of selection of sel	ANCILLARY CLAIM/TREAT 18. Place of Treatment Provider's Office Ho 10. Its Treatment for Orthodomico No (28xp 41-42) 1 4. Meeths of Treatment 42, n 4. Meeths of Treatment 42, n 5. Treatment Resulting Itom	TMENT INFORMATH spital EOF Or 17 19 19 10 10 10 10 10 10 10 10 10 10	DN 30. Planbor of Enclosure hadrogenetics 41. Date Applance Placed e7. A& Date Price Placement () 41.	
IF TPL I AUTHORIZATIONS 20.1 Ihave been information to the baseting determined of the baseting determined and the baseti	the trialbroad p ind materials in practice has a semitted by its wort activities i	clin and association of peed by my de- contractual agree as, I consection with	ord frees. I agree to what benefit plan, u ement with my plan our upe and dioclot in this claim. Ou	be responsible to mess posibled to probleming at o was of my poster de e, deedly to the be	y lax, or a portion of a doubting a doubting	ANCILLARY CLAMATREAT III Place of Treatment Provider's Office Ho III Treatment for Orthodonoco IIII Treatment for Orthodonoco IIII Treatment 40, Fil Remaining 1 12. Months of Treatment 40, Fil Permaining 1 13. Statement 1 14. Fil	TMENT INFORMATH spital ECF C Or i7 res (Complete 41-42) epiacement of Prosthese No Visi (Complete 4 ny Auto ac	DN 30. Planbor of Enclosure hadrogenetics 41. Date Applance Placed e7. A& Date Price Placement () 41.	
If TPL I AUTHORIZATIONS 20.1 Nave been intermed of Chargen for details letroices a such charges. To the extent attermation to carry out pays and the subsection to carry out pays and the subsection of the Automation of the subsection of the details of detail with X Subsections and subsections.	the trialment (and materials of practice has a periodice has a sent activities of sent activities of t payment of the	olan and association of pany de contractual agree res. I consent to yr re connection with e dental terrefits de	ted fees. I agree to stal benefit pan. J event at the panel and disclose to the claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	x all y lax, or a poston of 4 iow named 4 iow named 4	ANCILLARY CLAIM/TREAT II. Place of Treatment Provider's Office Ho II. Treatment for Orthodoxido II. Treatment for Orthodoxido II. Treatment Fireuting from Compational Breating II. Date of Accident BMM/CO/CO	TMENT INFORMATH spital ECF C Of 17 17 19 19 19 19 19 19 19 19 19 19	ON 39 Number of Encionars 19 Number of Encionars Performance Placed 41. Date Applance Placed 10. Date Prior Placement # 10. Date Prior Placement # 10. Date Prior Placement # 10. Date Placemen	
IF TPL I AUTHORIZATIONS 20.1 Ihave been information to the baseting determined of the baseting determined and the baseti	The bi-altment p and mathemats or practice has a permitted by its watt activities of the payment of the DENTAL EN	olan and association of part by my de contractual Agree my L contractual Agree my L contractual Agree my contractual Agree to contractual Agree to contractual Agree to a contractual Agree to	ted fees. I agree to stal benefit pan. J event at the panel and disclose to the claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	r all 5 y last or a portion of led health 4 row named 4 rowiting 1	ANCILLARY CLAIM/TREAM IProvider's Office Ho Provider's Office Ho No (Bag 41-42) No No (Bag 41-42) No No (Bag 41-42) No No S. Treatment Firesulting from Cocupational Bitestinipu Cocupational BitMCCOCC TREATING DENTIST AND CONTINUE (CONTINUE) Continue (Continue) No No	TMENT INFORMATI space ECF C OR 17 19 19 10 19 10 19 19 19 19 19 10 19 10 10 10 10 10 10 10 10 10 10	ON 30 Transbur of Eindonser wedgesets 41. Date Applance Placed 42. Auto Accident Constrained of the Con	
If TPL I AUTHORIZATIONS 20.1 Issue beam distanced of the baseling destination of the such obagies. To the enset authoritized to carry out page 20.1 Protect Subdition to carry out page 20.1 Protect Subdition to and deer destinat or defailer entity. 21.2 Battorother tognithers Bibliolog DENTIST OR C cam on behalt of the page	The bi-admont p and materials a permitted by is watt activities a t payment of the DENTAL EN or IndunidStud	olan and association of part by my de contractual Agree my L contractual Agree my L contractual Agree my contractual Agree to contractual Agree to contractual Agree to a contractual Agree to	ted fees. I agree to stal benefit pan. J event at the panel and disclose to the claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	r all 5 y last or a portion of led health 4 row named 4 rowiting 1	ANCILLARY CLAIM/TREAM IProvider's Office Ho Provider's Office Ho No (Bag 41-42) No No (Bag 41-42) No No (Bag 41-42) No No S. Treatment Firesulting from Cocupational Bitestinipu Cocupational BitMCCOCC TREATING DENTIST AND CONTINUE (CONTINUE) Continue (Continue) No No	TMENT INFORMATI space ECF C OR 17 19 19 10 19 10 19 19 19 19 19 10 19 10 10 10 10 10 10 10 10 10 10	ON 39 Number of Encionars 19 Number of Encionars Performance Placed 41. Date Applance Placed 10. Date Prior Placement # 10. Date Prior Placement # 10. Date Prior Placement # 10. Date Placemen	
If TPL I AUTHORIZATIONS 20.1 Name bean intermed of chapter by details terrorized such charges. To the extent intermation to carry out pays and charges. To the extent intermation to carry out pays and charges. To the extent intermation to carry out pays and the extent of the extent of the extent of the extent and the extent of the extent of the extent and the extent of the extent of the patient 48. Name, Address, City, the	he beetweet p nd materials n periodice has a periodice has a periodice has a periodical basis to periodical basis to periodical basis or instantiation to instantiation to instantiation	olan and association of part by my de contractual Agree my L contractual Agree my L contractual Agree my contractual Agree to contractual Agree to contractual Agree to a contractual Agree to	ted fees. I agree to stal benefit pan. J event at the panel and disclose to the claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	r all 5 y last or a portion of led health 4 row named 4 rowiting 1	ANCILLARY CLAIM/TREAM IProvider's Office Ho Provider's Office Ho No (Bag 41-42) No No (Bag 41-42) No No (Bag 41-42) No No S. Treatment Firesulting from Cocupational Bitestinipu Cocupational BitMCCOCC TREATING DENTIST AND CONTINUE (CONTINUE) Continue (Continue) No No	TIMENT INFORMATH solution of EOF Con- tor re- re- re- re- re- re- re- re	ON 30 Transbur of Eindonser wedgesets 41. Date Applance Placed 42. Auto Accident Constrained of the Con	
If TPL I AUTHORIZATIONS D5.1 in Name Dean instrumed of chargen by details instructed as sach charges, To the extent automation to carry out pays X Patients/Guardian signature X Automation to detail write X Automation to detail write X BILLING DENTIST OR I Cam on outhait of the patient 48. Taime, Address, City, Sin XYZ Dential O	The bisistment p and materials in periodice has a second by a periodice has a periodice has a periodic by a period	Clan and intercent of period by in per- oder the period of the period of the period of the period in connection with in connection with in connect	ted fees. I agree to stal benefit pan. J event at the panel and disclose to the claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	r all 3 y last or 4 a portion of 4 a conditing 4 a conditing 7 y	ANCILLARY CLAIM/TREAM IN Place of Treatment Provider's Cfiloe Ho (See 14-20) In Treatment for Orthodoxido In Treatment for Orthodoxido In Treatment For Units (See 14-20) In Treatment (See 14-20) In Tr	TIMENT INFORMATH solution of EOF Con- tor re- re- re- re- re- re- re- re	ON	
If TPL I AUTHORIZATIONS D5.1 in Name Down instrumed of chargen to develop there were such charges. To the evident instrumention to carry out pays X Patients/Councilian signature X Datascription of the patient X Datascription of the patient BILLING DENTIST OR Came on contait of the patient 48. Taime, Address, City, Site XYZ Dental C 89566 No Cav	The Instituted for institution of the Institution products has a periodic to be a next activities in the Institution of the DENTAL EN or institution to a provide the Sroup ity Ave	Clan and intercent of period by in per- oder the period of the period of the period of the period in connection with in connection with in connect	ted fees. I agree to stal benefit pan. y arrent with my pa our use and disclor to this claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	A data of a second	ANCILLARY CLAMMTREAM M. Place of Treatment Providents Office Houses In treatment for Othoosnoto In treatment for Othoosnoto In to Espational Metal Streatment Resulting from Compational Resulting M. Dear of Acceler MMACOCO FREATING DENTIST AND S. Include Scotler Information Compational Resulting M. Dear of Acceler Information Compational Resulting Dear Macrog Color Espect (Treating Contest)	TMENT INFORMATH spital ECF Core 17 19 19 19 19 19 19 19 19 19 19	ON 39 Fumber of Enclosure ber 41. Date Applance Placed 41. Date Applance Placed 43. Codest Codes	
If TPL I AUTHORIZATIONS D5.1 in Name Dean instrumed of chargen by details instructed as sach charges, To the extent automation to carry out pays X Patients/Guardian signature X Automation to detail write X Automation to detail write X BILLING DENTIST OR I Cam on outhait of the patient 48. Taime, Address, City, Sin XYZ Dential O	The Instituted for institution of the Institution products has a periodic to be a next activities in the Institution of the DENTAL EN or institution to a provide the Sroup ity Ave	Clan and intercent of period by in per- oder the period of the period of the period of the period in connection with in connection with in connect	ted fees. I agree to stal benefit pan. y arrent with my pa our use and disclor to this claim. Dr henere physice to m Dr	be responsible to resea protected profibilities all o uses of my protec- de e, descilly to the be one	y all y lan, or 3 (4) (4) (4) (4) (4) (4) (4) (4) (4) (4)	INCILLARY CLAMMTREAM IPiace of Treatment Providen's Office IPioviden's Office IPioviden's Office IN: Intreatment for Othodoreco IN: Intreatment for Othodoreco IN: Intreatment for Othodoreco IN: International International IN: International International IN: Othodorecon InterConcent InterConcent IN: Othodorecon International IN: Othodorecon II: Othod	TMENT INFORMATH spatial ECF Con 17 19 19 19 19 19 19 19 19 19 19	ON 39 Fumber of Enclosure her 41. Date Applance Placed 43. codest	
If TPL I AUTHORIZATIONS D5.15 how been informed of the thermal delement of the	the bieldweet of practice has a practice has a practice has a event activities i to payment of the pental even of the p	Nan and anoccus or past by my do contractual age in connection with is connection with is connection with is connection with the dental terrefits of the dental terrefits of	ted fees 1 agree to wat benefit plan, u ement with try plan disc our use and disc to use and disc benefit plan to the feestion of the benefit plan to the Data for the dist for the dist fo	be responsible to the probability at our probability of the best our probability to the best our probability to the best our probability to not set ou	y all y lan, or 3 (4) (4) (4) (4) (4) (4) (4) (4) (4) (4)	ANCILLARY CLAMMTREAM M. Place of Treatment Providents Office Houses In treatment for Othoosnoto In treatment for Othoosnoto In to Espational Metal Streatment Resulting from Compational Resulting M. Dear of Acceler MMACOCO FREATING DENTIST AND S. Include Scotler Information Compational Resulting M. Dear of Acceler Information Compational Resulting Dear Macrog Color Espect (Treating Contest)	TMENT INFORMATH spatial ECF Con 17 19 19 19 19 19 19 19 19 19 19	ON 39 Fumber of Enclosure ber 41. Date Applance Placed 41. Date Applance Placed 43. Codest Codes	
If TPL I AUTHORIZATIONS 20. I have been information to Compare to detail terretives a such charges to detail terretives a such charges. To the evident automation to carry out page X Pathent/Couldition tagnature X Dataset a submitted and one detail of detail rently X Dataset a submitted and one cam on obtail of the pathent 48. Taime, Addives, City, the XYZ Dental C 8956 No Cav Smiley, LA 70 20, NP1	the bieldweet of practice has a practice has a practice has a event activities i to payment of the pental even of the p	Clan and intercent of period by in per- oder the period of the period of the period of the period in connection with in connection with in connect	ted fees. I agree to stal benefit pan. y arrent with my pa our use and disclor to this claim. Dr henere physice to m Dr	be responsible to the probability at our probability of the best our probability to the best our probability to the best our probability to not set ou	y all y lan, or 3 (4) (4) (4) (4) (4) (4) (4) (4) (4) (4)	INCILLARY CLAMMTREAM IPiace of Treatment Providen's Office IPioviden's Office IPioviden's Office IN: Intreatment for Othodoreco IN: Intreatment for Othodoreco IN: Intreatment for Othodoreco IN: International International IN: International International IN: Othodorecon InterConcent InterConcent IN: Othodorecon International IN: Othodorecon II: Othod	TMENT INFORMATH spatial ECF Con 17 19 19 19 19 19 19 19 19 19 19	ON 39 Fumber of Enclosure ber 41. Date Applance Placed 41. Date Applance Placed 43. Codest Codes	
If TPL I AUTHORIZATIONS D5.15 how been informed of the thermal delement of the	the bestmed of the transmission of the transmi	Alen and issociation of part by my de- contractual ages in connection with e dental tarvetts of TTTY (Leave bia biolitier)	ted fees 1 agree to wat benefit plan, u ement with try plan disc our use and disc to use and disc benefit plan to the feestion of the benefit plan to the Data for the dist for the dist fo	be respectible to probabiling at or probabiling at or probabiling at or probabiling at or probabiling at or probabiling at or or to a, descripted the be- to to to to to to to to to to to to to	ri all villa con a porten of a porten of a porten of 4 porten of 4 porten of 4 conting 5 con	INCILLARY CLAMMTREAM IPiace of Treatment Providen's Office IPioviden's Office IPioviden's Office IN: Intreatment for Othodoreco IN: Intreatment for Othodoreco IN: Intreatment for Othodoreco IN: International International IN: International International IN: Othodorecon InterConcent InterConcent IN: Othodorecon International IN: Othodorecon II: Othod	TMENT INFORMATH spital ECF Con 27 1745 (Complete 41-42) 1745 (Complete 41-42) 1745 (Complete 41 179 Auto ac 179 TREATMENT LOCA Units as indicated by date 179 Constends 18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ON 39 Fumber of Enclosure ber 41. Date Applance Placed 41. Date Applance Placed 43. Codest Codes	

J400 (Same ap ADA Dental Claim Form - J401, J402, J403, J404)

LOUISIANA MEDICAID PROGRAM

CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS RELATED INFORMATION

PAGE(S) 32

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 <u>www.lamedicaid.com</u>. Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

PAGE(S) 32

Instructions for Completing 209 Adjustment/Void Form (EPSDT)

Locator #	Description	Instructions	Alerts
1	Adj/Void	Check the appropriate box.	
2 3 4	Patient's Last Name, First Name, MI	Adjust - Enter the information exactly as it appeared on the original invoice. 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. 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. 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. 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. 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. 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. 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. 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. Void - Enter the information exactly as it appeared on the original invoice.	

PAGE(S) 32

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. 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. 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). 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	Requestfor 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 DXC Technology 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.

PAGE(S) 32

Sample of 209 Adjustment/Void Form (EPSDT)

					Patie	nt ID/Account Number]		
0E PEEAL/THOREZATION POS PAYMENT MI SOCIO POS PAYMENT RAME TO: MI SOCIO POS PAYMENT Molina Mic-loi MI SOCIO POS PAYMENT Molina Mic-loi MI SOCIO POS PAYMENT Molina Mic-loi MIR ADDRA ARM, DOS 110 Molina Mic-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 Molina Mic-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 Molina Mic-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 MOLINA MIC-loi Molina Mic-loi MIR ADDRA ARM, DOS 110 <th></th> <th>DEP</th> <th>BUREAU OF MEDIC/ PR</th> <th>TE OF LOUISIANA OF HEALTH AND HOSP HEALTH SERVICES FROMON LASSISTANCE PROGRAM OVIDER BILING FOR SOT DENITAL SERVICES</th> <th>6</th> <th>SAI</th> <th></th> <th>LE</th> <th>=</th>		DEP	BUREAU OF MEDIC/ PR	TE OF LOUISIANA OF HEALTH AND HOSP HEALTH SERVICES FROMON LASSISTANCE PROGRAM OVIDER BILING FOR SOT DENITAL SERVICES	6	SAI		LE	=
		3 745	NAM		8-	FOR OFFICE USE OF			_
Smith		_	ally		L	1 2 3 4		0 1	2 3
NATION'S ADDRESS (2110) NUMBER, CITY, STATE, 29	CODE (RL HO)					02 15	2002		۲.
REPERING AGENCY NO.	OF REFERENCE	-	EMER	SENC NAME	GROUP REPENSES		_		
	NONE NO.	-		ADOR	ESS			_	_
INFID DEVISITOR GROUP				TEL. N		ANT FRAME PROCESSOR		_	_
in any				1800000		VES NO		_	_
ADDRESS		-		A. EMPLOYMENT	VES NO	THE CAMPER-CODE	Base Higher		
CITY ST		28		B. ACCIDENT/INJURY		1			_
			Y SERVICE.		LINO	2			_
	CHECK BLO	CK AND S	END TO OFS	DENTAL PROGRAM		3			_
	TOOPH	ATION	AND TREATA	AENT PLAN - UST IN ORDER FR	OM TOOTH N	O. 1 THRU NO. 32 - USE	the first of the second s	SHOWN, G	
ACAL ACAL	1000H #OR 147788	EARAGE	ROCEDURE	DESCRIPTION OF SERV	ACI.	UNITS MO, DAY		CUEIOM	AND ART FEE
6 6990	16		D2931	Stainless Steel (Crown	02[16]	12	135	00
As General Charles					-		100	12.50	1
9°0 - 0°2			er .	01		0	YABLE BY	s	
BOTHLE REPORT				L THE S N	CHUNCING ON CONNECT CONT ON THE REALTS	ICE NUMBER AS	OF BUILDING ADVICE T	wi	
 	2061	11987	65400	ADVINIS	ANCALMED (03	/16/2012		_
FACIAL A INK IN RESIDENTIONS B INCOME IN A INCOME FACIAL A INK IN RESIDENTIONS B INCOME IN A INCOME INTERNAL C INCOME IN AN INTERNAL AN O.	REAS	01 19 02 M 03 M 90 S	ROVIDER CON	ABUTY RECOVERY RECTIONS ERROR USE ONLY - RECOVERY		illed wrong to tooth #16, no		d	
D. INDICATE TEETH TO BE EXTRACTED WITH-/.	REAS	ONS FOR	VOID						_
NEWARD FOR CHURCH, BEINCE		11 0.		R WIIONG RECIPIENT WRONG PROVIDER ERRAIN					
HAM READ THE CERTIFICATION ON THE R HOURS FOR ADMONIATION - SING TO ON DOM ADMONG ODVIDES SIGNA	AL FROGRAM	FORM AP	APPR	OVED - YES NO	NEW	s 🗌 🏝 🤅	in Smiley, DD, xmisers conters	NO-LANGE	
				123456780		1888	888 1	1/05/20	12
RONDR HUMBLE		840	AUTONIZI	CONTRACTOR .		DAX	HOVER NEW		-

PAGE(S) 32

Instructions for Completing 210 Adjustment/Void Form (Adult)

Locator #	Description	Instructions	Alerts
1	Adj/Void	Check the appropriate box.	
2 3 4	Patient's Last Name First Name MI	Adjust - Enter the information exactly as it appeared on the original invoice. 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. 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. 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. 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. 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. 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. 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. 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. Void - Enter the information exactly as it appeared on the original invoice.	

PAGE(S) 32

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. 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. 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). 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	Requestfor 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.

PAGE(S) 32

Sample of 210 Adjustment/Void Form (Adult)

R PREAUTHORIZATION FOR PAYMENT ALTO: REMIT TO					Patient ID/Account Number			
CODDL OF CONTENTING Modiana Minedica DOUD DOTTL: PROGRAM P.D. DOD 1992 PUDDED.MIC, DOTTL: PROGRAM P.D. DOD 1992 ADJ VOID ADJ VOID	aid Solutions DEP 7081	ARTMENT OF H MEDICAL PRO	TE OF LOUISIAI OF HEALTH ANI EALTH SERVICES ASSISTANCE PR VIDER BILLING PA T DENTAL SERVI	D HOSPITALS S FINANCING OGRAM OR	S/	AMF	LE	
PATIENT'S LAST NAME (PRINT)	3 8	RSTNAME		0		ASSISTANCE LD. NUMBER		
Que	S	usie	/			3 4 5 6 7 8	19 0 1 2	
PATIENT'S ADDRESS (STREET NUMBER, CI	ITY, STATE, 2P CODE) (TEL	NO.)	/		06 19			
REFERRING AGENCY NO.	DATE OF REFERINAL	-	/	12 DENTIST OR GR	OUP REFERENCE TO	1000		
REFERRED BY: (SIGNATURE)	TELEPHONE NO.	15 ACESC	ACCOUNT & ADDRESS OF THE	ADORESS	_			
PAY TO DENTIST OR GROUP				TEL. NO.		NS ENCLOSED?		
PAY TO DENTIST OR GROUP			1800000	T DA GROUP PROVIDE	Y	IS NO		
			THE TREATMENT NE	CESSITATED BY	PAYMEN	OF X-PAYE F SOURCE OTHER THAN TITL	E XIX	
DORESS			A. EMPLOYME			ANER CODE:		
ITY \$1	T ZP _		A DIFLOTING					
# PROSTHESIS, IS THIS			B. ACCIDENT/INJURY		YES 2	2		
THE INITIAL PLACEMENT?	YES	NO	a. mountain		NO 3			
	A PROCEDURE	8.	DESCRIPTION	OF SERVICE	C-DATE SE PERFO	RVICE D. ADJUSTED FEE	E USUAL AND CUSTOMARY FE	
INCOM.	D0999	Encour	nter All Inclu	isive	01 20	1 internet	125 0	
de d	F. ORAL CAVITY	1		0. TOOTH		PAD OR PAYABLE BY OTHER CARRIE	s	
	COMMENTS .					R LOW		
MON.	(2) NAME AND		OF DENTIST	LAST DENTURE MAD			and a start of the second s	
INDICATE TEETH TO BE EXTRACTED WITH A/.	(2) NAME AND		OF DENTIST	LAST DENTURE MAD		YES 🗋	Parks.	
	(2) NAME AND	J EVER RECE	OF DENTIST		AID PROGRAM?	VES -	NO 🗆	
EXTRACTED WITH A/.	(2) NAME AND (3) HAVE YOU CONTROL NUM 2 131198765	JEVER RECE WEER 5400 R ADJUSTME		UNDER THE MEDICA THE IS FOR CHANGIN IT ALL IN COMPANY AND A COMPANY IN COMPANY AND A COMPANY ALL INFO PEOLIPPED.)	ALD PROGRAM?	611 Canadiana 05/18/12	NO 🗆	
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X.	(2) NAME AND (3) HAVE YOU CONTROL NUM 2131198761 REASONS FOR 01 THM	JEVER RECE WBER 5400 R ADJUSTIME RD PARTY LM	OF DENTIST EVED A DENTURE	UNDER THE MEDICA THE IS FOR CHANGIN IT ALL IN COMPANY AND A COMPANY IN COMPANY AND A COMPANY ALL INFO PEOLIPPED.)	AID PROGRAMT	05/18/12		
EXTRACTED WITH AJ.	(2) NAME AND (3) HAVE YOU 2 CONTROL NUM 2 131198761 REASONS FOR 01 THE X 02 PRO	U EVER RECE WEER 5400 R ADJUSTME RD PARTY LM SWIDER CORP	OF DENTIST EVED A DENTURE	UNDER THE MEDICA THE IS FOR CHANGIN IT ALL IN COMPANY AND A COMPANY IN COMPANY AND A COMPANY ALL INFO PEOLIPPED.)	AID PROGRAMT	611 Canadiana 05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND	(2) NAME AND (3) HAVE YOU 2131198763 (3) REASONS FOR (3) REASO	U EVER RECE VIBER 5400 R ADJUSTME RD PARTY LIV SVIDER CORF CAL AGENT E ITE OFFICE U	DF DENTIST EIVED A DENTURE	UNDER THE MEDICI THE IS FOR CHARGE INTER IN CONSTOL	AID PROGRAMT	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED	(2) NAME AND (3) HAVE YOU 2131198763 (3) REASONS FOR (3) REASO	J EVER RECE VIBER 5400 R ADJUSTME RD PARTY LIA SVIDER CORF CAL AGENT E	DF DENTIST EIVED A DENTURE	UNDER THE MEDICI THE IS FOR CHARGE INTER IN CONSTOL	AD PROGRAM?	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND	(2) NAME AND (3) HAVE YOU 2131198763 CONTROL NUM 2131198763 FREASONS FOO 01 THE X 02 FIRC 03 FISC 90 STA 96 OTH	JEVER RECE WIBER 5400 R ADJUSTME RD PARTY LIX SVIDER CORP CAL AGENT E LITE OFFICE U WER - PLEASE	DF DENTIST EIVED A DENTURE	UNDER THE MEDICI THE IS FOR CHARGE INTER IN CONSTOL	AD PROGRAM?	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND	(2) NAME AND (3) HAVE YOU 2131198761 CONTROL NUM 2131198761 CONTROL NUM 2131198761 CONTROL NUM 2131198761 CONTROL NUM 2131198761 CONTROL NUM 2131198761 CONTROL NUM	JEVER RECE WEER 5400 R ADJUSTME RD PARTY LM SWIDER CORF CAL AGENT E LTE OFFICE U WER - PLEASE R VOID	ENT STORES STATE STA	UNDER THE MEDICI Ties a ron-owner Trease of the real activity feasiver) Y	AD PROGRAM?	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND	2) NAME AND (3) HAVE YOU 2 131198764 1 REASONS FOR 0 9 FIG 0 10 CLA	J EVER RECE WEER 5400 A ADJUSTME TA ADJUSTME A ADJUSTME CAL AGENT E TTE OFFICE U VER - PLEASE R VOID MM PAID FOR	DE DENTIST INED A DENTURE NIT ABLITY RECOVER RECTIONS IRIOR IE ONLY - RECOV IE ORLY - RECOV IE ORLAN	UNDER THE MEDIC This is pronounced This is from owned the observer a source from the feature a so	AD PROGRAM?	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND	2) NAME AND (3) HAVE YOU 2131198761 PREASONS FOR 03 FISC 05 FISC 05 FISC 05 FISC 05 FISC 05 FISC 10 CLA 11 CLA	JEVER RECE VIBER 5400 R ADJUSTME FOR ADJUSTME CAL AGENT E TTE OFFICE U VIDER CORF CAL AGENT E TTE OFFICE U VIDER CORF CAL AGENT E TTE OFFICE U VIDER CORF AUTO DUAL PAD FOR VIDER CORF AUTO DUAL FOR VIDER CORF AUTO VIDER CORF AUTO DUAL FOR VIDER CORF AUTO DUAL FOR VIDER CORF AUTO CORF AU	PEDENTIST INED A DENTURE INIT ABILITY RECOVER RECTIONS IRIORI IE SPLAIN IE SPLAIN	UNDER THE MEDIC This is pronounced This is from owned the observer a source from the feature a so	AD PROGRAM?	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND	2) NAME AND (3) HAVE YOU 2131198761 PREASONS FOR 03 FISC 05 FISC 05 FISC 05 FISC 05 FISC 05 FISC 10 CLA 11 CLA	J EVER RECE WEER 5400 A ADJUSTME TA ADJUSTME A ADJUSTME CAL AGENT E TTE OFFICE U VER - PLEASE R VOID MM PAID FOR	PEDENTIST INED A DENTURE INIT ABILITY RECOVER RECTIONS IRIORI IE SPLAIN IE SPLAIN	UNDER THE MEDIC This is pronounced This is from owned the observer a source from the feature a so	AD PROGRAM?	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE CONSTRUCTED TEETH TO BE CLASPED.	(2) NAME AND (3) HAVE YOU 2131198761 ECONTROL NUM 2131198761 EFEASONS FOR 03 FISC 90 STA 99 OTH 10 CLA 11 CLA 99 OTH	U EVER RECE MINER 5400 R ADJUSTME RD PARTY LM VIDER CORF CAL AGENT E TTE OFFICE U MER - PLEASE R VOID R VOID PARD POR M PAID TO V KER - PLEASE	OF DENTIST INED A DENTURE ADDITION NELLTY RECOVER RECTIONS ISROR SE ONLY - RECOVER RECTIONS ISROR RECOVER INFORMATION RECOVER	UNDER THE MEDICI Tests s ponowene testown of the common activity features activity f	AID PROGRAM CONVOCING A MAC CONVOCING A MAC CONVOCING A CONVOCING Billed wrong Initially bille \$125.00	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE COSTRUCTED TO BE COSTRUCTED TO BE CLASPED. TEETH TO BE CLASPED.	2) NAME AND (3) HAVE YOU 2 131198764 01 THE 02 FPG 03 FPG 03 FPG 03 FPG 04 THE 04 THE 05 FPG 05 FPG	J EVER RECE NIBER 5400 R ADJUSTME D PARTY LU VIDER CORJ VIDER CORJ VIDER CORJ AL AGENT E TTE OFFICE U WER - PLEASE R VOID IM PAID FOR MM PAID TO V KER - PLEASE NO DO HEREP	OF DENTIST INED A DENTURE INIT ABLITY RECOVER ABLITY RECOVER SE ONLY - RECOV ISE ONLY - RECOVER SE ONLY - RECOVER ISE ONLY - RE	UNDER THE MEDIC This is pronounced This is pronounced the operator assessments assessments reaction reaction reaction the composition assessments reaction the reaction the	AID PROGRAM CONVOCING A MAC CONVOCING A MAC CONVOCING A CONVOCING Billed wrong Initially bille \$125.00	05/18/12		
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE OBNICATING TO BE DENTURE TO BE CLASPED.	2) NAME AND (3) HAVE YOU 2 131198764 01 THE 02 FPG 03 FPG 03 FPG 03 FPG 04 THE 04 THE 05 FPG 05 FPG	U EVER RECE MISER 5400 R ADJUSTME R ADJUSTME R ADJUSTME R ADJUSTME MID PARTY LM SVIDER CORF A VOID MID PARTY LM PARTY LM R ADJUSTME R ADJ	PEDENTIST INED A DENTURE INIT BISLITY RECOVER RECTIONS IRIORI IE XPLAIN WRONG RECIPIE WRONG PROVIDEN IE XPLAIN INIT VERTIFY THAT I AN TOKAN DIRACTORY	UNDER THE MEDICI THE IS FOR OWNER THE IS FOR OWNER THE OWNER A MARS REAL HED A MARS REAL HED A MARS REAL HED A FERY - THE COMPLANCE THESE ON ETAIL (SEE ONLY)	AID PROGRAMT	Charge amount d \$12.50 instead	NO C	
EXTRACTED WITH A/. INDICATE MIBSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE CONSTRUCTED INDICATING TEETH TO BE CONSTRUCTED INDICATING TEETH TO BE CLASPED.	(2) NAME AND (3) HAVE YOU (3) HAVE YOU (3) HAVE YOU (3) THE (3) THE ADONS FOR (4) THE (5) OS FISS (5)	J EVER RECE NIBER 5400 R ADJUSTME D PARTY LU VIDER CORJ VIDER CORJ VIDER CORJ AL AGENT E TTE OFFICE U WER - PLEASE R VOID IM PAID FOR MM PAID TO V KER - PLEASE NO DO HEREP	PEDENTIST INED A DENTURE INIT BISLITY RECOVER RECTIONS IRIORI IE XPLAIN WRONG RECIPIE WRONG PROVIDEN IE XPLAIN INIT VERTIFY THAT I AN TOKAN DIRACTORY	UNDER THE MEDICI THE IS FOR OWNER THE IS FOR OWNER THE OWNER A MARS REAL HED A MARS REAL HED A MARS REAL HED A FERY - THE COMPLANCE THESE ON ETAIL (SEE ONLY)	AID PROGRAM CONVOCING A MAC CONVOCING A MAC CONVOCING A CONVOCING Billed wrong Initially bille \$125.00	Charge amount d \$12.50 instead	NO C	
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESIGN OF PARTIAL DENTURE TO BE COSTRUCTED TO BE COSTRUCTED TO BE CLASPED. TEETH TO BE CLASPED.	(2) NAME AND (3) HAVE YOU (3) HAVE YOU (3) HAVE YOU (3) THE (3) THE ADDRS FOR (4) THE (5) OS FISS (5)	U EVER RECE MISER 5400 R ADJUSTME R ADJUSTME R ADJUSTME R ADJUSTME MID PARTY LM SVIDER CORF A VOID MID PARTY LM PARTY LM R ADJUSTME R ADJ	PEDENTIST INED A DENTURE INIT BISLITY RECOVER RECTIONS IRIORI IE XPLAIN WRONG RECIPIE WRONG PROVIDEN IE XPLAIN INIT VERTIFY THAT I AN TOKAN DIRACTORY	UNDER THE MEDICI THE IS FOR OWNER THE IS FOR OWNER THE OWNER A MARS REAL HED A MARS REAL HED A MARS REAL HED A FERY - THE COMPLANCE THESE ON ETAIL (SEE ONLY)	AID PROGRAMT	Charge amount d \$12.50 instead	NO -	
EXTRACTED WITH A/. INDICATE MISSING TEETH WITH AN X. SKETCH IN DESION OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE CONSTRUCTED INDICATING TEETH TO BE CONSTRUCTED INDICATING TEETH TO BE CLASPED.	(2) NAME AND (3) HAVE YOU (3) HAVE YOU (3) HAVE YOU (3) THE (3) THE ADDRS FOR (4) THE (5) OS FISS (5)	U EVER RECE MISER 5400 R ADJUSTME R ADJUSTME R ADJUSTME R ADJUSTME MID PARTY LM SVIDER CORF A VOID MID PARTY LM PARTY LM R ADJUSTME R ADJ	PEDENTIST INED A DENTURE INIT BISLITY RECOVER RECTIONS IRIORI IE XPLAIN WRONG RECIPIE WRONG PROVIDEN IE XPLAIN INIT VERTIFY THAT I AN TOKAN DIRACTORY	UNDER THE MEDICI THE IS FOR OWNER THE IS FOR OWNER THE OWNER A MARS REAL HED A MARS REAL HED A MARS REAL HED A FERY - THE COMPLANCE THESE ON ETAIL (SEE ONLY)	AID PROGRAMT	Charge amount d\$12.50 instead d\$12.50 instead		